

Foot and Ankle Associates of North Texas—PATIENT REGISTRATION

Legal First Name _____ MI _____ Last Name _____

Date of Birth _____ / _____ / _____ Gender Female Male Social Security # _____ - _____ - _____ Marital Status Never Married Married Divorced Domestic Partner

Race Native American/Alaska Native Asian Black/African American Hispanic Native Hawaiian White
 Primary Language: _____ Ethnicity Hispanic/Latino Not Hispanic/Latino Patient Declined

Physical Address _____ City _____ State _____ Zip _____

Employment Employed Unemployed Student Other/Retired Employer Name _____

Home Phone _____ - _____ - _____ Work Phone _____ - _____ - _____ Cell Phone _____ - _____ - _____ Email _____

Mark Preferred Method of Call/Voice Mail Home Phone Work Phone Cell Phone Mark Preferred Method of Correspondence In addition to FAANT's Secure Portal Text Email Mail

Emergency Contact Name _____ Relationship Mother Father Friend Spouse _____ Home Phone _____ - _____ - _____ Cell Phone _____ - _____ - _____

Name of person(s) who can have access to your records/PHI or pick up items for you: _____

Primary Care Physician _____ Referred By ER/Urgent Care Family Friend Internet Insurance PCP/Referring Doctor Other: _____
 Office Phone: _____ - _____ - _____ Date last seen: _____

Primary Insurance— copy of card required for claim Secondary Insurance— when Medicare/Tricare is 1st/2nd

Insurance Name	Eligibility Phone	Insurance Name	Eligibility Phone
_____	_____ - _____ - _____	_____	_____ - _____ - _____
Medical Claims Address	_____	Medical Claims Address	_____
Member ID #	Group #	Member ID #	Group #
Insured Name	Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Insured Name	Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child
Insured Date of Birth	Insured Social Security #	Insured Date of Birth	Insured Social Security #
_____ / _____ / _____	_____ - _____ - _____	_____ / _____ / _____	_____ - _____ - _____
Insured Employer Name	Employer/HR Phone #	Insured Employer Name	Employer/HR Phone #
_____	_____ - _____ - _____	_____	_____ - _____ - _____

Third Party Liability

Your claim is: Compensable/Work Related Automobile Other Liability
 Not Related Work/Auto/Liability

_____ Signature _____ Relationship to Patient _____ Date _____
 Print Name of Patient or Legal Authorized Representative

Foot And Ankle Associates of North Texas

CURRENT MEDICAL HISTORY

Last Name: _____ Legal First Name: _____ MI: _____
 Date of Birth: _____ Weight: _____ Height: _____ Shoe Size: _____
 Reason for Visit with Us: _____ Date Occurred: _____

Current Problem

Location: (where) Bilateral Bottom of In between Inside of Left Outside of Right Top of

Site: (what) Ankle Arch Ball of foot Calf Foot/feet Heel Hip Leg Toe (s) Toenail Other: _____

Quality: Achy Brittle Bruised Burning Cramping Deep Dull Improving Inflamed Itching Numb
 Pressure Red Sharp Stabbing Swollen Tender Thick Tight Tingling Other: _____

Pain scale: (Circle) 0 1 2 3 4 5 6 7 8 9 10 –worst
 Severity: Mild Moderate Severe Unchanged

Duration: Today # _____ Days # _____ Week(s)
 # _____ Month(s) # _____ Year (s)

Timing: After exercise At night Constant
 In AM Off and on Recurrent Other: _____

Cause/Context: Fell Foot type Increased activity Injury
 Ortho ≥ 1 yr Running Standing Unknown Other: _____

Better with: Compression Elevation Heat Ice
 Orthotics Shoe gear Medication Rest Other: _____

Worse with: Barefoot Increased activity In shoes
 Pressure Running Walking Other: _____

Also have: Arthritis Back pain Dementia Diabetes Fatigue Headaches Infection Muscle spasm
 Numbness Osteoporosis Overweight Swelling OTC inserts Weakness Wound
 Other: _____

Current Conditions—mark NONE for each condition that does not apply

Symptoms: None Chills Decline in health
 Fever Night sweats Weight gain Weight loss

Eyes: None Blurry vision Cataracts
 Eyeglass use Glaucoma Vision loss

Ears, Nose, Throat: None Dizziness Frequent sore throat
 Hearing impairment Ears Ringing Sinus Infection

Respiratory: None Asthma Cough Short of breath
 Sleep apnea Snoring Wheezing

Heart: None Chest pain Extremity cold High Blood Pressure
 Heart murmur Swelling in legs Ulcers on legs

Intestinal: None Abdominal pain Constipation
 Diarrhea Heartburn Nausea Vomiting

Musculoskeletal: None Artificial joints Gout
 Joint pain Muscle cramps Soft tissue pain Weakness

Psychiatric: None Anxiety Claustrophobia
 Depression Excessive stress Mood swings

Endocrine: None Diabetes Excessive urination
 Increased thirst Thyroid trouble

Neurological: None Memory loss Migraines
 Numbness Paralysis Seizures Strokes

Skin: None Eczema Ingrown nail Lesion
 Nonhealing wound Nail appearance change Rash

Hematological: None Anemia Easy bruising
 Bleeding easily Blood transfusions

Immunologic: None Allergies HIV
 Recurrent Infections Seasonal allergies

Urinary, Reproductive: None Blood in Urine Pregnant
 Sexually Transmitted Disease Urinary incontinence

Pharmacy and Current Medications—mark CONSENT for RX history download

Consent for medication history download from pharmacy (limited to certain plans)

Pharmacy: _____
 Street: _____
 City/Zip: _____
 Phone: _____

<u>Medication</u>	<u>Dose</u>	<u>Frequency</u>	<u>Medication</u>	<u>Dose</u>	<u>Frequency</u>

Print Name of Patient or Legal Authorized Representative

Signature

Relationship to Patient

Date

PAST HISTORY —FAMILY HISTORY—SOCIAL HISTORY

Last Name: _____ Legal First Name: _____ MI: ___ DOB: _____

Allergies

None Adhesive/tape Anesthetics, local Asprin Blood thinners Codeine Dairy Eggs
 Demerol IV contrast dye Iodine Latex Oak Penicillin Seafood Sulfa Other: _____

Previous Procedures or Surgeries

<input type="checkbox"/> Angioplasty/stent	<input type="checkbox"/> coronary bypass	<input type="checkbox"/> Knee Surgery
<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Cosmetic Surgery	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Back/spine surgery	<input type="checkbox"/> Gallbladder	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Blood transfusion	<input type="checkbox"/> Gastirc banding	<input type="checkbox"/> Tonsilectomy
<input type="checkbox"/> Bunion	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Transplant: _____
<input type="checkbox"/> Cesarean section	<input type="checkbox"/> kidney transplant	<input type="checkbox"/> Other: _____

Past Medical History

<input type="checkbox"/> None	<input type="checkbox"/> Cancer	<input type="checkbox"/> Gout	<input type="checkbox"/> Lung disease	<input type="checkbox"/> Seizure disorders
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Lupus	<input type="checkbox"/> Sports related injury
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Circulation problems	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Stomach ulcers
<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> Hepatitis-Type: _____	<input type="checkbox"/> MRSA Infection	<input type="checkbox"/> Stroke
<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Swelling in legs/feet
<input type="checkbox"/> Blood clots	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Pain in legs/feet/toes	<input type="checkbox"/> Thyroid disorders
<input type="checkbox"/> Callus formation	<input type="checkbox"/> Foot ulceration(s)	<input type="checkbox"/> Liver disease	<input type="checkbox"/> RSD/CRPS	<input type="checkbox"/> Other _____

Social History

Live with: Children Grand- parent (s) No one Parent (s) Pet (s) Partner Friend(s)
 Roommate Sibling(s) Spouse Self Other: _____

Live in a: Single story home Multilevel home Hospice Skilled nursing facility

Occupation: _____

Position requirements: Climb stairs Lift+ 10 lbs Sit Stand Travel Walk Not employed

Smoking History: Number of years as a smoker: _____
 Current everyday smoker Current social smoker Former smoker
 Never a smoker Current status unknown Unknown if ever
 < 1 pack a day 1 pack a day 2 packs a day > 2 packs a day

Recreational Drug History:
 Never used recreational drugs
 Have used recreational drugs
 Currently use recreational drugs
 Been treated for substance abuse

 Print Name of Patient Legal Authorized Representative

 Signature

 Relationship to Patient

 Date

**Foot and Ankle Associates of North Texas (herein after collectively referred to as "FAANT")
Notification of Office Policies and Procedures**

- 1. Reading the following policies and procedures annually will keep you informed about our office.**
- 2. Appointments:** Physicians are available by appointment during posted hours. During a medical emergency, patients should seek care at the nearest emergency room or call 911. Other critical calls should page the on-call physician after hours.
- 3. Refills and Medication:** Refills are completed via a pharmacy request. Contact your plan regarding your drug coverage.
- 4. Messages:** Phone messages received before 3 PM are usually returned daily. Emails are returned less frequently.
- 5. Benefits:** FAANT will reiterate the benefits that were disclosed to us by your insurance plan. We will then collect based on the benefit level all applicable copays, deductibles, coinsurances and balances that apply at the time of service or at the pre-operative appointment.
- 6. Payment:** FAANT accepts VISA, MasterCard, Discover, American Express, and Cash
- 7. Insurance Claims:** FAANT files claims electronically for the patient's primary contracted plan and accepts payment via the patient's assignment. FAANT only files secondary claims for Medicare patients; non-Medicare patients may request itemized statements to file to multiple carriers.
- 8. Multiple Policies:** When multiple policies exist, it is the policy holder's responsibility to inform FAANT of their primary plan. Delayed filing to the primary plan can result in violating timely filing limits, resulting in a denial of service and full patient financial responsibility.
- 9. Insurance Networks:** FAANT only files claims to carriers whom we have a contractual relationship; our in-network list is available upon request or on our website. We are not contracted with any Medicare replacement plans.
- 10. Liability Claims:** FAANT does not accept workers compensation, personal injury protection, and letters of protection or other liability claims. These types of claims are to be paid in full by the patient.
- 11. Non-Covered Services:** FAANT will not submit claims for non-covered items including, but not limited to cosmetic services and over the counter convenience items (OTC eg. Biofreeze, Coban, Lyncos, Mycomist, etc...)
- 12. Referrals:** FAANT may refer patients to other providers, facilities, and labs. FAANT is not responsible for these entities. The patient should contact these non-FAANT providers, facilities or labs directly regarding any billing questions. The policy holder is also responsible for all insurance prior authorizations and/or managed care referrals necessary for payment to FAANT.
- 13. Missed Appointments:** A \$50 charge will apply for appointments broken or canceled without 24 hours advanced notice.
- 14. Appointment Hold:** Repetitive broken appointments, non-compliance, hostile behavior, and/or financially deficient accounts will result in appointment hold and/or the termination of the Foot and Ankle Associates of North Texas Doctor-Patient relationship. 30 days' advance notice will be given should the situation result in a transfer of the patient's care.
- 15. Remainder Statements:** FAANT will send a statement when benefits have been misrepresented by the carrier. Each statement will be accessed a \$10 rebilling fee for each month that it is reissued.
- 16. Delinquent Accounts:** Past due accounts are subject to collection proceedings and are reported to the credit bureau. All collection fees, attorney fees and court fees shall become the patient/guarantor's responsibility in addition to the balance due the office.
- 17. Refunds:** FAANT issues patient refunds by check within 30 days of a completed investigation of the potential overpayment, as long as other outstanding accounts have been resolved.
- 18. Returns:** Only unworn and non-custom items are returnable within 14 days of receipt, if no visible signs of wear, tear, or odor. Custom items are tailored to meet individual needs; custom items are non-returnable, non-refundable.
- 19. Medical Records:** The cost for copied medical records and completion of disability forms will be charged to the patient and collected prior to replication. The fees for these services are regulated by HIPAA and Texas Health and Safety Code.

The undersigned certifies that he/she has read and understands the foregoing 1-20 statements, and is either the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accepts its terms.

Print Name of Patient Legal Authorized Representative

Signature

Relationship to Patient

Date

Foot and Ankle Associates of North Texas (herein after collectively referred to as "FAANT") Authorization from Patient or Legal Representative

1. Consent to Treat: The undersigned consents to any initial or follow-up evaluations, examinations, x-rays, laboratory procedures, other tests, medications, medical treatment, surgery, physical therapy, home instructions, orthotics, other durable medical equipment, photographing and/or videotaping and/or other services rendered to the patient by FAANT and its providers. The undersign agrees that it is their responsibility to contact and/or schedule with FAANT for any follow up visits, other services, prescriptions and items ordered for the patient. The undersigned also understands that FAANT's providers exercise their care with reasonable skill and diligence, but make no guarantee as to the results or cure that will be attained.

2. Assignment of Benefits: I hereby irrevocably assign, transfer and convey to FAANT and any practitioner providing care and treatment to me/my child, any and all benefits and all interest and rights (including causes of action, the right to enforce payment and the right to appeal an adverse benefit determination) to which I am entitled under an employee benefit plan sponsored by my employer, all insurance policies, benefits, any third-party reimbursement, or prepaid health care plan for services rendered or products I received from FAANT.

3. Medicare Assignment: I certify that the information given by me in applying for payment under XVIII of the Social Security Act is correct and agree to complete the Medicare screening form annually. I authorize the release of information concerning me to the Social Security Administration or its intermediaries as well as any information needed for filing a Medicare claim; I request that payment and authorized benefits be made on my behalf. I assign benefits payable for services to FAANT.

4. Authorization to Release Information: I consent and authorize FAANT and its agents to release my health information for the purpose of payment, treatment, and healthcare operations to any of the following: insurance company and its affiliates, any practitioner, support staff or facility involved in my plan of care or transfer of care. In addition I understand that the potential uses and disclosures of my Health Information are detailed in the Privacy notice. The HIPAA Notice of Privacy Practices are available online at www.faant.com. Individual copies are also available in the office and posted in the lobby. I have read/had the opportunity to read my HIPAA rights, which include FAANT's fees for records.

5. Designation of Authorized Representative: I designate and appoint FAANT (and its agents) as my authorized representative and authorize it to act on my behalf to 1) request and receive a copy of the summary plan description, 2) pursue a benefit claim, 3) appeal and adverse benefit determination, and/or 4) file a legal/equitable action to recover benefits from my employee benefit plan, insurance policy, and any third-party reimbursement or prepaid health care plan. I understand and agree that my authorized representative shall have full authority to act, and receive notices, on my behalf with respect to an initial determination of the claim for health benefits relating to treatment and health care services received by me/my child at FAANT, any requests for documents relating to this claim and appeal of an adverse determination of the claim.

6. Financial Agreement: I hereby promise that premiums for my insurance are kept current. Furthermore, I agree to pay for all products received or services rendered to me/my child to the extent I am legally responsible for such payment. According to the language of the physician's insurance contract, I understand that I am responsible for all health insurance copayments, deductibles, coinsurances, OTC-over the counter convenience items and NCS-noncovered services and any other amounts that apply at the time of service or at the pre-operative appointment. Should the insurance misrepresent their coverage or delay payment of a claim greater than 45 days, as the designated responsible party, I am responsible for the for all monies owed to FAANT. I also understand that the insurance policy is a contract between me and the insurance company; therefore the policy holder should contact the insurance carrier first when there are questions regarding explanation of benefits.

The undersigned certifies that he/she has read and understands the foregoing statements 1-6, and is either the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accepts its terms. This document shall remain in force until a written revocation by me is delivered to FAANT.

Print Name of Patient or Legal Authorized Representative

Signature

Relationship to Patient

Date