FOOT SURGERY SPECIALISTS OF TEXAS

FOOT SURGERY SPECIALISTS OF TEXAS

MEDICAL HISTORY

PRESENT ILLNESS

W hat is the chief reason you are consulting the doctor?

_____

_____

_____

_____

_____

What is your current Occupation?: _____

When did the problem first begin? _____ Is the problem an on the job injury? _____

Have you had treatment for this problem before today? ◻ NO ◻ YES – PLEASE LIST_____

_____

Have you had any FOOT surgery in the past? ◻ NO ◻ YES – PLEASE LIST_____

Have you had any other surgery in the past? ◻ NO ◻ YES – PLEASE LIST_____

_____

_____

_____

PAST MEDICAL HISTORY

Circle any of the following illnesses you have or have had.

DIABETES	HIGH BLOOD PRESSURE	HIV	GOUT
HEART ATTACK	HIGH CHOLESTROL	LUNG DISEASE	ARTHRITIS
STROKE	HEPATITIS	SEIZURES	AUTOIMUN E DISEASE
VASCULAR DISEASE	ULCER DISEASE	ASTHMA	NEUROPATHY

LIST OTHERS ILLNESSES: _____

_____

CURRENT MEDICATIONS *(INCLUDING VITAMINS, DIET PILLS & OVER THE COUNTER:*

_____

_____

_____

_____

ALLERGIES TO MEDICINE ◻ NO ◻ YES – PLEASE LIST_____

_____

BLEEDING – Do you have any bleeding problems? ◻ NO ◻ YES – PLEASE LIST_____

ANESTHESIA – Have you ever had any problems with anesthesia? ◻ NO ◻ YES – PLEASE LIST_____

Have any of your family members had problems with anesthesia? ◻ NO ◻ YES – PLEASE LIST_____

SOCIAL HISTORY

Do you smoke? ◻ NO ◻ YES – How many per day? _____How many years? _____

Do you drink alcohol? ◻ NO ◻ YES – How many per day? _____

HOW DID YOU HEAR ABOUT THE PRACTICE? (circle one)

Internet/Google_____ **Friend/Family**_____ **Doctor Referral (who?)**_____

Insurance Company_____ **Facebook**_____ **Other**_____

Patient Signature _____ Date_____

FOOT SURGERY SPECIALISTS OF TEXAS

TEXAS PHYSIATRY

HAND SURGERY SPECIALISTS OF TEXAS

MEDICAL REVIEW OF SYSTEMS

Constitutional

Weight Gain	☐ Yes ☐ No
Weight Loss	☐ Yes ☐ No
Obesity	☐ Yes ☐ No
Cold Limbs (Feet/Hands)	☐ Yes ☐ No

Cardiology

Chest Pain	☐ Yes ☐ No
Palpitations	☐ Yes ☐ No
Hypertension	☐ Yes ☐ No
Heart Attack (MI)	☐ Yes ☐ No
Congestive Heart Failure	☐ Yes ☐ No
Pacemaker	☐ Yes ☐ No
Murmurs	☐ Yes ☐ No

Respiratory

Problems with anesthesia	☐ Yes ☐ No
Wheezing	☐ Yes ☐ No
Nasal Stuffiness	☐ Yes ☐ No
Shortness of breath	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No

Gastroenterology

Abdominal Pain	☐ Yes ☐ No
Heartburn	☐ Yes ☐ No
Ulcer	☐ Yes ☐ No

Musculoskeletal

Joint Pain	☐ Yes ☐ No
Joint Stiffness	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No
Sprains/Strains	☐ Yes ☐ No
Fracture	☐ Yes ☐ No

Integumentary

Rash	☐ Yes ☐ No
Lumps	☐ Yes ☐ No
Bruising	☐ Yes ☐ No
Skin Cancer	☐ Yes ☐ No

Neurology

Headache	☐ Yes ☐ No
Seizures	☐ Yes ☐ No
Weakness	☐ Yes ☐ No
Tremor	☐ Yes ☐ No
Gait difficulties	☐ Yes ☐ No

Psychology

Depression	☐ Yes ☐ No
Anxiety	☐ Yes ☐ No
Panic Attacks	☐ Yes ☐ No
Nervousness	☐ Yes ☐ No

Endocrinology

Excessive sweating	☐ Yes ☐ No
Excessive Thirst	☐ Yes ☐ No

Hematology/Lymph

Swollen Glands	☐ Yes ☐ No
Fevers	☐ Yes ☐ No
Abnormal bleeding	☐ Yes ☐ No

Patient Name: _____

Date of Birth: _____

Patient Signature: _____

Date: _____

Physician Review _____

Primary Care Physician Name: _____

_____

☐ I currently do not have a primary care physician

☐ I would like more information on being referred to a primary care physician

FOOT SURGERY SPECIALISTS OF TEXAS

TEXAS PHYSIATRY

HSST

HAND SURGERY SPECIALISTS OF TEXAS

Patient Name _____ Date of Birth _____

We are currently utilizing an EMR (electronic medical records) system to schedule appointments and document patient encounters. We are now taking the next step toward electronically ordering and submitting prescriptions through the computer, otherwise known as **ePrescribe**. Electronic prescribing or e-prescribing is the electronic transmission of prescription information from the prescriber's computer to a pharmacy computer. It replaces a paper prescription that the patient would otherwise carry or fax to the pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

In an effort to update your medical record in our system with your preferred pharmacy we will need to obtain this information from you. Please provide your "preferred" pharmacy as Pharmacy #1 and an alternative in Pharmacy #2. If you do not know the exact address, please list cross streets and we will try to assist you in locating the exact pharmacy. If you do not have a regular pharmacy, we can assist you by locating one using a preferred zip code, such as your home or work zip code. (***Please be sure to write clearly so that we can accurately enter your data into the system***)

Pharmacy #1 _____

Address (or cross streets) _____

City _____ **State** _____ **Zip** _____

Telephone # _____

Pharmacy #2 _____

Address (or cross streets) _____

City _____ **State** _____ **Zip** _____

Telephone # _____

Your Email Address _____

By signing this consent form you are agreeing that we can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to my provider to enroll me in the ePrescribe program. We appreciate your cooperation and look forward to a successful transition!

Patient Name _____ **Patient Signature** _____

Relationship to patient self other _____ Date _____

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Name _____ ☐ Female ☐ Male

PRINT YOUR LEGAL NAME ONLY

Date of Birth _____ Age _____ Social Security Number _____

Cell # _____ Work # _____ Email _____

Address _____ Apt _____

City _____ State _____ Zip _____

Driver's License # _____ State _____

Employer's Name _____ Occupation _____

Phone _____ Address _____

City _____ State _____ Zip _____

Spouse's Name _____ Telephone # _____

Person to notify in case of emergency _____ Relationship _____

Telephone # _____ Alternate # _____

Referring Provider Name _____ Telephone # _____

Primary Physician's _____ Telephone # _____

FINANCIAL INFORMATION ☐ Self-Pay ☐ Insurance ☐ Medicare ☐ Workers Comp ☐ Other

Primary Insurance Company _____ Telephone # _____

Insurance ID # _____ Group _____

Insured's Name _____ Insured's Employer _____

Insured's Social Security # _____ Insured's DOB _____

Relationship to Patient _____

Secondary Insurance Company _____ Telephone # _____

Insurance ID # _____ Group _____

Insured's Name _____ Insured's Employer _____

Insured's Social Security # _____ Insured's DOB _____

Relationship to Patient _____

Patient Signature _____ Date _____

FOOT SURGERY SPECIALISTS OF TEXAS

TEXAS PHYSIATRY

HAND SURGERY SPECIALISTS OF TEXAS

Welcome

Thank you for entrusting your care in our hands. We are a team of highly trained medical specialists and we take very seriously our responsibility to provide you with the highest quality medical care possible. We will be very professional, open and honest in every aspect of your care. We insist on a professional atmosphere and demeanor in the office because we owe it to you, the patient.

Copays and payments are due at the time of your visit. We accept cash, Care Credit, MasterCard, Visa, and Discover. There are no payments due for the first three post-operative visits, except for supplies and x-rays.

Please do not discuss fees with the physician. The doctor will focus only on your medical needs; the staff will answer all financial questions.

(REVIEW THE ATTACHED HIPAA BROCHURE)

HIPAA Acknowledgement

I have been presented with a copy of the Centers Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice and I request the following restriction(s) concerning the use of my personal medical information.

_____

_____

_____

_____

Further, I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed _____ Date _____

If not signed by the patient, please indicate relationship to patient (e.g. spouse)

Relationship _____

If the patient refuses to sign, indicate your attempt to obtain signature below

☐ Patient refused to sign this Acknowledgement

Date _____ Time _____

Employee Name _____

FOOT SURGERY SPECIALISTS OF TEXAS

TEXAS PHYSIATRY

Hand Surgery Specialists of Texas

MIGRAINE

INSURANCE ACKNOWLEDGMENT & ENDORSEMENTS

PATIENT LEGAL NAME_____DOB _____

RECORDS RELEASE

I hereby authorize ***Hand Surgery Specialists of Texas, Texas Physiatry, Foot Surgery Specialists of Texas, and Migraine Relief Center*** to furnish any medical records and/or other necessary information needed to process an insurance claim.

Signature of Responsible Party | Printed Name | Date

ASSIGNMENT OF BENEFITS

I, the undersigned, am the financially responsible party for the patient named above and agree to pay, in full, ***Hand Surgery Specialists of Texas, Texas Physiatry, Foot Specialists of Houston, and Migraine Relief Center*** for services rendered. I accept the HSST's, FSST's, TP's, MRC's fees as reasonable and customary.

In order to process an insurance claim, there must be complete patient and insurance information on file.

I irrevocably assign to ***Hand Surgery Specialists of Texas, Texas Physiatry, Migraine Relief Center, Foot Surgery Specialists of Texas,*** and/or its physicians all payments from insurance company(ies) for medical services rendered and accept responsibility for paying any balance owed after the insurance has paid.

All patients whose insurance providers pay the patient directly, rather than the physician, hereby agree to assign all benefit proceeds the patient receives from the insurance company to the physician's office. I agree to immediately endorse all checks received from my insurance company and to mail or bring them into the physician's office.

Signature of Responsible Party | Printed Name | Date

LABS, X-RAY AND DIAGNOSTIC TESTING

It is our policy that all results be reviewed by physician with patient present and results will not be given over the phone.

Signature of Responsible Party | Printed Name | Date

NON-WORKMAN'S COMP DECLARATION - PLEASE READ - THE PHYSICIAN IS UNABLE TO DETERMINE WHETHER OR NOT THE SYMPTOMS YOU ARE SUFFERING ARE WORK RELATED.

By signing below you declare that you do not have a compensable work injury covered under a workman's comp claim at this time. It is your responsibility as the patient to notify our office if you file a work comp claim.

You also understand that should your workman's comp claim be denied, you will be responsible for all balances in full. If group health insurance is available, we must receive a copy for processing as soon as you are aware the claim has been denied. This is not a guarantee that we accept your group insurance.

Signature of Responsible Party | Printed Name | Date

HSST, FSST, TEXAS PHYSIATRY, MIGRAINE RELIEF CENTER ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PERSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND/OR HEALTH BENEFITS PLAN (INCLUDING BREACH OF FUDIARTY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to the above-named health care billing provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement. If any, otherwise payable to me for services, treatment, therapies, and/or medications rendered or provided by the above-named health care billing provider, regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care billing administrator fiduciary, insurer, and/or attorney to release to the above-named health care billing provider any and all plan documents summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care billing provider or its attorneys in order to claim such medical benefits.

I intend by this assignment and designation of authorized representative to convey to the above-named billing provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or medications provided by the above-named health care billing provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above named billing provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefits plan, administrator or insurance company in my name with derivative standing at provider's expense. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

Pursuant to the provisions of the Patient Protections and Affordable Care Act, our commitment is to ensure that we provide the highest quality of care with affordable prices. In addition, we would like to protect our patients from unexpected bills. In making sure services are available to as many patients as possible at affordable prices, our financial policy is outlined below. Please read this carefully and sign prior to your treatment.

- WE MAY ACCEPT ANY ASSIGNABLE INSURANCE WITH APPLICABLE COVERAGE
- WE MAY OFFER FINANCIAL ASSISTANCE UNDER OUR FINANCIAL POLICY TO ELIGIBLE PATIENTS ON A CASE BY CASE BASIS

Insurance

We accept assignment of insurance benefits at our discretion if acceptable insurance identification is provided. Acceptable insurance identification is defined as a valid insurance card, policy/plan with applicable coverage, and telephone/verification. As a courtesy to our patients, verifiable and assignable insurance will be billed by our office. However, you are personally responsible for your account balance in the event your insurance company does not pay the full amount of your claims, unless you are eligible for a reduction in the amount owed under our financial policy.

Discounts or Reductions in Bill

We may offer a discount, reduction or waiver of the deductible, coinsurance or co-pay to eligible patients based on medical needs and ability to pay on a case-by-case basis under our Financial Policy in accordance with applicable federal and state laws.

Your Responsibility and Cooperation

If we accept your insurance assignment as a payment from your insurance company, you agree to timely cooperate with your insurance company or health plan in the course of insurance claim processing, such as insurance inquiries, request for additional information, claims status verification or any inquiries for the purpose of your claim processing. You also agree to notify us immediately of any insurance inquiry or request for additional information and provide us with a copy of any documentation received from the insurance company or submitted to the insurance company from you.

I have read the Financial Policy, I understand and agree to this Financial Policy.

X _____

Signature of Responsible Party Print Name Date

FOOT SURGERY SPECIALISTS OF TEXAS

TEXAS PHYSIATRY

HSST

Hand Surgery Specialists of Texas

MIGRAINE

The HIPAA Privacy Rule gives individuals the right to direct how and where their healthcare provider communicates with them, such as sending correspondence to the individual's office instead of the individual's home. We invite you to share with us your preferred place and manner of communication. You may update or change this information at any time; please do so in writing.

Patient Name: _____ **DOB:** _____

I prefer to be contacted in the following manner (check all that apply):

Home Telephone: _____

____ OK to leave message with detailed information

____ Leave message with call-back number only

Cell Telephone: _____

____ OK to leave message with detailed information

____ Leave message with call-back number only

Work Telephone: _____

____ OK to leave message with detailed information

____ Leave message with call-back number only

____ Other: _____

Preferred Contacts:
We respect your right to indicate who you prefer that we involve in your treatment or payment decisions and/or who we share your information with, including information about your general medical condition and diagnosis (such as treatment and payment options), access to medical records (PHI), prescription pick-up and scheduling appointments. Please note, however, that we may share your information as set forth in our Notice of Privacy Practices to other persons as needed for your care or treatment or the payment of services we have provided. Please update this information promptly if your preferences change.

Please indicate the person(s) you prefer we share your information with below:

•Name: _____ Telephone: _____ Relationship: _____
•Name: _____ Telephone: _____ Relationship: _____
•Name: _____ Telephone: _____ Relationship: _____

Patient Signature: _____ **Date:** _____

To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)