Hill Country Advanced Foot & Ankle Center, PA

Quinton Solomon, DPM **Leslie Rowe, DPM** **David Carmack, DPM**

Welcome to Our Office……….
Thank you for selecting our office to serve your foot care needs. We will strive to provide you with the very best Podiatric care. The following information is needed to better serve you. Thank you for taking the time to provide us this information.

Patient Name____Date of Birth______________Age_________

Mailing Address________________________________City___________________State_________Zip___________

Social Security #____________________

Please check the best number to reach you: ☐ (Home)________________ ☐ (Cell) ____________________

Sex: ☐ M ☐ F Marital Status: ☐ Married ☐ Separated ☐Single ☐ Widowed ☐ Divorced

Employed by____Occupation_______________________________

Name of Spouse or Parent__________________________ Birthdate of Spouse or Parent_____________________

Employed by____Occupation__________________________________

In Case of Emergency notify________________________Relationship______________Phone___________________

How did you hear about our office? ____________________ What pharmacy do you use regularly? ________________

♦♦

INSURANCE: ***Please fill out <u>completely</u> even if copies of your insurance cards were provided.***

Primary Medical Insurance: __________________________________ Insurance Phone ____________________

Policy ID: ___________________________ Group #: ____________ Subscriber: ☐ Self ☐ Other

If Subscriber is someone other than patient: Name: ____

Subscriber's birthdate ______________________ Subscriber's SSN: ________________________________

Subscriber's relationship to patient? ☐ Spouse ☐ Mother ☐Father ☐ Other ______________________________

Secondary Medical Insurance: __________________________________ Insurance Phone ____________________

Policy ID: ___________________________ Group #: ____________ Subscriber: ☐ Self ☐ Other

If Subscriber is someone other than patient: Name: ____

Subscriber's birthdate ______________________ Subscriber's SSN: ________________________________

Subscriber's relationship to patient? ☐ Spouse ☐ Mother ☐Father ☐ Other ______________________________

♦♦

Diabetic? Y N Height__________________ Weight_________________ Shoe Size_____________

Primary Doctor_______________________________Location_____________________ Last Visit________________

Former Podiatrist_____________________________Location______________________Last Visit________________

♦♦

I certify that the above information is accurate and complete. I hereby give my permission to administer treatment, and to perform such procedures as may be deemed necessary in diagnosis and/or treatment of my foot conditions.

Signed____ Date____________________

Hill Country Advanced Foot & Ankle Center, PA

MEDICAL HISTORY: (Please check any of the following that you have been diagnosed with or treated for in the past):

☐ None apply

☐ diabetes - year:_____	☐ high blood pressure	☐ COPD	☐ tuberculosis
☐ heart problems - CHF, CAD, A-fib	☐ high cholesterol	☐ bronchitis	☐ thyroid problems
☐ heart attack – year:_____	☐ non-healing wound	☐ asthma	☐ hepatitis
☐ stroke - year:_____	☐ osteoarthritis	☐ pneumonia	☐ AIDS/HIV
☐ bleeding problem-type:_____	☐ rheumatoid arthritis	☐ emphysema	☐ cancer

☐ Other (please list) _____

SURGICAL HISTORY: ☐ None (Please check the following surgeries that you have had):

☐ heart surgery -type: Bypass, pacemaker, heart valve		☐ tonsillectomy	☐ tubal ligation
☐ arthroscopy-type:_____	☐ spine surgery	☐ appendectomy	☐ hysterectomy
☐ hernia repair	☐ removal of gallbladder	☐ repair of fracture_____	
☐ cataract	☐ Other: _____		

MEDICATIONS TAKEN DAILY: (List all and doses or provide list)

☐ None ☐ Attached list ☐ Are you on a blood thinner- Yes / No Coumadin Aspirin Plavix

_____ _____ _____

_____ _____ _____

ALLERGIES: Are you allergic to any of the following or any other medication? ☐ None

☐ Novocaine/anesthetic ☐ Penicillin ☐ Adhesive Tape ☐ Latex - type of reaction_____

☐Others_____

SOCIAL HISTORY: (Please answer each of the following)

Smoke:	YES or NO	Quit? year:_____	Packs per day / # years _____
Chew tobacco	YES or NO	Quit: year:_____	Amount _____
Alcohol	YES or NO	Amount _____	

FAMILY HISTORY: (Do any of your primary family members have any of the following problems?)

☐ None apply

☐ high blood pressure	☐ diabetes	☐ bleeding problems	☐ tuberculosis
☐ heart problems	☐ cancer	☐ rheumatoid arthritis	
☐ strokes	☐ Gout	☐ osteoarthritis	

REVIEW OF SYSTEMS: (Are you currently suffering from any of the following?)

☐ None	☐ chest pain	☐ fever/chills	☐ rashes
☐ numbness/tingling in legs/feet	☐ heart palpitations	☐ nausea/vomiting	☐ trouble with vision
☐ joint pain (hips, knees, etc)	☐ shortness of breath	☐ stomach/abdominal pain	☐ difficulty hearing
☐ back pain	☐ coughing up blood	☐ blood in stools	☐ memory loss
☐ muscle aches	☐ bleeding problems	☐ constipation/diarrhea	☐ depression
☐ swollen ankles	☐ frequent nose bleeds	☐ trouble urinating	☐ headaches
☐ pain in calf with activity	☐ phlebitis/blood clots	☐ frequent urination	☐ night sweats

Reason for visit _____

Patient Name_____ Date of Birth_____ Age_____

Signed_____ Date_____

Hill Country Advanced Foot and Ankle Center
INSURANCE/BILLING/COLLECTIONS POLICIES

We must emphasize that as healthcare providers, our relationship is with you, our patient, and **NOT** with your insurance company. As a courtesy to you and per our contract with your insurance company, we will bill them directly, assuming you have given us all your insurance information. We charge what is usual and customary for our area. The patient is responsible for any remaining unpaid charge as determined by your insurance company.

Please read and initial beside each paragraph.

_____ ***You are responsible for knowing what your insurance benefits are, with regards to what insurance will and will not pay for. If you are in doubt, please contact your insurance carrier. Please understand that payment of your bill is considered part of your treatment.***

_____ This is not a Worker's compensation injury.

_____ There will be a $15.00 charge for missed appointments or appointments not canceled 24 hours in advance.

_____ I understand that HCAFA will file with my primary insurance company charges that incur on my initial visit, testing, procedures, and future visits. There will be no fee for filing these charges. I will promptly inform the office of a change in my medical insurance. I understand that I am responsible for the co-pay amount at each office visit as directed by my insurance. I understand that the patient portion amounts directed by my insurance for services rendered are due at time of service. I also agree to pay any remaining collectible balances as governed by my insurance plan. I understand that my release of direct payment of insurance benefits does not release me from responsibility for full payment for services (if unpaid by my insurance) rendered by HCAFA.

_____ I request payment of authorized benefits be made to Hill Country Advanced Foot & Ankle Center for any services furnished to me by a physician from the group. I authorize any holder of medical information about me to release any information needed to determine these benefits or benefits for related services. If the physician is a participating provider for my insurance carrier, I understand the physician will accept the insurance carrier's allowable. If the physician is not a participating member, I understand I will be responsible for the difference between the amount billed by the physician and the amount paid by the insurance carrier. If my insurance carrier has not paid within 90 days, I understand I am responsible for payment at that time, and will be reimbursed appropriately when my insurance carrier makes payment.

We accept VISA, Mastercard, Discover, and American Express as well as debit cards, cash, and personal checks drawn on American funds.

We do offer payment plans for outstanding balances due, not for co-pays. Please call our billing department to discuss and make payment arrangements. **Any accounts sent to collections will be charged an additional 33-50% fee of the total balance.**

Children of divorced/separated parents

Unless you give us a signed, notarized court order to keep on file, the parent or guardian who brings the child in for their office visit will be considered ultimately financially responsible. We will entrust you to tell our billing department who the bill needs to be sent to for any remaining balance after your insurance pays.

We thank you for understanding our financial policies. This has become necessary in order to continue to accept your insurance plans without having to bill you at the time services are rendered. Our goal is to make your visit with us as pleasant and professional as we can. If you have any questions, please feel free to ask or call our billing department for assistance. Thank you again for choosing us for your foot/ankle care.

IF YOU DO NOT HAVE INSURANCE, PAYMENT IS DUE IN FULL AT THE TIME SERVICES ARE RENDERED.

I understand these policies and agree to be bound by their terms. I also understand that such terms are subject to change or be amended and I will be notified of any such changes or amendments.

_____ _____

Patient/Guardian or Parent Date

Hill Country Advanced Foot and Ankle Center
ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I, (name of patient) _____, acknowledge and agree that I have reviewed a copy of Hill Country Advanced Foot and Ankle Center's Notice of Privacy Practices and have completed the form below to the best of my knowledge.

_____	_____	_____
Signature of Patient or Guardian	Relationship to Patient	Date

FAMILY AND FRIENDS

Persons who are involved in your care (family, "spouses", friends, other doctors, "PCP", etc) may inquire about your treatment, lab results, prescriptions, etc. IF THEY ARE NOT ON THIS LIST, WE CANNOT SPEAK WITH THEM REGARDING YOU. Please let us know what person(s) we may share information with and list them below.

_____ _____

_____ _____

_____ _____

_____ _____

What other ways may we contact you? From time to time we will need to leave a message for you (as stated in our Notice of Privacy Practices) on answering machine, voice mail, or another individual in your absence. Is it OK to leave a message that includes details (such as diagnosis and medication information, appointment times) at the numbers you have provided below:

Home Number: _____ YES or NO

Work Number: _____ YES or NO

Cell Number: _____ YES or NO

Other Number: _____ YES or NO

MEDICARE AUTHORIZATION

Hill Country Advanced Foot and Ankle Center

I, the undersigned, request that payment of authorized Medicare benefits be made on my behalf directly to HILL COUNTRY ADVANCED FOOT AND ANKLE CENTER for services rendered. I hereby authorize the doctor to release to the Center of Medicare and Medicaid Services (CMS) all information necessary to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other insurance is indicated, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-payment, and charges associated with non-covered services. Co-payments and deductibles are based upon the charger determination of the Medicare carrier.

If you have a PRIVATE SENIOR PLAN, this replaces your Medicare and you are subject to a co-payment, every visit, which is due at the time of service.

Initials _____

If you have a SECONDARY INSURANCE, we will file the claim as a **courtesy** to you. It is our office policy that if the secondary has not paid the 20% within 60 days of our filing the claim, the bill will be sent to you for immediate payment and you will be responsible for submitting to get reimbursement from your secondary insurance. *It is also our policy that you pay any co-pay that your secondary insurance states you have. This is a contract that you have with them. Please be prepared to pay at the time services are rendered.*

Initials _____

Patient Signature: _____

Date: _____