The Foot Clinic
Euless, TX

New Patient Intake Form

Patient Name: _____

Today's Date: _____/_____/_____ DOB: _____/_____/_____ Age: _____ Sex: M F

Home Address: _____ City/State: _____ Zip: _____

Home Phone: _____ May we leave a message? Yes No

Cell Phone: _____ May we leave a message? Yes No

E-Mail: _____

Marital Status: Single Married Partnered Separated Divorced Widowed

Primary Language: _____

Do you have a legal guardian or power of attorney? Yes No If yes, please provide legal documentation.

Emergency Contact: _____ Phone: _____

Primary Care Doctor: _____ Send treatment updates? Yes No

Pharmacy: _____ Phone: _____

Is there a family member or other person that you would like for us to share your medical information? Yes No

If yes, name: _____

Who is responsible for payment? _____ Relationship? _____

Address: _____ City/State: _____ Zip: _____

Insurance Information

Primary Insurance: _____ Member ID: _____

Secondary Insurance: _____ Member ID: _____

Who may we thank for referring you to our office: _____

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Please list all medications you are currently taking (including over the counter meds and herbal supplements)

Medication	Dosage	How often do you take?

Please list all prior surgeries:

Type of Surgery	Date	Type of Surgery	Date

Social History

Use of alcohol: Never Occasionally No longer use History of alcohol abuse

Use of Tobacco: Never Current Smoker _____packs a day for _____ years Quit _____ ago

Use of recreational drugs: Never Current Use – Type_____ for how long? _____

Employer: _____ Occupation: _____

How much are you on your feet at work: 10% 25% 50% 75% 100%

Do others depend on you for their care? Children Elderly or disabled family member Pets Other

Do you exercise? Never Rarely Occasionally Weekly Several times a week Daily

Type of exercise: _____

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Family History

Do you have a family history of?

Condition	Mother	Father
Diabetes		
Cancer		
Heart Disease		
High Blood Pressure		
Stroke		
Coronary artery disease		
Thyroid Disorder		
Rheumatoid arthritis		
Other		

Your Medical History

Do you have any allergies to?

Medications Anesthesia Foods Tape Latex Shellfish Iodine Other No Known Drug Allergies

Please list all medications you are allergic to:

Medication	Reaction

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Have you ever had any of the following?

Acid Reflux	Yes	No	Fibromyalgia	Yes	No	Neuropathy	Yes	No
Anemia	Yes	No	Gout	Yes	No	Open Sores	Yes	No
Arthritis	Yes	No	Heart Attack	Yes	No	Pneumonia	Yes	No
Asthma	Yes	No	Heart Disease	Yes	No	Polio	Yes	No
Back Trouble	Yes	No	Hepatitis	Yes	No	Rheumatic Fever	Yes	No
Bladder Problems	Yes	No	HIV+/AIDS	Yes	No	Sickle Cell Disease	Yes	No
Abnormal Bleeding	Yes	No	High Blood Pressure	Yes	No	Skin Disorder	Yes	No
Blood Clots	Yes	No	Kidney Disease	Yes	No	Sleep Apnea	Yes	No
Blood Transfusions	Yes	No	Liver Disease	Yes	No	Stomach Ulcers	Yes	No
Bronchitis	Yes	No	Low Blood Pressure	Yes	No	Stroke	Yes	No
Cancer	Yes	No	Migraine Headache	Yes	No	Thyroid Disease	Yes	No
Diabetes T1 T2	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No

Current Problem

What specific problem brings you to our office today? _____

_____

_____

_____

_____

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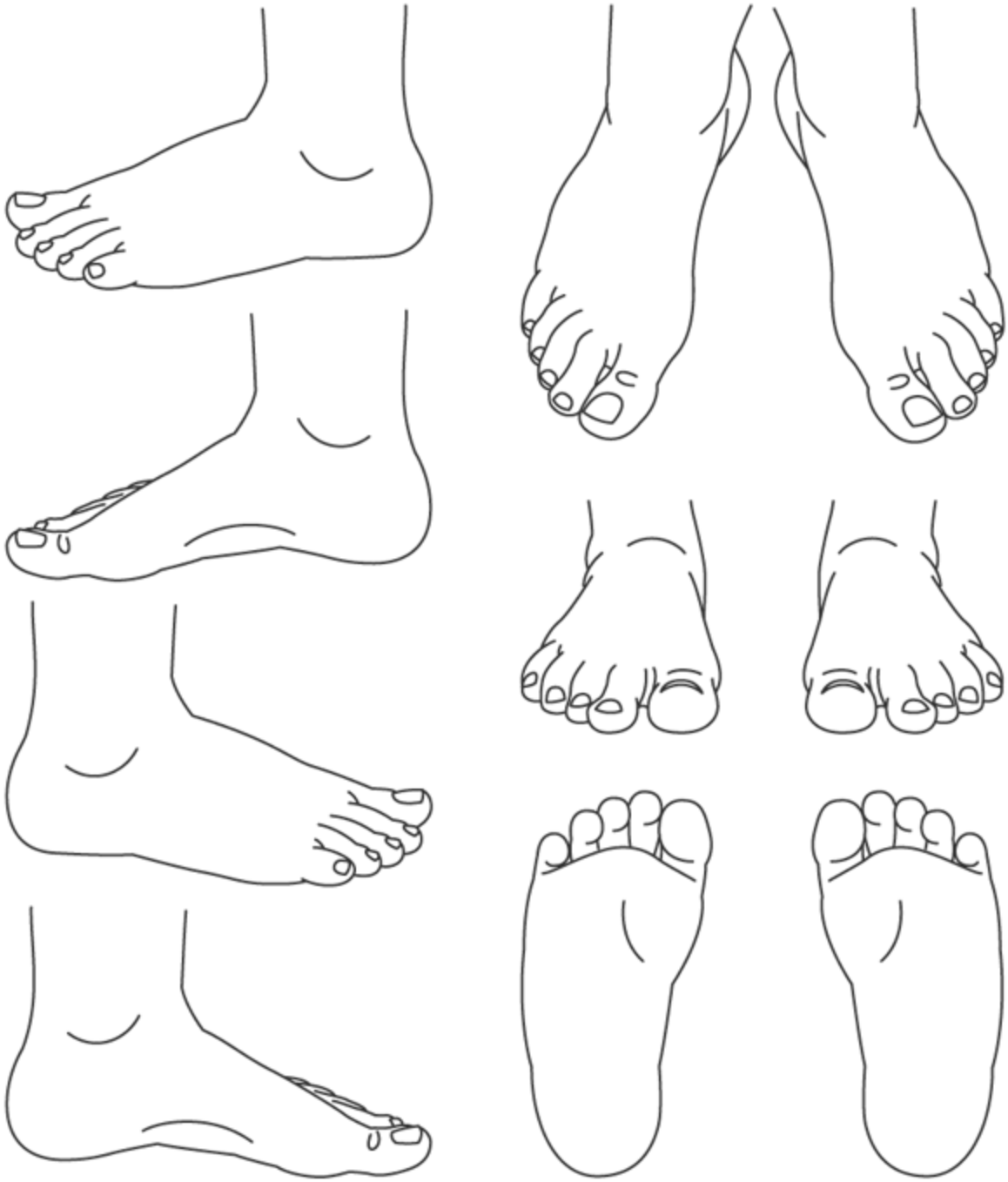
Where is the pain/problem located? Mark on the pictures below:



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How long ago did this problem start? _____ days / weeks/ months / years

Did you pain or problem begin: All of a sudden Gradually develop over time

How would you describe your pain? No pain Sharp Dull Aching Burning Radiating Itching Stabbing

How would you rate your pain on a scale from 1 to 10? 0 1 2 3 4 5 6 7 8 9 10

Since the time your pain or problem began, has it: Stayed the same Become worse Improved

What makes your pain or problem feel worse?

Walking Standing Daily activities Resting Dress shoes High heels Flat shoes Closed toe shoes

What makes your pain or problem feel better? _____

_____

What treatments have you had for this problem? _____

_____

How has this problem affected your lifestyle or ability to work? _____

_____

Was this problem caused by an injury? No Yes – describe _____

_____

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

_____ _____

Print Name of Patient Signature of Patient

_____ _____

Doctor Signature Date Signed

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Do I need a Test for PAD?

Answers to the following questions will help determine if you are at risk for Peripheral Arterial Disease (PAD) and if a vascular examination can help better assess your vascular health status.

Patient Name: _____ Date: _____

1	Do you experience any pain in your legs or feet while are rest?	YES	NO	
2	Do you have uncomfortable aching, fatigue, tingling, cramping or pain in your feet, calves, buttocks, hip or thig during walking/exercise?	YES	NO	
3	If yes to Question 2, does the pain go away when you stop walking/exercising?	YES	NO	1 yes ABI
4	Do your feet get pale, discolored, or bluish at any time during the day?	YES	NO	
5	Do you have an infection, skin wound or ulcer on your leg or foot that is slow to heal over the past 8-12 weeks?	YES	NO	
6	Are you over the age of 65?	YES	NO	
7	Are you over the age of 50?	YES	NO	
8	Do you have high cholesterol or other blood lipid (fat) problems or require cholesterol medication?	YES	NO	
9	Do you have high blood pressure or take medication to reduce blood pressure?	YES	NO	
10	Do you have diabetes?	YES	NO	2 Yes ABI
11	Do you have a history of chronic kidney disease?	YES	NO	
12	Do you currently or have you ever smoked?	YES	NO	
13	Do you have a history of stroke or mini stroke (TIA)?	YES	NO	
14	Do you have a history of heart disease (heart attack, MI)?	YES	NO	
15	Do you have a history of carotid stenosis, AAA (abdominal aortic aneurysm), or stent placement?	YES	NO	

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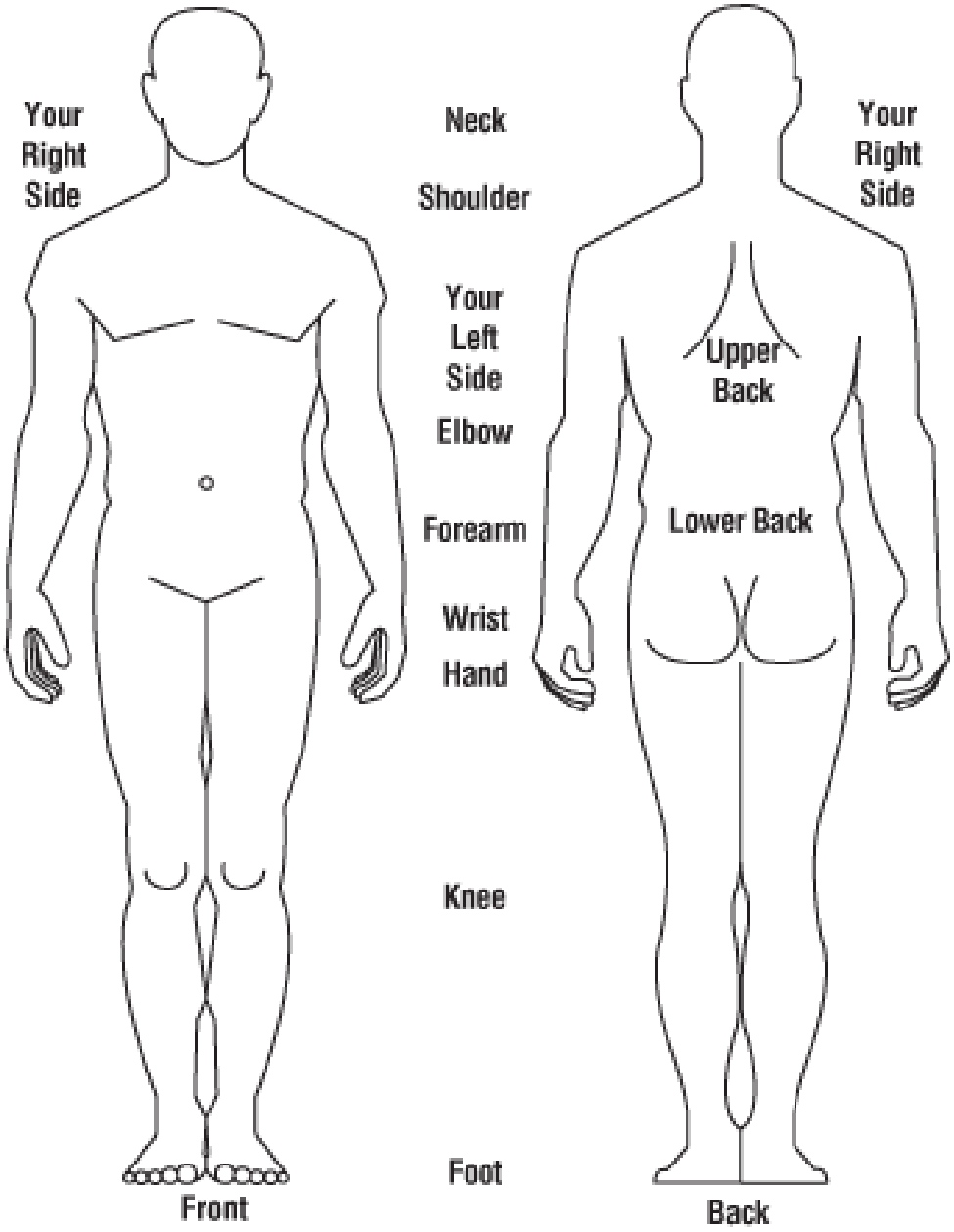
Name: _____ **Date:** _____

We are an integrated practice combining foot & ankle care with orthopedic and vascular medicine. If you are experiencing pain in parts of your body other than your lower legs and feet and would like more information about the services we provide, please use the diagram below to circle all points of pain.



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Office Policy

Welcome to our office! Please read this policy carefully and feel free to ask questions regarding any part of this form. We believe that a clear definition of our office and financial policies will allow us to concentrate on the primary goal of restoring or maintaining the health of your feet. Our practice will strive to provide you with the finest quality podiatric care. If you have any questions regarding your treatment, please do not hesitate to ask. We welcome referrals and look forward to establishing a satisfactory doctor-patient relationship.

Appointments: If you are unable to keep an appointment please call the office to reschedule at least 24 hours in advance. Patients with three missed appointments may be asked to transfer their records to another doctor. Patients who are more than 15 minutes late may be asked to reschedule.

At times it will be necessary for the office to change your appointment due to emergencies that arise or a change in the physician's schedule. We will make every attempt to limit these changes and will give you as much prior notice as possible. We ask that you understand this and work with us so that we may get you rescheduled quickly.

Transferring Records: Patient requests for copies of records may take 2-4 weeks to receive and will require a current signed patient HIPPA release form on the date of the request. Charges for records are as follows: $1 per page for the first 25 pages and then .50 per page after that. To protect your security, emailed requests for records are not acceptable.

Financial Policy: To make our services available to as many patients as possible on an affordable basis, we have adopted the financial collection policy outlined below. We ask you to read the policy carefully and sign prior to any treatment.

- We may accept any assignable insurance with applicable coverage.
- We offer financial assistance (discount, waiver or reduction of deductibles, co-pays, and coinsurance) under our indigency policy to all eligible patients on case to case basis.
- Full payment is due at time of service unless arranged otherwise.
- We accept cash, checks, Visa, Mastercard, American Express, and Discover.
- Dishonored checks will be charged back to the patient's account with a service fee of $25.00.

Insurance: We may 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, or telephone verification. As a courtesy to our patients, verifiable and assignable insurance will be filed by our office. However, you will be personally responsible for your account balance regardless of whether your insurance will pay for the total balance of your claims, unless you're eligible for discounts under our indigency policy, which should be predetermined before the

services are rendered. Your insurance policy/employee benefits plan is a contract between you and your insurance company/employee benefits plan. We are not a party to that contract. In the event we do not accept assignment of benefits, we require that you be

preapproved on our extended payment plan by providing a credit card with authorization to charge that amount for the balance due if your insurance

company/employee benefits plan has not paid your account in full within 45 days or has determined your claims to be your responsibility for the reasons of annual deductible, co-payment, non-covered services and not medically necessary. We encourage our patients to contact their plans for clarification of benefits prior to services rendered. As our patient, you are responsible for all authorizations/referrals needed to seek treatment.

If a patient chooses or is required to bill his/her own insurance, this office will provide an itemized statement and a HCFA-1500 Form to the patient but will treat the account as a self-pay.

Patients must inform the office of all insurance changes and authorization referral requirements. In the event the office is not informed in a timely manner, you will be responsible for any charges denied.

Regarding Discount due to the Affordable Healthcare Act, we may offer discounts, reduction or waiver of deductibles, coinsurance and co-pay to any eligible patient under our indigency Policy in accordance with applicable federal and state laws. These discounts are based on medical needs and ability to pay on a case-by-case basis and patients may apply for financial indigency discount assistance by asking our staff to determine if you're eligible.

Referrals: If your insurance company requires a referral and/or preauthorization/pre-certification you are responsible for obtaining it. We will not be able to obtain a referral on the date of service. If you arrive for your appointment without your referral you have 3 options available to you:

1) You may attempt to contact your PCP and obtain the referral. However, if you do not have the referral by your appointment time, you will need to choose one of the other two options.
2) You may reschedule your appointment without penalty.
3) You may leave us two checks at the end of your appointment. One check will be for your co-pay/co-insurance. The second check will be for the full amount of your visit. If you can obtain a referral within 48 hours of your appointment, we will return the full amount check to you un-cashed. Otherwise, we will return the co-pay check to you.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We do not accept "Letters of Protection" and subsequently cannot bill your attorney for charges incurred due to a personal injury case.

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Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for the child will be responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. Unless other arrangements have been made, the balance on your statement is due in full when the statement is issued. Accounts not paid in full by the next statement period will incur a late fee.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we must litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment in our office may become a matter of public record.

FMLA and Disability Forms: We are happy to complete disability paperwork for you as required by your employer. Please submit the forms **one week prior to the due date**. We will fax the forms to the appropriate department for you, however, if after several attempts they have still not received the forms, it will become your responsibility to send them in. There will be a fee of $25.00 to have the initial disability forms completed, and a $10.00 fee per set after that.

Medical Information: I authorize the release of medical information to my insurance company necessary to process my claim. I also authorize the payment medical benefits directly to my physician. I understand I am financially responsible for charges not covered by my insurance carrier.

Effective Date: Once you have signed this document, you agree to all the terms and conditions contained herein. This agreement will be in full force until terminated in writing.

I have read the above office policy and have had the opportunity to have all my questions answered.

Patient Signature: _____ Date: _____

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Physician Disclosure

As required by Section 102.006 of the Texas Occupations Code

Texas law requires a physician to disclose to a patient those arrangements permitted under applicable Texas law whereby such physician accepts remuneration to secure or solicit a patient or patronage for a person licensed, certified or registered by a Texas health care regulatory agency. The purpose of this Disclosure is to notify you, the patient, that your attending physician(s) may receive remuneration for referring you to any of the following ancillary healthcare providers for certain healthcare services:

Accordingly, I hereby acknowledge that my attending physician(s) have disclosed to me, at the time of initial contact and at the time of referral (i) his or her affiliation with the foregoing ancillary healthcare provider(s) for whom, I, the patient am being referred, and (ii) that he/she will receive, directly or indirectly, remuneration for the referral to such ancillary healthcare provider. I understand that I, the patient, have the right to choose the providers of my healthcare services and/or products and, as such, I have the option of receiving ancillary healthcare services from any ancillary healthcare provider and/or facility that I choose.

Patient Signature: _____ Date: _____

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E-Prescribing Consent Form

ePrescribing is defined by a Physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) 2003 listed standards that must be included in an ePrescribe program.

These include:

Formulary and benefit transactions - gives the prescriber information about which drugs are covered by the drug benefit plan.

Medication history transactions – provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

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

Understanding all the above, I hereby provide informed consent to The Foot Clinic to enroll me in the ePrescribe program. I have had the chance to ask questions and all my questions have been answered to my satisfaction.

This consent will remain enforce until revoked or changed.

Patient Name (Print):_____ DOB: _____

Patient Signature: _____ Date: _____

Pharmacy (Name & Location) _____