

Referring doctor: _____

PATIENT INFORMATION

Name: _____ Date of birth: ____/____/____
First Middle Last

Home phone: () _____ FAX : () _____

Work phone: () _____ Ext.: _____ Cell phone: () _____

Address: _____
Street City State ZIP

E-mail address: _____

Social Security #: _____ Sex: [] M [] F Marital Status _____

Pharmacy & phone #: _____

Other referring source: [] Advertisement [] Family/friend [] Insurance [] Newspaper [] Phone book [] Other

PATIENT EMPLOYER INFORMATION

Patient's employer name: _____

Address: _____
Street City State ZIP

Patient's occupation: _____ Contact person (at work): _____

Contact phone: () _____ Fax: () _____

- 1) If today's visit is due to an injury at work please check: []
2) Have you notified your personnel department? [] YES [] NO
3) Please give brief description of injury: _____

POLICY HOLDER (GUARANTOR) EMPLOYER INFORMATION

Policy holder name: _____

Address: _____
Street City State ZIP

Policyholder date of birth: _____ Social Security #: _____ Sex: [] M [] F

Policy holder employer name: _____

Address: _____
Street City State ZIP

INSURANCE INFORMATION

Primary insurance company name: _____ ID/Member #: _____

Group name: _____ Group #: _____

Effective date: _____ Expiration date: _____

Patient's relationship to policyholder: _____ Policyholder name: _____

Secondary insurance company name: _____ ID/Member #: _____

Group name: _____ Group #: _____

Effective date: _____ Expiration date: _____

Patient's relationship to policyholder: _____ Policyholder name: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Address: _____

Home phone: () _____ Work phone: () _____ Ext.: _____

EXPLANATION OF PAYMENT POLICY AND INSURANCE FILING PROCEDURES

I hereby authorize Academy Foot & Ankle Specialists, to release medical information and necessary data pertinent to the filing of insurance papers in the interest of the patient named above and the facility. I authorize my insurance carriers to pay benefits directly to Academy Foot & Ankle Specialists on any unpaid services filed on my behalf. I understand that I am responsible for payment to Academy Foot & Ankle Specialists for charges for the above patient, regardless of my insurance coverage. I also understand that Academy Foot & Ankle Specialists is not ultimately responsible for collecting my insurance or negotiating settlements of claims.

Patient's signature: _____ Date: _____

Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability & Accountability Act of 1996("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal Healthcare operations such as quality assessments and physician certifications.

I have been given the right to review the Notice of Privacy Practices prior to signing this acknowledgment. I understand that Academy Foot & Ankle Specialists reserves the right to change these policies at any time and I may contact this office for an update copy at any time.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient's Name: _____

Relationship to Patient: _____

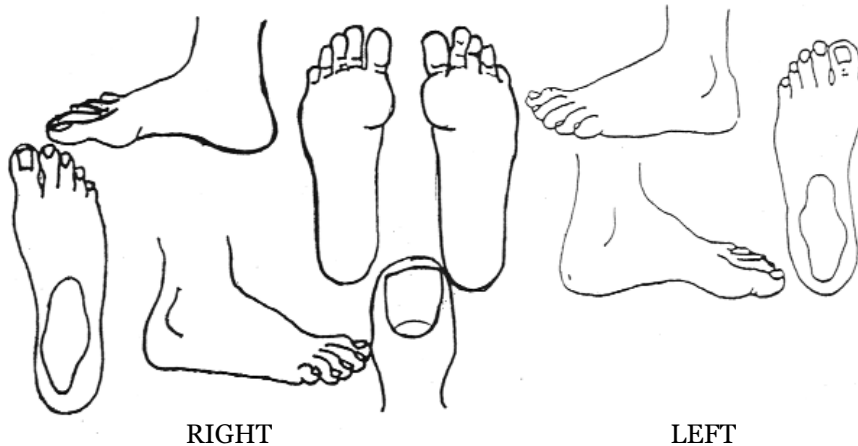
Signature: _____

Date: _____

OFFICE USE ONLY

Patient History Form

Please fill out the following confidential form for our records. Please indicate where you feel pain on the foot and ankle diagram below.



Patient name: _____

Age: _____ Race: _____ Gender: _____ Height: _____ Weight: _____ Shoe size: _____

Current foot or ankle problem:

Nature (Sharp, Dull Achy, Burning, Etc): _____

Location (Where Is The Pain): _____

Duration (How Long Have You Had The Problem): _____

Onset (What Happened?, New Activities, New Shoes, New Job, Accident,etc): _____

Course(Intermittent, Constant, Progressive): _____

Aggravates (What Makes The Pain Worse?, Standing,Sitting, Not Wearing Shoes, Climbing,Etc): _____

Treatment (What Has Been Done and Did It Help?) _____

REVIEW OF SYSTEMS

Do You Currently Wear Eyewear? (Glasses Or Contacts) ____ Yes Or ____ No

MEDICAL HISTORY

Do you or have you had any of the following medical conditions:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Hypothyroid | <input type="checkbox"/> Diabetes Mellitus |
| <input type="checkbox"/> Anemia/sickle cell | <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Immune disease (HIV, AIDS) | <input type="checkbox"/> Pulmonary Fibrosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Insulin Dependent Diabetes Mellitus | <input type="checkbox"/> PVD |
| <input type="checkbox"/> Artificial joint replacement | <input type="checkbox"/> GI bleeding/ulcers | <input type="checkbox"/> Kidney or bladder | <input type="checkbox"/> Raynoud's Disease |
| <input type="checkbox"/> Asthma/bronchitis | <input type="checkbox"/> GI Reflux | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Basal Cell | <input type="checkbox"/> Gout | <input type="checkbox"/> Malignant Melanoma | <input type="checkbox"/> RSD |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Heart disease/heart attack | <input type="checkbox"/> Melanoma | <input type="checkbox"/> Rosacea |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis A, B, or C | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Squamous Cell |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hernia | <input type="checkbox"/> Muscular Dystrophy/Muscular Disorders | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Charcot Foot | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Non-insulin Dependent | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Charcot Marie Tooth Disease | <input type="checkbox"/> High Cholesterol | | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Depression or anxiety | <input type="checkbox"/> Hyperthyroid | | |

List any other medical problems not listed above: _____

Patient History Form

SURGERIES and HOSPITALIZATIONS: (describe procedure, year and any complications)

- 1) _____
- 2) _____
- 3) _____
- 4) _____

ALLERGIES: (aspirin, sulfa drugs, penicillin, iodine, novocaine, tape, foods, drugs, etc.)

- 1) _____
- 2) _____
- 3) _____
- 4) _____

Have you ever had a reaction to local or general anesthesia? Yes No

MEDICATIONS (Please include dosage of each. Include vitamins and supplements)

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____
- 7) _____
- 8) _____

SOCIAL HISTORY

Occupation: _____

Do you spend most of your time standing, walking, heavy lifting, etc. _____

Disabled _____ Retired _____

Sports and Exercise _____

Tobacco: No Yes How much & what kind? _____

Caffeine: No Yes How much & what kind? _____

Alcohol: No Yes How much & what kind? _____

Illicit drugs: No Yes How much & what kind? _____

FAMILY HISTORY

List medical problems your parents have/had such as high blood pressure, diabetes, cancer, bunions, flatfeet, hammertoe, poor circulation, etc.

Mother Alive Deceased _____

Father Alive Deceased _____

Name of family physician _____

Date last seen (approx.) _____

Name of former podiatrist _____

Date last seen (approx.) _____

Whom may we thank for referring you to our office? _____

I hereby give Academy Foot & Ankle Specialists, permission to diagnose and administer treatment for my foot and ankle condition and authorize any release of information obtained in the course of my treatment.

Signature: _____

Date: _____

Consent for Release of Information/Records

Date: ____/____/____

Patient's name: _____

Social Security #: _____ - _____ - _____

I hereby give my permission for: _____
(name of agency, hospital, doctor, etc...)

Address: _____
Street City State ZIP

To release or disclose to: _____
(name of agency, hospital, doctor, etc...)

Address: _____
Street City State ZIP

Home phone: () _____ Work phone: () _____ Ext.: _____

The following information, which shall be limited to: _____

For the period between _____ through _____

I authorize this information to be released in written form verbally

The requested information will be used for: _____

This consent is subject to revocation at any time in the form of written notice from me, except to the extent that action has been taken in reliance thereon, or without revocation, will expire on ____/____/____ (this is not to exceed one year.)

Signature of patient: _____ Date: ____/____/____

Signature of parent: _____ Date: ____/____/____

Signature of witness: _____ Date: ____/____/____

TRACKING FORM

Patient name _____ E-mail address _____

WHO IS THE ACADEMY FOOT & ANKLE SPECIALIST YOU ARE VISITING TODAY?

Doctor seeing Dr. Paul Marciano Dr. Greg Amelung Dr. Kennedy Legel

Existing patient yes no

HOW DID YOU HEAR ABOUT US?

Doctor referral Name of doctor _____

Existing patient Name of patient _____

Word of mouth Name of friend _____

Web site www.texasfootdoctor.org Google Yahoo Other

Insurance company

Direct mail Postcard

Newspaper Keller Paper Flower Mound Paper Southlake Journal Colleyville Courier
 FTW Star Telegram Alliance Regional Paper Hiddenlake Newsletter
 Welcome letter neighborhood Not sure which paper

Brochure/handout

Magazine OD Magazine Healthwhere

Yellow pages OSBC – FTW, Grapevine, Southlake, Colleyville Verizon – Arlington
 OSBC – Northwest Verizon – Arlington/Spanish
 OSBC – Grand Prairie Verizon – FTW
 OCommunity phone book – Coppell Verizon – Southlake, GV, Colleyville
 OCommunity phone book – Plano Verizon – Denton
 ONot sure which phone book Verizon – Transwestern Plano
 Verizon – Lewisville, Coppell, Flower Mound

Radio

Billboard/signage

Health Fair/expo/trade show American Airlines Health Fair OSBC Health Fair OCity of Hurst OCity of Southlake OCity of Grapevine
 OCornell Health Fair OAT&T Health Fair ONot sure which health fair

Other

Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please read and sign our financial policy prior to treatment.

Please take note of the following office policies:

- FULL PAYMENT IS DUE AT THE TIME OF SERVICE.
- IF YOU ARE CONTRACTED WITH AN HMO, PPO, POS OR THIRD PARTY INSURANCE COMPANY, THEN CO-PAYMENT/CO-INSURANCE DOES APPLY.
- ALL CO-PAYS ARE COLLECTED UP FRONT TO ASSIST IN A SMOOTHER CHECK-OUT TIME.
- YOU ARE RESPONSIBLE FOR PROVIDING US WITH ANY UPDATED INSURANCE INFORMATION PRIOR TO TREATMENT OTHERWISE; YOU WILL BE RESPONSIBLE FOR BALANCE.

REGULAR INSURANCE

We require all patients who are contracted with regular indemnity insurance to pay at the time of service unless other arrangements have been made with the office manager. We will provide you with the necessary documentation at the end of your visit.

MEDICARE INSURANCE

After your yearly deductible has been met, we will accept assignment of benefits as set forth in your Medicare Part B. Medicare sets the fees that we may charge and Medicare requires all patients to pay their 20% of the approved amount at the time of service. If you have supplemental coverage (MEDIGAP), we may be able to file this for your as well if it is a plan that we participate in. Please provide us with your secondary insurance information so that we may appropriately inform you. Medicare does not cover all services. Our staff is aware of most of the non-covered services and will alert you prior to your treatment if possible.

HMO-PPO-POS-THIRD PARTY INSURANCE

All co-payments, co-insurance and deductibles are due at the time of treatment. In the event your insurance coverage changes, please advise us immediately. If your plan requires a primary care physician referral, it is your responsibility to obtain the appropriate referral prior to the appointment. We will attempt to assist in reminding you when you need a referral. PLEASE BE ADVISED THAT SOME, AND PERHAPS ALL OF THE SERVICES PROVIDED MAY BE NON-COVERED SERVICES UNDER YOUR PLAN AND THEY MAY BECOME YOUR RESPONSIBILITY REGARDLESS OF WHAT TYPE OF COVERAGE YOU HAVE.

MINOR PATIENTS

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For the unaccompanied minors, non-emergency treatment will be denied unless appropriate consent has been received and charges have been pre-authorized and payment has been made prior to treatment.

MISSED APPOINTMENTS

Unless cancelled at least 24 hours in advance, our policy is to charge 1/2 of the normal office visit fee. We do understand circumstances do arise where 24 hours advance notice is not possible and we will take that in to consideration.

DELINQUENT ACCOUNTS

All accounts that are past due NINETY(90) days or more will be charged a cumulative interest rate of 12% or \$30.00 collection fee which ever is greater on all outstanding charges. Please keep your account current and if this is not possible, please alert us immediately. We are always able to come to an amicable solution.

RETURNED CHECKS

All checks returned by the bank for "Non-Sufficient Funds" will be charged with a \$25.00 processing fee and we do require the check to be replaced by cash or money order within 7 days.

REFUNDS OF SUPPLIES

There will be no refund of supplies. Unfortunately, every supply prescribed may not work for all patients; however, we strive to ensure we make every effort to have a satisfactory outcome.

ADDITIONAL FEES

X-rays are the property of the office and are a very important part of your record. We can make arrangements to get copies of your x-rays with a fee of \$10.00 per film.

Disability forms that need to be completed by our office will incur a charge of \$10.00 per form.

Medical records for copies we require 30 days written notice and there is a \$2.50 charge per page.

With the ever changing environment of healthcare, it is necessary we set guidelines for our patients to ensure no future misunderstandings. We all must work together to make sure your experience with our office is a good one. Thank you for your understanding of our financial policy. Please let us know if you have any questions or concerns.

I HAVE READ THE ABOVE FINANCIAL OFFICE POLICY. I UNDERSTAND AND AGREE TO COMPLY WITH THIS FINANCIAL POLICY.

X _____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

DATE