



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): _____

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: _____

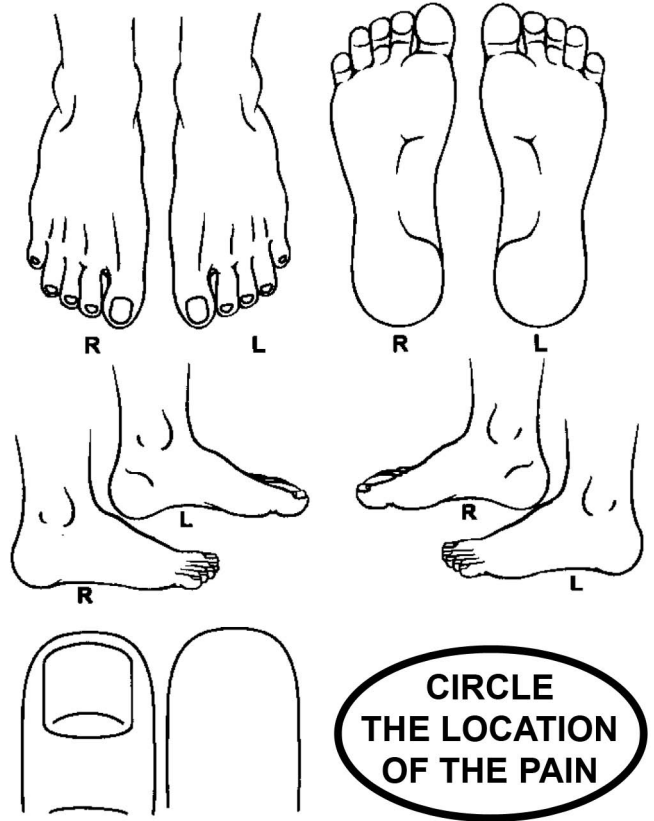
List any serious injuries and the age at which they occurred: _____

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**
- | | | | |
|------------------------------------|----------------------------------|--------------------------------------|--------------------------------|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tetanus | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Influenza | <input type="checkbox"/> Typhoid | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> TB |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Other | | |

- FAMILY HISTORY** Is there a Family History of any of these disorders?
- | | | | |
|------------------------------------|---------------------------------------|------------------------------------|---------------------------------|
| <input type="checkbox"/> TB | <input type="checkbox"/> Heart | <input type="checkbox"/> Migraines | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Kidney | <input type="checkbox"/> Spine | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mental |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Other | | |

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

Are you pregnant? Yes No Delivery Date? _____

REVIEW OF SYSTEMS

- | | | | | |
|--------------------------|---|---|--|--|
| Gastro-Intestinal | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Excessive hunger | <input type="checkbox"/> Difficult chewing | <input type="checkbox"/> Hemorrhoids |
| | <input type="checkbox"/> Difficult swallowing | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Nausea | <input type="checkbox"/> Liver Trouble |
| | <input type="checkbox"/> Vomiting food | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Weight loss |
| | <input type="checkbox"/> Constipation | <input type="checkbox"/> Black Stool | <input type="checkbox"/> Bloody stool | <input type="checkbox"/> Ulcers |
| | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Belching | <input type="checkbox"/> Gas |
| | <input type="checkbox"/> Stomach trouble | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Indigestion | |
| | <input type="checkbox"/> Gallbladder Trouble | <input type="checkbox"/> Other | | |
| Genito-Urinary | <input type="checkbox"/> Bladder trouble | <input type="checkbox"/> Excessive urination | <input type="checkbox"/> Scanty urination | <input type="checkbox"/> Kidney Stones |
| | <input type="checkbox"/> Painful urination | <input type="checkbox"/> Discolored urine | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Difficult Urination |
| | <input type="checkbox"/> Prostate trouble | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Blood in urine | |
| | <input type="checkbox"/> Other | | | |
| Nervous | <input type="checkbox"/> Numbness | <input type="checkbox"/> Loss of feeling | <input type="checkbox"/> Seizure | <input type="checkbox"/> Paralysis |
| | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fainting | <input type="checkbox"/> Stroke | <input type="checkbox"/> Headaches |
| | <input type="checkbox"/> Muscle jerking | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Weakness | <input type="checkbox"/> Forgetfulness |
| | <input type="checkbox"/> Confusion | <input type="checkbox"/> Depression | <input type="checkbox"/> Spine disease | <input type="checkbox"/> Brain disease |
| | <input type="checkbox"/> Other | | | |
| Eyes | <input type="checkbox"/> Eye strain | <input type="checkbox"/> Eye inflammation | <input type="checkbox"/> Vision problem | <input type="checkbox"/> Impaired sight |
| | <input type="checkbox"/> Eye disease | <input type="checkbox"/> Eye injury | <input type="checkbox"/> Other | |
| Ears/Nose/Throat | <input type="checkbox"/> Ear pain | <input type="checkbox"/> Ear noises | <input type="checkbox"/> Ear discharge | <input type="checkbox"/> Sore Mouth |
| | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Nose pain | <input type="checkbox"/> Nose bleeding | <input type="checkbox"/> Sore throat |
| | <input type="checkbox"/> Nose discharge | <input type="checkbox"/> Breathing difficulty | <input type="checkbox"/> Sore gums | <input type="checkbox"/> Hoarseness |
| | <input type="checkbox"/> Sore mouth | <input type="checkbox"/> Sore throat | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Speech difficulty |
| | <input type="checkbox"/> Dental problems | <input type="checkbox"/> Other | | |
| Cardio-Vascular | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Pain over Heart | <input type="checkbox"/> Leg pain on walking | <input type="checkbox"/> Tiredness |
| | <input type="checkbox"/> Heart attack | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Rapid heart beat | <input type="checkbox"/> Weakness |
| | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Hands swell |
| | <input type="checkbox"/> Feet swell | <input type="checkbox"/> Other | | |
| Respiratory | <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Difficult breathing | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Coughing |
| | <input type="checkbox"/> Lung problems | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Asthma |
| | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Other |
| Integument | <input type="checkbox"/> Itching | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Bruises | <input type="checkbox"/> Deformed nails |
| | <input type="checkbox"/> Skin rash | <input type="checkbox"/> Abrasions | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Birth marks |
| | <input type="checkbox"/> Moles | <input type="checkbox"/> Discolorations | <input type="checkbox"/> Skin cancers | <input type="checkbox"/> Eczema |
| | <input type="checkbox"/> Hives | <input type="checkbox"/> Other | | |
| Musculoskeletal | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Club foot | <input type="checkbox"/> Muscle pain |
| | <input type="checkbox"/> Joint disease | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Fractures | <input type="checkbox"/> Sciatica |
| | <input type="checkbox"/> Sprains | <input type="checkbox"/> Other | | |
| Allergies | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Morphine | <input type="checkbox"/> Adhesive tape | <input type="checkbox"/> Aspirin |
| | <input type="checkbox"/> Sulfa drugs | <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Any foods | <input type="checkbox"/> Codeine |
| | <input type="checkbox"/> Other drugs | <input type="checkbox"/> Any chemicals | <input type="checkbox"/> Other | |
| Hematologic | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Take coumadin | <input type="checkbox"/> Anemia | <input type="checkbox"/> Jaundice |
| | <input type="checkbox"/> Take aspirin | <input type="checkbox"/> Other | | |

Signature: _____

Date: _____



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OFFICE POLICIES AND PROCEDURES

We would like to take this opportunity to personally thank you for choosing Austin Foot and Ankle Specialists to treat your podiatric needs and concerns. Below is a list of our office policies. Please take a moment of your time to review our policies and please do not hesitate to ask any questions. **After reviewing the policies below, please initial next to each policy indicating you have read, understand, and will adhere to the written policies. Either typed or hand-written initials will constitute this acknowledgement.**

_____ **Patient treatment:** It is our primary goal to restore and maintain the health of your feet. We strive to provide you with the highest quality podiatric care. If you have any questions regarding your treatment, please feel free to consult with your physician who is providing your care. It is our responsibility to deliver the best health care possible. We highly value your confidence in our practice and we will make a sincere effort to satisfy all your podiatric needs. Your initials and signature will act as an authorization and consent for treatment.

_____ **Appointments:** If you are unable to keep your appointment we require that you contact our office. As a courtesy to other patients who are waiting for an appointment, we request that you call to cancel your appointment within 24 hours. Patients with 3 or more missed appointments without proper notification will be asked to transfer their records to another physician. Also as a courtesy to the doctor and to other patients, we require that you be on time for your appointment. When you are late, you put the doctor behind schedule with their other patients. If you are more than 15 minutes late you will be required to reschedule your appointment.

_____ **Release of Records:** If you want your records released to another physician or facility you must sign a Release of Information form indicating who we are releasing records to, as well as, which relevant information you would like us to release. If you wish to receive a copy of your records for your personal files, you must send us a written request. Please allow 7-10 business days to have your records available. Any x-rays taken within our office are our personal property which we are legally responsible to maintain with your records. Therefore we DO NOT release our films. Copies are available upon request for a fee of \$8.00 per CD.

_____ **Referrals:** If your insurance company requires a referral, it is your responsibility for obtaining it. The contract is between you and your insurance carrier. Therefore, we are not responsible to obtain your referral. If you present to the office without your referral you will be required to reschedule your appointment or you may opt to payout of pocket for services rendered. Referrals must be generated from your primary care physician or referring doctor.

_____ **Insurance:** Your insurance coverage is a contract between you and your insurance company. We are not a party to this contract. We will bill your insurance company (primary and secondary, if applicable) as a courtesy. Your insurance company does not guarantee payment for services rendered. Your insurance company makes the final determination of benefits and eligibility at the time the claim is reviewed. By signing the line below you hereby agree that you understand you are solely responsible to pay any portion of charges not covered by your insurance carrier.

_____ **Verification of Benefits:** You as the policyholder are primarily responsible to know your insurance benefits. We may assist you, if time permits to verify your podiatric coverage available under your policy. The insurance DOES NOT guarantee payment of the benefits quoted and subsequently you will be responsible for any coinsurance or deductibles for services not covered by your insurance carrier. We must have a copy of your insurance card and photo ID in order to process your claim. Therefore, please give your cards to the receptionist. If you are a first-time patient, or if your insurance information has changed, we must be notified. Failure to cooperate will mean that you will be responsible for the charges incurred.

_____ **Required Payments:** You be will be responsible to pay any co-payment, deductible, coinsurance, or fees not covered by your insurance carrier at the time services are rendered. We do not accept letters of protection. Any outstanding balances greater than 60 days must be paid prior to being seen by the physician or you will be required to reschedule your appointment. You may choose to pay by cash, check, or Credit Card.

_____ **Monthly Statements:** You will receive a statement only if you have an outstanding balance on your account. The statement will reflect any balance pending with your insurance carrier as well as any outstanding balance for services not covered by your insurance company. We request that if you receive a statement, that you make payment within 30 days of receipt. If your balance becomes delinquent past 60 days, your account will be referred to a collection agency.

Signature: _____

Date: _____



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NOTICE OF PRIVACY PRACTICES

This page serves to inform you of the privacy practices of Austin Foot and Ankle Specialists and its representatives. The privacy of your medical information is important to us. We intend to honor your privacy in every way possible. By signing below you will allow us to disclose your personal health information:

I, _____ understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- o A basis for planning my care and treatment
- o A means of communication among the many health professionals who contribute to my care
- o A source of information for applying my diagnosis and evaluation information to my bill
- o A means by which a third-party payer can verify that services billed were actually provided
- o A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have reviewed and understand the Notice of Information Practices. I understand that I have the right to review the complete policy prior to signing this consent. I understand that the organization reserves the right to change their notice and practices. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

We respect your rights in maintaining the utmost in privacy in regards to your individual health information. We will not release any of your health information to non-medical entities without your prior written permission. Austin Foot and Ankle Specialists maintains physical and electronic safeguards that restrict unauthorized access to your health information. Such safeguards include secured office facilities, locked file cabinets and controlled computer network systems and password accounts.

We will only disclose your medical information to your health plan or other health care professionals or facilities for purposes of diagnosis or treatment of your medical condition. If you prefer that we do not disclose any or all of your medical condition(s), please inform us so that we may take any necessary precautions.

No restrictions

I request the following restrictions to the use or disclosure of my health information:

Signature of Patient or Legal Representative Witness

Date