BRAZOS VALLEY FOOT CARE, PA

PATIENT INFORMATION SHEET

FIRST NAME: _____ **MI:** _____ **LAST NAME:** _____ **GEN:** ☐ Jr. ☐ Sr.

PREFERRED NAME: _____ **BIRTHDATE:** _____ **AGE:** _____

GENDER: ☐ Male ☐ Female SSN: _____-_____-_____ TX DL #: _____

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

HOME PH #: _____ **WORK PH #:** _____ **CELL PH #:** _____

E-MAIL ADDRESS: _____

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 EMPLOYER: _____

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

NAME: _____ BIRTHDATE: _____

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

PHONE #: _____ RELATION TO PATIENT: _____

HOW WERE YOU REFERRED TO THE OFFICE?

☐ BVFC Website ☐ Friend or Relative ☐ Referral from Insurance ☐ Phone Book ☐ Other _____
☐ Established Patient ☐ Facebook/Social Media ☐ Found us on Internet ☐ Physician ☐ Referral from Another Patient

PRIMARY CARE PHYSICIAN: _____ **CITY/STATE:** _____

DATE LAST SEEN BY PCP: _____

EMERGENCY CONTACT: _____ PHONE #: _____ RELATION: _____

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☐ CASH PAY ☐ INSURANCE ☐ EAP ☐ WC (Employment Injury)

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PRIMARY INSURANCE:

INSURANCE COMPANY NAME: _____

NAME OF CARD HOLDER: _____

ID NUMBER: _____ GROUP NUMBER _____

INSURED BIRTHDATE (IF DIFFERENT FROM PATIENT): _____ SSN: _____

SECONDARY INSURANCE:

INSURANCE COMPANY NAME: _____

NAME OF CARD HOLDER (SELF, SPOUSE, PARENT): _____

ID NUMBER: _____ GROUP NUMBER _____

INSURED BIRTHDATE (IF DIFFERENT FROM PATIENT): _____ SSN: _____

WORKER'S COMPENSATION:

INSURANCE COMPANY: _____ CLAIM #: _____

ADJUSTER'S NAME: _____ PHONE #: _____

EMPLOYER: _____ OCCUPATION: _____ DATE OF LOSS: _____

STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

Patient Name: _____ Date: _____

PATIENT HISTORY FORM

Reason for Visit: _____

Are you having any foot pain? ☐ Yes ☐ No Please rate pain on scale of **1-10**: No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

When did your discomfort begin? _____

Describe pain/discomfort: ☐ Burning ☐ Numbness ☐ Sharp ☐ Other _____

Have you previously been treated for this problem? ☐ Yes ☐ No If yes, list type of treatment: _____

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

List all current **Medications & Vitamins** (Include dosage, frequency & route of administration)**:** ☐ *Not currently taking any medication*

_____

_____

_____

List any **Allergies** to medications**:** ☐ *No Known Drug Allergies*

_____

_____

Past Medical History: ☐ *No Past Medical History*

☐ Arthritis	☐ Bleeding Disorder	☐ Cancer	☐ Circulatory Problems	☐ Diabetes
☐ Gout	☐ Heart Disease	☐ Hepatitis	☐ High Blood Pressure	☐ High Cholesterol
☐ HIV/Aids	☐ Kidney Disease	☐ Neurological Disorder	☐ Stroke	☐ Other: _____

Surgical History:

_____

_____

Social History: (Please check the below conditions that apply to your social history)

☐ Tobacco Use If yes: ☐ Light/Social ☐ Heavy/Everyday ☐ Former
☐ Alcohol Use
☐ Caffeine Use
☐ Drug Use (Recreational or IV)

Family History: ☐ *No Known Family History*

☐ Bleeding Disorder (Mother/Father) ☐ Cancer (Mother/Father) ☐ Diabetes (Mother/Father) ☐ Heart Disease (Mother/Father)
☐ Hypertension (Mother/Father) ☐ Kidney Disease (Mother/Father) ☐ Stroke (Mother/Father) ☐ Other: _____

Preferred Pharmacy: _____ Street/City: _____

Primary Care Physician: _____ City**:** _____ Date Last Seen: _____

Are you **Diabetic**? ☐ Yes ☐ No

Diabetic Physician: _____ City: _____ 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

Have you experienced any changes, issues and/or complications with vision? ☐ Yes ☐ No

Have you experienced any problems with Heart Rate and/or Heart Rhythm? ☐ Yes ☐ No

Have you experienced any problems with Incontinence? ☐ Yes ☐ No

Patient Name _____ Podiatrist _____

REVIEW OF SYSTEMS

Please check the conditions that you are currently experiencing and/or have previously experienced:

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Constitutional:

☐ Fever ☐ Chills ☐ Sweats ☐ Weight Loss ☐ None Apply

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Eyes:

WEARING OF: ☐ Contacts ☐ Cataracts ☐ Eye Glasses ☐ None Apply HAVE/HAVE HAD: ☐ Cataracts ☐ Double Vision

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ENTM:

☐ Difficulty Swallowing ☐ Neck Pain ☐ Sore Throat ☐ Nose Bleeds
☐ Dizziness ☐ Ringing of Ears ☐ Dentures ☐ None Apply

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Cardiovascular:

☐ Chest Pain ☐ Heart Attack ☐ Congestive Heart Failure ☐ Heart Murmur
☐ Palpitations ☐ Circulatory Disease ☐ Swelling in Legs/Ankles ☐ Leg Pain w/ Exercise
☐ Cardiovascular Surgery ☐ Hypertension ☐ Pace Maker ☐ None Apply

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Hematologic:

☐ Bleeding Abnormalities ☐ Anemia ☐ Lump in Groin or Armpit ☐ Lymphoma ☐ Swollen Glands ☐ None Apply

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Respiratory:

☐ Shortness of Breath ☐ Emphysema ☐ Cough ☐ Bronchitis ☐ Difficulty Breathing
☐ Wheezing ☐ Asthma ☐ Pulmonary Disease ☐ TB Exposure/Treatment ☐ Pneumonia ☐ None Apply

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Gastrointestinal:

☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Stomach Ulcers
☐ Decrease in Appetite ☐ Blood in Stool ☐ Hepatitis ☐ Acid Reflux ☐ None Apply

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Endocrine:

☐ Often Thirsty ☐ Often Urinating ☐ Kidney Disease ☐ Pancreatitis
☐ Diabetes Mellitus ☐ Prostate Problems ☐ Thyroid Disorder ☐ None Apply

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Musculoskeletal:

☐ Tendonitis ☐ Bursitis ☐ Broken Bones ☐ Arthralgia
☐ Weakness in Limbs ☐ Feeling Weak ☐ Joint Pain ☐ None Apply

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Neurologic:

☐ Migraines ☐ Seizures ☐ Stroke ☐ Ataxia (Loss of Balance) ☐ Aphasia (Loss of Speech)
☐ Confusion ☐ Fainting ☐ Neuropathy (Loss of Sensation) ☐ Speech Difficulties ☐ None Apply

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Integumentary:

☐ Rash ☐ Skin Ulcers ☐ Lesions ☐ Cracking of Skin ☐ Sensitivity to Sun ☐ Change in Skin Color
☐ Growth on Skin ☐ Recurrent Infections ☐ Eczema ☐ Keloid ☐ Hair Loss ☐ None Apply

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Psychological:

☐ Nervousness ☐ Tension ☐ Depression ☐ Anxiety ☐ None Apply

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient/Guardian Signature: _____ Date: _____

CONSENT FOR TREATMENT

I hereby give permission to Brazos Valley Foot Care to examine and/or perform diagnostic tests, and treat my condition medically, surgically or orthopedically. The undersigned consents to and authorizes the administration and performance of medical care that may be in the judgment of the physician considered advisable and necessary, why may include the performance of certain blood tests for communicable diseases such as Hepatitis and HIV. BVFC is authorized to furnish information, necessary to process claims, to an insurer, compensation carrier or welfare agency that may be providing financial acceptance for hospital care. I understand that although I have medical insurance, **I am solely responsible for payment of medical bills. I agree to pay all fees billed to me immediately upon completion of all services unless other arrangements have been made in advance. I also understand that payment is not dependent upon my insurance.**

SIGNATURE: _____ DATE: _____

Signature of Patient or Legal Guardian

PATIENT HIPAA ACKNOWLEDGMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Practice's Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP). I have read and/or was given the opportunity to read if I so chose and understood the Notice and agree to its terms. ***Notice of Privacy Practice is available at the front window upon request***

_____ _____

Name of Patient (Please Print) Date of Birth

_____ _____

Signature of Patient/Parent/Guardian Date

II. Designation of Certain Relatives, Close Friends & Other Caregivers as my Personal Representative

I agree that the practice may disclose certain health information to a personal representative of my choosing, since such person is involved with my healthcare and/or payment relating to my healthcare. In that case, the practice will disclose only information that is directly relevant for the person's involvement with my healthcare and/or payment relating to my healthcare.

Print Name: _____ Last 4 digits of his/her SSN (required) _____

Print Name: _____ Last 4 digits of his/her SSN (required) _____

Print Name: _____ Last 4 digits of his/her SSN (required) _____

III. Request to Receive Confidential Communications by Alternate Means

I authorize the practice to communicate with me in confidence about my protected health information by the alternative means that I have listed below, upon request.

Home Telephone Number: _____

____ OK to leave message with detailed information

____ Leave message with call back numbers only

Written Communication Address: _____

____ OK to mail to address listed above

____ OK to email me at: _____

Fax Communication: _____

____ OK to fax to the number listed above

Other: _____

_____ _____

Name of Patient (Please Print) Date of Birth

_____ _____

Signature of Patient/Parent/Guardian Date

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 you 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 you 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.

☐ Pathology & lab records
☐ Radiology/x-ray records
☐ Prescription
☐ Medication records
☐ Billing records
☐ Last dilated retinal eye exam
☐ Other *(give description)*
_____

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: _____