TEXAS FOOT SURGEONS

Patient information and Consent to Treat *Date:_____*

Last Name:_____First Name_____MI_____

Date of Birth:_____Sex M F Height:_____ Weight:_____

Physician you are here to see (please circle) Dr. Eric Pack Dr. Ginger Sellars

Please Circle One: NEW Patient/ESTABLISHED Patient

Reason for visit:_____

How did you hear about Dr. Pack/Sellars?_____

Primary Care Physician:_____Date of last visit_____

Diabetic doctor (if applicable):_____Date of last visit_____

When did symptoms first start?_____

Pain Scale (circle one): 0 1 2 3 4 5 6 7 8 9 10

Symptoms occur (circle one): Daily Weekly Occasionally Constantly

Symptoms are relieved with:_____

Made worse by:_____

If an injury, where, how and when did it occur:_____

_____

_____

Drug allergies and reactions:_____

Current medications:_____

_____

Any personal/family history of: P F Diabetes P F High Blood Pressure
(Circle all that apply) P F Heart Disease P F Stroke
P F Cancer

Please list any other medical problems:_____

Previous Surgeries:_____

Do you smoke: No Yes Amount:_____ **Quit? (what year?)**_____

Do you drink alcohol? No Yes Amount/week:_____

Marital Status: Married Single Divorced Widowed

How many hours per day do you spend on your feet?_____**hrs/day**

What type of shoes do you wear?_____

Pharmacy name and location:_____

Do you have any problems with the following (please circle all that apply):

Fever	**Vomiting**	**Rash**
Night Sweats	**Change in Appetite**	**Numbness**
Weight Gain/Loss	**Diarrhea**	**Seizures**
Vision Changes	**Incontinence**	**Dizziness**
Difficulty Hearing	**Difficulty Urinating**	**Headaches**
Nose/Sinus Problems	**Blood in Urine**	**Depression**
Sore Throat	**Increased Frequency**	**Sleep Disturbances**
Chest Pain	**Muscle Aches**	**Alcohol Abuse**
Shortness of Breath	**Weakness**	**Fatigue**
Palpitations	**Joint Pain**	**Hair Loss**
Heart Murmur	**Back Pain**	**Cold/Heat Intolerance**
Cough	**Swelling**	**Swollen Glands**
Wheezing	**Abnormal Mole**	**Bruising**
Abdominal Pain	**Jaundice**	**Seasonal Allergies**

TEXAS FOOT SURGEONS

Patient Health Insurance Information ***Date:_____***

PATIENT NAME_____ SOCIAL SECURITY #_____
(If different from Guarantor)

RESPONSIBLE PARTY INFORMATION (GUARANTOR)

LAST NAME _____FIRST NAME_____ MI_____

DOB_____ SEX M F SOCIAL SECURITY #_____

MAILING ADDRESS_____

RELATION TO PATIENT_____

HOME PHONE_____CELL PHONE_____WORK PHONE_____

EMAIL ADDRESS_____

MARITAL STATUS:_____

EMERGENCY NAME, PHONE, RELATIONSHIP:_____

_____

CONSENT FOR TREATMENT

I voluntarily give my permission to the health care providers at Texas Foot Surgeons, PLLC and such assistants as they may deem necessary to provide medical care services to me. I understand that by signing this form, I am authorizing them to treat me as long as I seek care from Texas Foot Surgeons providers, or until I withdraw my consent.

I also understand and agree that I am financially responsible for the services provided to myself and/or dependents. These services include: charges not covered or denied by insurance, co-pays, deductible and co-insurance.

SIGNATURE OF PATIENT OR GUARDIAN **DATE**

_____ **_____**

PRINTED NAME OF PATIENT OR GARDIAN **RELATIONSHIP TO PATIENT**

_____ **_____**

WITNESS:_____ **DATE:_____**

Texas Foot Surgeons Patient Financial Policy

Thank you for choosing Texas Foot Surgeons to provide you with medical care. We are committed to providing you with quality and affordable health care. The medical services provided by our office are services you have elected to receive which may result in a financial responsibility on your part.

Please read the following office payment policy and feel free to ask us any questions you may have. Once you accept this policy, please sign in the space provided below. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but you do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Medicare.** We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However, that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any copayments, which are usually 20% of the allowed amount for an item or service.
3. **Secondary Insurance.** Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.
4. **Copayments and deductibles.** All copayments and deductibles must be paid at the time of service. The arrangement is part of your contract with your insurance company. Failure on our part to collect copayments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your copayments at each visit.
5. **Self Pay:** Payment in full is due at the time of service if you do not have health insurance.
6. **Non-covered services.** In certain circumstances, some – and perhaps all – of the services you consent to receive may be uncovered by your benefit plan or not considered reasonable or necessary by Medicare or other insurers. If you have questions regarding coverage for recommended treatment please ask your provider. You are responsible for payment of non-covered services.
7. **Proof of Insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the current insurance information in a timely manner, you may be responsible for the balance of the claim.
8. **Referrals/Authorizations.** We are required to follow the guidelines of your managed care plan. If required, obtaining the proper referral from your Primary Care Physician is your responsibility. Patients presenting to our office without a valid referral will be asked to pay in full or have the option to reschedule their appointment. This payment will be held for 48 hours and will become non-refundable if the proper referral is not obtained by then. We will keep track of necessary documentation, referrals and pre-certifications you will need to be treated at our office. However, as the patient, you are ultimately responsible for all authorizations/referrals needed to seek treatment in this office. You must inform our office of all insurance changes and authorization referral requirements. In the event our office is not informed, you will be responsible for any charges denied.

   If you are undergoing a surgical procedure, insurance out of pocket for surgery fees are required prior to surgery. If not covered by insurance, payment is expected in full. It is expected that all fees be paid in full within 90 days of the date of surgery whether your insurance payment has been received or not. Pre-certification of surgical procedures will be done by our office as a courtesy to you; however it is ultimately your responsibility to notify your insurance carrier prior to any surgical procedure.

9. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It

is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

10. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
11. **Patient Billing.** If your insurance company does not pay the practice within a 90 day period following an office visit you will be responsible for the unpaid balance. We will bill those plans with which we have an agreement and will only require you to pay the copay/coinsurance/deductible at the time of service. You will be sent up to three notices for your financial responsibility on any remaining unpaid balances after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account may be forwarded to collections. Please let our office know if you are having any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check or Visa/Mastercard. An additional $25.00 will be added to your statement if a check is returned for insufficient funds. In the event that your insurance company should happen to send payment to you, the patient, we expect that you forward it to our office to be applied to your balance. All health care plans are not the same and do not cover the same services. In the event that your health plan determines a service to be "not covered", or you do not have an authorization, you will be responsible for charges of any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

I have read the above policy regarding my financial responsibility to **Texas Foot Surgeons, PLLC** for medical services provided. I agree to pay **Texas Foot Surgeons** any balance unpaid by my insurance carrier for myself or the below named person.

Privacy Statement. Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

Patient Acknowledgement of Notice Of Privacy Practice: By signing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices, and that I have (or had the opportunity to read if I so chose) and understand the Notice and agree to its terms.

Assignment of Benefits: I the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **Texas Foot Surgeons, PLLC** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize this signature on all insurance submissions.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health information and acknowledge I was provided with a copy of the Notice of Privacy Practices and understand and accept its terms:

_____ _____

PRINT Patient Name Signature

FINANCIALLY RESPONSIBLE PARTY:

_____ _____

PRINT Name Signature

Relationship to Patient:_____ Date:_____

TEXAS
FOOT SURGEONS

Dr. Eric Pack

Dr. Ginger Sellars

690 S. Loop 336 W., Suite 150

Conroe. TX 77304

Tel: (936) 760-1200 Fax: (936) 760-1210

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I am aware/have reviewed Texas Foot Surgeons PLLS's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Name of Patient:_____

Signature of Patient or Personal Representative:_____

Relationship of Personal Representative to Patient:_____

Date:_____

RECONOCIMIENTO DE EXAMEN DE AVISO O PRACTICAS DE PRIVACIDAD

Soy consciente/ha revisado Texas Foot Surgeons PLLC Aviso de Practicas de Privacidad, que explica como mi informacion medica sera utilizada y divalgada. Yo entiendo que tengo derecho a recibir una copia de este document.

Nombre de Paciente:_____

Firma de Paciente o Representante Personal:_____

Relacion de Personal Representativos:_____

Fecha:_____

TEXAS FOOT SURGEONS

PATIENT AUTHORIZATION
TO RELEASE PROTECTED HEALTH INFORMATION
TO DESIGNATED REPRESENTATIVE(S)

I, _____, give my authorization to release my protected health information including results of my laboratory test, x-ray and/or other test results to the following designated representative(s):

Patient Initials

_____ My Spouse _____

_____ My Child _____

_____ Other _____

_____ Personal Representative _____

_____ May be left on my answering machine at home.

_____ May be left on my personal cell phone voice mail.

_____ May be left o my voice mail at work.

Patient Signature:_____ Date:_____

Witness:_____ Date:_____

As a patient, you have the right to revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization or if applicable during a contestability period. In order for the revocation of this authorization to be effective, Texas Foot Surgeons, PLLC must receive the revocation in writing. The revocation must include: 1) the patient's name, address and date of birth, 2) the patient's desire to revoke the authorization and 3) the patient's signature and date of the revocation.

TEXAS FOOT SURGEONS

PATIENT MEDICATION HISTORY AUTHORITY SIGNATURE FORM

With your permission Texas Foot Surgeons, PLLC can access your medication history through a pharmaceutical database and upload this information into our electronic medical record. This information can give us a more comprehensive look at your medical history

_____ **Yes, I give Texas Foot Surgeons, PLLC authority to access my medication history via Athena Health Net.**

_____ **No, I do not give Texas Foot Surgeons, PLLC authority to access my medication history via Athena Health Net.**

Signature:_____ **Date:**_____

Printed Name:_____