DeNiel Foot & Ankle Center, PLLC

15003 FM 529 Road, Suite B
Houston, TX 7709

Telephone: (832) 415-1790
Fax: (281) 619-7998

Email: info@denielfootandanklecenter.com
Website: www.denielfootandanklecenter.com

Patient Information

Name: _____ Nickname: _____

Address:_____

City: _____ State: _____ Zip: _____

DOB _____Age_____ Home #_____

Email: _____ Cell # _____

Sex: M/F SS#: _____ Work # _____

Primary Care Physician: _____ PCP Phone #: _____

PCP Address_____

Primary Language: □English □Spanish □Other

Emergency Contact Name: _____

Relationship to Patient: _____ Emergency Contact Phone: _____

Marital Status: □ Single □Married □Partner □Divorced □Widowed

Spouse/Partner name: _____

Occupation/Employer/School:_____

Please provide a copy of your insurance card to our staff. If the card is not in your name:
Insurance Policy Holder Name: _____ Policy Holder DOB: _____
Name: _____ Nickname: _____

How did you hear about us?
□Family/Friend (Who?): _____ □Patient (Who?): _____
□ Search Engine (Google, Yahoo, Bing): _____
□ Newspaper/Magazine (which?): _____
□ Physician Referral (Dr?): _____ □ Our Website: _____
□ Insurance company: _____ □ Employer/other: _____

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Medications:

_____

_____

_____

Preferred Pharmacy Address and Phone number:

_____

_____

Shoe size: _____Height: _____Weight: _____

_____

Family history: Mother/Father/Brother/Sister: (e.g diabetes/heart disease/cancer/high BP/other): _____

_____

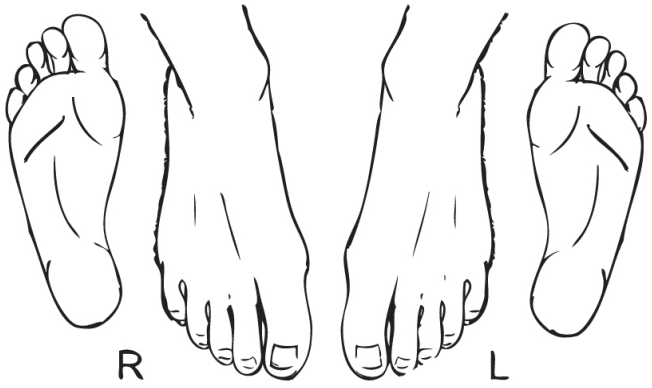
Current Foot problem(s):

_____

_____

PLEASE INDICATE AREA OF CONCERN/ISSUE:

PAIN:
- ☐ DULL ACHE
- ☐ SHOOTING
- ☐ BURNING
- ☐ SHARP
- ☐ THROBBING



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Where: _____ How long? ____ □ Days □ Weeks □ Months□ Years

Pain scale (1-10): _____ Describe pain: _____

_____

Cause of foot problem: Injury/Deformity/Unknown/Other _____

Aggravated by: □ Walking □ Standing □ Shoes □ Physical Activity

Treatment provided in the past: □PCP □ Foot doctor □ Chiropractor □ ER doctor
□ Orthopedic Surgeon □ Physical Therapist

Treatment type: □ X-rays □ Taping padding □ Medication (what med?):_____
□ Injections □ Orthotics □ Wound care □ Foot surgery

Type of foot surgery: _____
_____

Foot doctors seen in the past and when:
_____

Have you ever had (check all that apply):

□ Bunions □ Hammertoes □ Heel spurs □ Corns / Calluses □ Ingrown toenails □ Fungus toenails □ Athlete's Foot □ Warts □ Flat Feet □ High Arches □ Pinched Nerves

Do you regularly take:

□ Blood Thinners? (e.g Aspirin, Coumadin, Vitamin E): _____
□ Cortisone or Other Steroids? (What and Dosage?): _____

<u>Past/Current Medical History</u> (Please indicate if you have a problem with any of the following):

□ Diabetes (insulin/pills/diet controlled?) _____ □ Congestive Heart Failure

□ Hepatitis/Cirrhosis □ Bladder/Kidney/Urinary issues □ Blood Clots/DVT/PE

□ Alcoholism □Gout □ Stomach/Bowel □ Sleep Apnea

□ Breathing Issues □ Heart Disease □ High BP/Stroke □ Asthma

□ Irregular heartbeat □ Circulatory Issues/Varicose veins □ Skin

□ Joint Replacement (specify) _____□ Neurological (specify) _____

□ Arthritis (specify): _____ □ Thyroid(specify): _____□ Depression _____

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Medication/Substance allergies (circle all that apply):
□ Latex □ Tape □ Iodine □ Ivp dye □ Shellfish
Other: _____

Have you ever taken a medication that caused a skin rash, facial swelling, or difficulty breathing?
□ Y / □ N

If yes, please list medication name and reaction:

_____
_____

Have you ever taken a medication that caused vomiting, nausea, dizziness, diarrhea, or headache?
□ Y / □ N

If yes, please list medication name and reaction:

_____
_____

Have you ever had trouble with spinal, general, or local anesthesia?
□ Y / □ N

If yes, please explain:

_____
_____

Social history
□ Yes □ No Do you smoke? If yes, how many cigarette packs per day?

□ 1/2 ppd □ 1 ppd □ 1 ½ ppd □ 2 ppd

□ Yes □ No Did you smoke in the past? If yes, how many years did you smoke? _____
□ Yes □ No Do you drink alcohol? If yes How many drinks per □ Day ___ □ Week ___
□ Month ___

Surgeries / Hospitalizations / Childbirth History (list dates/procedures):

_____
_____
_____

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PATIENT FINANCIAL POLICY

We are dedicated to providing the best possible care and service to you. Your complete understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED.
I PLAN TO MAYE PAYMENT OF MY MEDCIAL EXPENSES AS FOLLOWS:
☐ **CASH** ☐**CHECK** ☐**CREDIT CARD**

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high 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.

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% of the allowed amount for an item or service.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

COPAYMENTS AND DEDUCTIBLES: All co-payments and deductible must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment 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 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

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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 notices for your financial responsibility (co-insurance, 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 billing 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. A fee may be charged if you fail to cancel your appointment within 24 hours and/or do not show for your appointed time. In addition, all unpaid balances 91 days past due will incur interest of 1.5% per month which will be applied from day 31 from the date of service until the balance is paid in full. All payments are due by the tenth (10^{th}) day of each month. Thank you for your understanding or our Financial Policy.

I have read the above policy regarding my *financial responsibility* to DeNiel Foot and Ankle Center PLLC for medical services provided. I agree to pay DeNiel Foot and Ankle Center PLLC 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.

PATIENT ACKNOWLEDGE OF NOTICE OF PRIVACY PRACTICES: By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices, and that I have (or had the opportunity to read if I so chose) and understand the Notice and agree to its terms.

Assignment of Benefits
I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **DeNiel Foot and Ankle Center PLLC** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, 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 physician 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 information and acknowledge I was provided with a copy of the Notice of Privacy Practices and understand and accept its terms:

PRINT Patient Name: _____ Signature: _____

FINANCIALLY RESPONSIBLE PARTY:

PRINT Name: _____ Signature: _____

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MEDICAL AND FINANCIAL CONSENT FORM

Patient Name: Last: _____

First: _____ **MI**_____

Date of Birth: _____ **Sex:** _____

SSN: _____

Address: _____

_____

Telephone: _____

Responsible Party Name: _____

Medical Responsibility? ↑Yes ↑No Financial Responsibility? ↑Yes ↑No

Address: _____

_____

Daytime phone: _____

Primary Insurance: _____

Policy/ID# _____ **Group#** _____

Claims Address: _____

Phone: _____

Secondary Insurance: _____

Policy/ID# _____ **Group#** _____

Claims Address: _____

Phone: _____

AUTHORIZATION FOR TREATMENT AND ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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I authorize all treatments and care as deemed reasonable and necessary by DeNiel Foot and Ankle Center PLLC and agree to be responsible for decisions relating to such. I also agree to be responsible for charges for services to above patient in excess of, partial (or lack of) coverage by insurance, as per the guidelines of Medicare, Medicaid or applicable Private Insurance. I also authorize the use of medical information pertaining to the above patient as deemed appropriate within the guidelines of the HIPAA act.
I acknowledge that I was provided the Notice of Privacy Practices and that I have read (or had the opportunity to read if I chose) and understood it.

PRINT Patient Name: _____ Signature: _____

FINANCIALLY RESPONSIBLE PARTY:

PRINT Name: _____ Signature: _____

WITNESS

PRINT Name of Witness: _____

Signature of Witness: _____

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PATIENT CONSENT FOR MEDICAL PHOTOGRAPHY

Patient Name:_____ Date: _____

☐ Check here if minor or unable to provide consent

I consent for medical photographs to be made of me or my child (or a person for whom I am legal guardian). I understand that the information may be used in my medical record, for purposes of medical teaching, or for publication in medical textbooks or journals as I have designated below. By consenting to these medical photographs, I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future, I may contact the office via phone call and/or via email at info@deneilfootandanklecenter.com

By signing this form below, I confirm that this consent form has been explained to me in terms which I understand.

1. I consent for these photographs to be used in medical publications, including medical journals, textbooks, and electronic publications. I understand that the image may be seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes and to be used for my medical record.

   _____(Signature) _____(Witness)

2. I agree for my image to be shown for teaching purposes **AND** to be used for medical record but **NOT FOR** medical publication.

   _____(Signature) _____(Witness)

3. I agree to use my image for medical records **ONLY:**

   _____(Signature) _____(Witness)

For patients between ages 7 and 18 years, a signature below indicates that the information in this consent form has been explained to me, and I assent to use of my images as outlines above:

_____ _____

(Signature of Patient) (Witness)