AUSTIN FOOT AND ANKLE SPECIALISTS
5000 Bee Cave Road
Suite 202
Austin TX 78746
www.austinfootandankle.com
Phone (512) 328-8900
Fax (512) 328-8903

Patient Information:

First Name: _____ Last Name:_____ M.I.:_____

Suffix (Jr., Sr., III):_____ SS#:_____ Age:_____ Date of Birth:_____

Marital Status: ○Married ○Single ○Domestic Partner ○Divorced ○Separated ○Widowed ○Minor

Gender: ○M ○F Address:_____

City:_____ State:_____ Zip Code:_____

Contact Information: Home ( )_____ Cell ( )_____ Business ( )_____

Preferred contact: ○Home ○Business ○Cell May we leave detailed messages at that number?:_____

E-mail:_____

Employed: ○Yes ○No Employer Name:_____ Occupation:_____

Emergency Contact:_____ Relation:_____ Phone#:( )_____

Primary Care Physician:_____ Physician Phone#:( )_____

In Order for us to file a claim on your behalf, this section must be completed in its entirety

Responsible Party for Account (if different than patient)

Name:_____ Relationship to patient:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Contact Information: Home ( )_____ Cell ( )_____ Business ( )_____

Insurance Information:

Primary Insurance Name:_____ Plan Type:○HMO ○PPO ○Other:_____

Policy#:_____ Group#:_____ Effective Date:_____

Insured Name: :_____ Employer:_____

Date of Birth:_____ SS#:_____ Relationship to patient:_____

Secondary Insurance Name:_____ Plan Type:○HMO ○PPO ○Other:_____

Policy#:_____ Group#:_____ Effective Date:_____

Insured Name:_____ Employer:_____

Date of Birth:_____ SS#:_____ Relationship to patient:_____

How did you hear about Austin Foot and Ankle Specialists?

○ Google ○ Website ○ Facebook ○ Patient or Friend Name:_____

○ Physician Reference -- *please complete the following:*

*Referring Physician Name:*_____ *Physician Phone#:( )*_____

○ *Other (please specify):*_____

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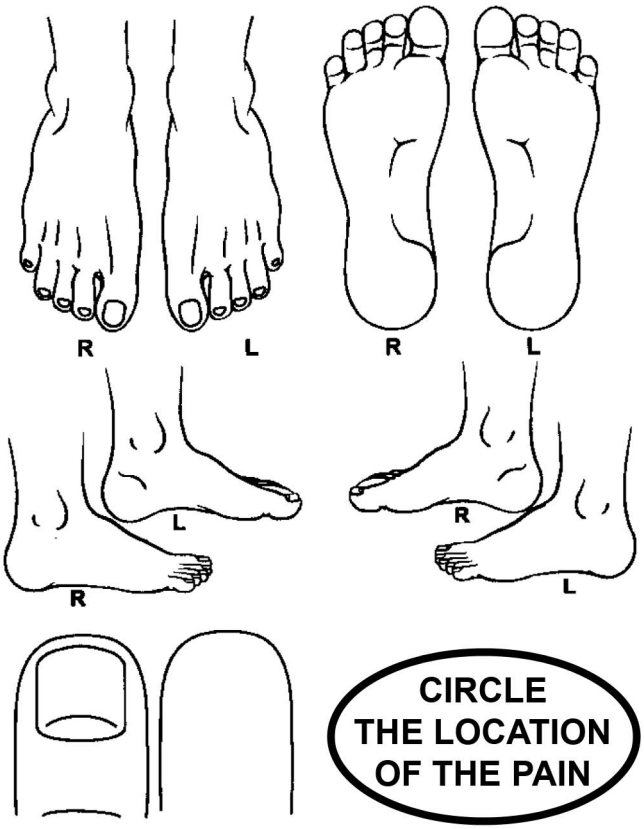
INITIAL PODIATRIC HISTORY



Description of Symptoms: _____

_____

_____

Onset of pain/disability? _____

_____

Duration of pain/disability? _____

_____

What makes it hurt? _____

_____

_____

What makes it better? _____

_____

_____

Describe the symptoms of pain: _____

_____

Do you have any other problems with your feet or ankles? _____

_____

MEDICAL HISTORY

List all Medical conditions you take medication for: _____

_____

List any serious injuries and the age at which they occurred:_____

_____

List any allergies and type of reaction:_____

_____

List all prior surgeries:_____

_____

List any medications you take on a daily basis – include pills, injectables, and vitamins:_____

_____

Do you use: ☐Tobacco ☐Alcohol ☐Drugs Frequency of use:_____

IMMUNIZATIONS
☐ Measles ☐ Mumps ☐ Tetanus ☐ Polio
☐ Influenza ☐ Typhoid ☐ Chicken Pox ☐ TB
☐ Pneumonia ☐ Other

FAMILY HISTORY Is there a Family History of any of these disorders?
☐ TB ☐ Heart ☐ Migraines ☐ Cancer
☐ Kidney ☐ Spine ☐ Diabetes ☐ Gout
☐ Arthritis ☐ Hypertension ☐ Epilepsy ☐ Mental
☐ Allergies ☐ Other

Height: _____ Weight: _____ Shoe Size: _____ Shoe Width: _____

Are you pregnant? ◯ Yes ◯ No Delivery Date?_____

REVIEW OF SYSTEMS

Gastro-Intestinal
☐ Poor Appetite ☐ Excessive hunger ☐ Difficult chewing ☐ Hemorrhoids
☐ Difficult swallowing ☐ Excessive thirst ☐ Nausea ☐ Liver Trouble
☐ Vomiting food ☐ Abdominal pain ☐ Diarrhea ☐ Weight loss
☐ Constipation ☐ Black Stool ☐ Bloody stool ☐ Ulcers
☐ Weight loss ☐ Weight gain ☐ Belching ☐ Gas
☐ Stomach trouble ☐ Appendicitis ☐ Indigestion
☐ Gallbladder Trouble ☐ Other

Genito-Urinary
☐ Bladder trouble ☐ Excessive urination ☐ Scanty urniation ☐ Kidney Stones
☐ Painful urination ☐ Discolored urine ☐ Frequent urination ☐ Difficult Urination
☐ Prostate trouble ☐ Kidney disease ☐ Blood in urine
☐ Other

Nervous
☐ Numbness ☐ Loss of feeling ☐ Seizure ☐ Paralysis
☐ Dizziness ☐ Fainting ☐ Stroke ☐ Headaches
☐ Muscle jerking ☐ Convulsions ☐ Weakness ☐ Forgetfulness
☐ Confusion ☐ Depression ☐ Spine disease ☐ Brain disease
☐ Other

Eyes
☐ Eye strain ☐ Eye inflammation ☐ Vision problem ☐ Impaired sight
☐ Eye disease ☐ Eye injury ☐ Other

Ears/Nose/Throat
☐ Ear pain ☐ Ear noises ☐ Ear discharge ☐ Sore Mouth
☐ Hearing loss ☐ Nose pain ☐ Nose bleeding ☐ Sore throat
☐ Nose discharge ☐ Breathing difficulty ☐ Sore gums ☐ Hoarseness
☐ Sore mouth ☐ Sore throat ☐ Hoarseness ☐ Speech difficulty
☐ Dental problems ☐ Other

Cardio-Vascular
☐ Chest Pain ☐ Pain over Heart ☐ Leg pain on walking ☐ Tiredness
☐ Heart attack ☐ High blood pressure ☐ Rapid heart beat ☐ Weakness
☐ Varicose veins ☐ Heart problems ☐ Night sweats ☐ Hands swell
☐ Feet swell ☐ Other

Respiratory
☐ Persistent cough ☐ Difficult breathing ☐ Bronchitis ☐ Coughing
☐ Lung problems ☐ Coughing blood ☐ Emphysema ☐ Asthma
☐ Wheezing ☐ Hay fever ☐ Shortness of breath ☐ Other

Integument
☐ Itching ☐ Psoriasis ☐ Bruises ☐ Deformed nails
☐ Skin rash ☐ Abrasions ☐ Ulcerations ☐ Birth marks
☐ Moles ☐ Discolorations ☐ Skin cancers ☐ Eczema
☐ Hives ☐ Other

Musculoskeletal
☐ Arthritis ☐ Stiffness ☐ Club foot ☐ Muscle pain
☐ Joint disease ☐ Bursitis ☐ Fractures ☐ Sciatica
☐ Sprains ☐ Other

Allergies
☐ Penicillin ☐ Morphine ☐ Adhesive tape ☐ Aspirin
☐ Sulfa drugs ☐ Antibiotics ☐ Any foods ☐ Codeine
☐ Other drugs ☐ Any chemicals ☐ Other

Hematologic
☐ Bleeding disorder ☐ Take coumadin ☐ Anemia ☐ Jaundice
☐ Take aspirin ☐ Other

Signature:_____ Date:_____

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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: AFAS 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: AFAS accepts VISA, MasterCard, Amex, Cash or Checks. All checks are immediately scanned for processing. Our office does not accept temporary checks and we will contact the bank directly to verify checks over $500. We do not offer payment plans. We offer CareCredit and dependent on the amount will allow between 6-18 month payment plans.

7. Insurance Claims: AFAS files claims electronically for the patient's primary contracted plan and accepts payment via the patient's assignment. AFAS files secondary claims if provided at time of service. If not provided 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 AFAS 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: AFAS only files claims to carriers whom we have a contractual relationship; our in-network list is available upon request or on our website.

10. Liability Claims: AFAS does not accept personal injury protection, letters of protection or other liability claims. These types of claims are to be paid in full by the patient.

11. Non-Covered Services: AFAS 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, Powerstep, Superfeet, Mycomist, etc…)

12. Referrals: AFAS may refer patients to other providers, facilities, and labs. AFAS is not responsible for these entities. The patient should contact these non-AFAS 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 AFAS.

13. Missed Appointments: A $25 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 Austin Foot and Ankle Specialists Doctor-Patient relationship. 30 days' advance notice will be given should the situation result in a transfer of the patient's care.

15. Patient Balance Statements: AFAS will send a remainder or balance statement to the patient when the 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. Returned Checks: A $25.00 fee will be assessed on all returned checks. Any NSF or Closed Account will result in future services on a pre-pay cash or credit basis. The District Attorney's Office will prosecute unresolved checks.

18. Refunds: AFAS 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.

19. Returns: Only unworn and non-custom items are returnable within 3 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.*

20. **Medical Records**: The cost for copied medical records and completion of disability forms will be charged to the patient and collected prior to replicating. 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 or Legal Authorized Representative	Relationship to Patient	Date

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Authorization from Patient or Legal Representative

Austin Foot and Ankle Specialists (herein after collectively referred to as "AFAS")

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 AFAS and its providers. The undersign agrees that it is their responsibility to contact and/or schedule with AFAS for any follow up visits, other services, prescriptions and items ordered for the patient. The undersigned also understands that AFAS'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 AFAS 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 AFAS.

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 AFAS.

4. Authorization to Release Information: I consent and authorize AFAS 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.austinfootandankle.com.** Individual copies are also available in the office upon request and posted in the hallway adjacent to Reception. I have read/had the opportunity to read my HIPAA rights, which include AFAS's fees for records.

5. Designation of Authorized Representative: I designate and appoint AFAS (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 AFAS, any requests for documents relating to this claim and appeal of an adverse determination of the claim.

6. Financial Agreement: I hereby promise 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. Regardless of the assignment of benefits, should the insurance misrepresent their coverage or delay payment of a claim greater than 60 days, as the designated responsible party, I am responsible for the for all monies owed to AFAS. 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 AFAS.

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