

BRAZOS VALLEY FOOT CARE, PA
PATIENT INFORMATION SHEET

FIRST NAME: _____ MIDDLE INITIAL: _____ LAST NAME: _____

BIRTHDATE: _____ SSN: _____ - _____ - _____ E-MAIL: _____

BILLING ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

MARITAL STATUS: Single Married Divorced Separated Widowed Life Partner

STUDENT STATUS: Full-Time Part-Time Not a Student

EMPLOYMENT STATUS: Full-Time Part-Time Not Employed

EMERGENCY CONTACT: _____ PHONE #: _____ RELATION: _____

LEGAL REPRESENTATIVE/RESPONSIBLE PARTY: Who financially responsible for bill, if other than patient?

NAME: _____ BIRTHDATE: _____ PHONE NO: _____

BILLING ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE: _____ POLICY NO: _____ GROUP NO: _____

SECONDARY INSURANCE: _____ POLICY NO: _____ GROUP NO: _____

Height: _____ Weight: _____ Shoe Size: _____ Shoe Width: _____

REASON FOR VISIT: _____

Do you have FOOT PAIN? Yes No If yes: Rate pain on scale of **1-10**: No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

List all ALLERGIES to Medications: _____

List all current MEDICATIONS & VITAMINS (Include dosage, frequency & route of administration): _____

List all current MEDICAL PROBLEMS: _____

List all SURGERIES in the last year: _____

PREFERRED PHARMACY: _____ STREET/CITY: _____

PRIMARY CARE PHYSICIAN: _____ CITY: _____ DATE LAST SEEN: _____

Are you DIABETIC? Yes No If yes: DIABETIC PHYSICIAN: _____ DATE LAST SEEN: _____

IF YOU ARE 65 YEARS OR OLDER, PLEASE ANSWER THE BELOW QUESTIONS BELOW:

Have you fallen in the past 12 months? Yes No If yes: How many falls? _____ Injured due to fall? Yes No

Any changes, issues and/or complications with vision? Yes No

Any problems with heart rate and/or heart rhythm? Yes No

Any problems with incontinence? Yes No

FINANCIAL POLICY FOR BRAZOS VALLEY FOOT CARE, PA

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. All insurance information must be provided to our office at the time of service.

MEDICARE: We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However, that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any copayments, which are usually 20% for the allowed amount for an item or service

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if applicable) after payment and/or explanation of benefits (EOB) is received from your primary insurance company. If payment is not received from your secondary insurance within 45 days the balance becomes your responsibility.

COINSURANCES/COPAYMENTS AND DEDUCTIBLES: All coinsurances, copayments and deductibles must be paid at the time of services. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments or deductibles from patients can be considered fraud. Please help us in upholding the law by paying your copayment at each visit.

SELF PAY: Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES: Please be aware that some of the services that you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment of these services.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of this visit. If you do not have a referral from your primary care physician at the time of a visit, you will be financially responsible for all services received due in full upon completion of the visit. Full credit will be given if a referral is presented to our office within 48 hours of this visit. You will also be given the option to reschedule your appointment

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

PATIENT BILLING: You will be sent up to three (3) notices/statements of your financial responsibility (copay/coinsurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account may be forwarded to collections. Please let the office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check or Visa/MasterCard. An additional \$25.00 will be added to your statement if the check is returned for insufficient funds. In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance.

I have read the above policy regarding my financial responsibility to Brazos Valley Foot Care, PA for medical services provided. I agree to pay Brazos Valley Foot Care, PA any balance unpaid by my insurance carrier for myself or the below named person.

PRIVACY STATEMENT: Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

Assignment of Benefits

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Brazos Valley Foot Care, PA all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, copayments, coinsurances and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested by physicians to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance.

PRINT Patient Name: _____ Signature: _____

FINANCIALLY RESPONSIBLE PARTY (If not the patient)

PRINT Name: _____ Signature: _____

Relationship to Patient: _____ Date: _____

BRAZOS VALLEY FOOT CARE, P.A.
MEDICAL RECORDS REQUEST/RELEASE

Patient Information (Please Print):

Name: _____ Date of Birth: ____ / ____ / ____
Address: _____ City: _____ State: _____ Zip: _____
Phone No: _____

I give authorization to the current custodians of _____ to disclose or release the following medical records.

- | | |
|--|--|
| <input type="checkbox"/> Pathology & lab records | <input type="checkbox"/> Billing records |
| <input type="checkbox"/> Radiology/x-ray records | <input type="checkbox"/> Last dilated retinal eye exam |
| <input type="checkbox"/> Prescription | <input type="checkbox"/> Other (give description) |
| <input type="checkbox"/> Medication records | _____ |

The above records are for services provided on date(s) of service _____

The above listed records should be released to the following listed person(s)

Name: _____ Facility: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Telephone No: _____ Fax No: _____

Name: _____ Facility: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Telephone No: _____ Fax No: _____

The information released may only be used for the purposes listed below.

- For medical reasons Insurance purposes Employment purposes

This authorization shall expire on ____ / ____ / ____.

I understand that this authorization is voluntary and it gives the authorized persons permission to release records as stated.

Patient Signature: _____ Date: _____
Legal Representative: _____ Date: _____