Hill Country Advanced Foot & Ankle Center, PA

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 # _____-_____-_____ Sex: ☐ M ☐ F E-mail _____

How did you hear about our office? _____

Please check the best number to reach you: ☐ Home (___) _____ ☐ Cell (___) _____

Marital Status: ☐ Married ☐ Unmarried ☐ Single ☐ Widowed ☐ Divorced

Employed by _____ Occupation _____

Name of Spouse or Parent _____ Date of Birth of Spouse or Parent _____

Employed by _____ Occupation _____

In case of an Emergency notify _____ Relationship _____ Phone _____

Primary Care Doctor _____ Location _____ Last Visit _____

Acknowledgement of Notice of Privacy Practices

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

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

_____ _____ _____

Signature of Patient or Guardian | Relationship to Patient | Date

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

Cell Number: _____ YES or NO

What other ways may we contact you?

Cell Number: _____ YES or NO

Other Number: _____ YES or NO

Emergency Contact: _____ YES or NO

Family and Friends

Persons who are involved in your care (family, 'spouses', friends, other doctors, etc.) may inquire about your treatment, lab results, prescriptions, appointment, 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.

_____ _____

_____ _____

_____ _____

_____ _____

Hill Country Advanced Foot & Ankle Center, PA

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.

Please read and initial beside each paragraph.

____ You're responsible for knowing what your insurance benefits are, with regards to what the 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 cancelled 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 visit as directed by my insurance, and 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 services (if unpaid by my insurance) rendered by HCAFA. I request payment of authorized benefits be made to Hill Country Foot & Ankle Center PA 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 participated 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, American Express, and Care Credit 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.

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

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, feel free to ask or call our billing department for assistance. Thank you again for choosing us for your foot/ankle needs.

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.

Print	Patient/Guardian Signature	Date

Hill Country Advanced Foot & Ankle Center, PA

Medicare Authorization

I, the undersigned, request that the payment of authorized Medicare benefits be made on my behalf directly to Hill Country Advanced Foot & Ankle Center PA 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 indicated, my signature authorizes releasing of the information to the insurer of agency shown. In the 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 insurance has not been 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 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 _____

INSURANCE: Please fill out completely even if copies of your insurance cards were provided.

Primary Medical Insurance: _____ Insurance Phone: _____

Policy ID: _____ Group#: _____ Subscriber: ☐ Self ☐ Other ☐ HMO ☐ PPO

If Subscriber is someone else other than patient: Name: _____ Relation: _____

Subscriber's Date of Birth: _____ Subscriber's Social Security Number: _____

Secondary Medical Insurance: _____ Insurance Phone: _____

Policy ID: _____ Group#: _____ Subscriber: ☐ Self ☐ Other ☐ HMO ☐ PPO

If Subscriber is someone else other than patient: Name: _____ Relation: _____

Subscriber's Date of Birth: _____ Subscriber's Social Security Number: _____

_____	_____	_____
Print	Patient/Guardian Signature	Date

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Patient History

Patient Name: _____ DOB: _____

What Pharmacy do you use? _____ City: _____

What is your Height _____ Weight _____ Shoe Size _____

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

- ☐ None Apply
- ☐ Diabetes – year: _____
- ☐ Heart Problems – CHF, CAD, A-Fib
- ☐ Heart Attack – year: _____
- ☐ Stroke – year: _____
- ☐ PAD (Peripheral Arterial Disease)
- ☐ Other (please list): _____
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Non-Healing Wound
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis/Lupus
- ☐ Bleeding Problem – type: _____
- ☐ COPD
- ☐ Asthma
- ☐ Emphysema
- ☐ Gout
- ☐ Cancer-type: _____
- ☐ Tuberculosis
- ☐ Thyroid Problems
- ☐ Hepatitis
- ☐ AIDS/HIV

SURGICAL HISTORY: (Please check the following you have had):

- ☐ None
- ☐ Heart Surgery – type: Bypass, Pacemaker, Heart Valve, Stents
- ☐ Arthroscopy – type: _____
- ☐ Hernia Repair
- ☐ Cataract
- ☐ Foot Surgery: _____
- ☐ Spine Surgery
- ☐ Removal of Gallbladder
- ☐ Other: _____
- ☐ Tonsillectomy
- ☐ Appendectomy
- ☐ Repair of Fracture: _____
- ☐ Tubal Ligation
- ☐ Hysterectomy

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

☐ None ☐ See Attached List Are you on a blood thinner – YES/NO ☐ Coumadin ☐ Aspirin ☐ Plavix ☐ Eliquis ☐ Xerelto ☐ Pradaxa

_____ _____

_____ _____ _____

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

☐ Novocain/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 / # of 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
- ☐ Heart Problems
- ☐ Strokes
- ☐ Diabetes
- ☐ Cancer
- ☐ Gout
- ☐ Bleeding Problems
- ☐ Rheumatoid Arthritis/Lupus
- ☐ Osteoarthritis
- ☐ Tuberculosis

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

- ☐ None
- ☐ Numbness/Tingling in legs/feet
- ☐ Joint Pain (hips, knees, ect.)
- ☐ Back Pain
- ☐ Muscle Aches
- ☐ Swollen Ankles
- ☐ Pain in calf with activity
- ☐ Stomach/Abdominal Pain
- ☐ Heart Palpitations
- ☐ Shortness of Breath
- ☐ Coughing up Blood
- ☐ Bleeding Problems
- ☐ Frequent Nose Bleeds
- ☐ Phlebitis/Blood Clots
- ☐ Fever/Chills
- ☐ Nausea/Vomiting
- ☐ Night Sweats
- ☐ Blood in Stools
- ☐ Constipation/Diarrhea
- ☐ Trouble Urinating
- ☐ Frequent Urination
- ☐ Rashes
- ☐ Trouble w/ Vision
- ☐ Difficulty Hearing
- ☐ Memory Loss
- ☐ Depression
- ☐ Headaches
- ☐ Chest Pain

_____ _____ _____

Patient Name (PRINT) Patient/Guardian Signature Date