

Tanglewood Foot Specialists

Welcome to our office...

Patient Information Sheet

Attention: Please fill out this form COMPLETELY. Write N/A where applicable and sign it. Thank you.

Social Security#:				
First Name:		Last Name:		Middle Initial:
Date of Birth: (MM/DD/YYYY) ____ / ____ / ____	Age: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other	
E-Mail Address:				
Address:		Apt.#:	City:	State: Zip:
Home Phone: (____) _____	Work Phone: (____) _____	Cell Phone: (____) _____		
Emergency Contact:		Emergency Telephone#: (____) _____		
Employer Name:		Employer's Address / City / State / Zip		

Referred by:	Referring Person's Address / City / State / Zip	Referring Person's Phone# (____) ____ - ____
Primary Care Physician:	Primary Care Physician's Address / City / State / Zip	P.C.P.'s Phone# (____) ____ - ____

PRIMARY Insurance Company Information:	SECONDARY Insurance Company Information:
Policy Holder's First Name & Last Name:	Policy Holder's First Name & Last Name:
Policy Holder's SSN: Policy Holder's Date of Birth: _____ / _____ / _____	Policy Holder's SSN: Policy Holder's Date of Birth: _____ / _____ / _____
Gender: Relationship to Policy Holder: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Gender: Relationship to Policy Holder: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Policy Holder's Address: <input type="checkbox"/> Same as patient	Policy Holder's Address: <input type="checkbox"/> Same as patient
City: State: Zip:	City: State: Zip:
Insurance's Name:	Insurance's Name:
Policy ID: Group #:	Policy ID: Group #:
Claims Submission Address:	Claims Submission Address:
Effective Date: _____ / _____ / _____	Effective Date: _____ / _____ / _____
Do you have a Co-pay? <input type="checkbox"/> No <input type="checkbox"/> Yes, Amt \$ _____	Do you have a Co-pay? <input type="checkbox"/> No <input type="checkbox"/> Yes, Amt \$ _____
Referral Required: <input type="checkbox"/> Yes <input type="checkbox"/> No	Referral Required: <input type="checkbox"/> Yes <input type="checkbox"/> No

Responsible Party Information – Please complete if the party responsible for payment is not the <u>Patient</u> or the <u>Policy Holder</u> .		
Responsible Party's Name (Last / First):	Responsible Party's SSN:	Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Other
Responsible Party's Address / City / State / Zip:		

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENDENTS OR MYSELF. I UNDERSTAND THAT IT IS AS A COURTESY THAT THE DOCTOR ACCEPTS MY INSURANCE FOR PAYMENT AND THAT IF FOR ANY REASON THEY DO NOT PAY MY BILL THAT I AM RESPONSIBLE.

I have received the Confidentially Agreement (HIPAA) and agree to comply with all its terms.

Today's Date: _____ Patient's Signature: _____

Tanglewood Foot Specialists

PODIATRY HISTORY

What is the chief concern for which you came to be treated?

When did you notice the problem? _____
 Any other concerns? _____

Have you ever been to a Podiatrist before? Yes No

If yes, please list:

Name _____ Last Visit _____

Is there any personal or family history of diabetes? Yes No

Your occupation _____

Activities in which you participate (frequency):

Please indicate which foot problem(s) you now have or have had:

- Ankle Pain Yes No
- Arthritis Yes No
- Athlete's Foot Yes No
- Corns and Calluses Yes No
- Cramps or Numbness in Feet or Legs ... Yes No
- Arch Problems..... Yes No
- Foot or Leg Cramps Yes No
- Gout Yes No
- Heel Pain Yes No
- Ingrown Toenails Yes No
- Plantar Warts Yes No
- Swelling in Ankles or Feet Yes No
- Tired Feet Yes No

What makes it better? _____

What makes it worse? _____

MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- | | | | | | |
|-----------------------------------|--|-----------------------|--|-------------------------|--|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Circulatory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Phlebitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies to Anesthetics | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies to Medicine or Drugs | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ear Problem | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies to Latex | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rash | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies to Penicillin | <input type="checkbox"/> Yes <input type="checkbox"/> No | Eye Problem | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina | <input type="checkbox"/> Yes <input type="checkbox"/> No | Foot or Leg Cramps | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves or Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling in Ankle, Feet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis or Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tired Feet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chronic Diarrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Varicose Veins | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cigarette/Tobacco Use | <input type="checkbox"/> Yes <input type="checkbox"/> No | Neuropathy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Surgeries/Hospitalizations you have had _____

Family Physician _____ Last Visit Date _____

Are you now or have you been under any other doctor's care for any reason over the past two years? Yes No

If yes, please explain _____

MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins: _____

Pharmacy Name(s) _____

Pharmacy Phone(s) _____

ALLERGIES

- Adhesive/Tape
- Anticoagulant Therapy
- Aspirin
- Demerol
- Iodine
- Other: _____
- Local Anesthetics
- Novocaine
- Seafoods
- Sulfa

Payments: Patients are responsible for all fees including missed visits and returned checks. Interest and late fees may apply on past due balances. Payment is expected at the time services are rendered. Payments must be arranged before treatment.

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to provide podiatric services, and medicines, submit my insurance form, consider my signature "on file" for payment, and to release any & all records needed. I understand the privacy policy, and have read and understand the above and agree to be personally responsible for all charges & fees.

Signature of Patient, Parent, Guardian or Personal Representative _____

Date _____

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE REVIEW IT CAREFULLY**

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of **Tanglewood Foot Specialists**. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

Fund raising. Unless you request us not to, we will use your name and address to support our fund raising efforts. If you do not want to participate in fund raising efforts, please check off the following box.

- Please do not use my information for fund raising purposes.**

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Tanglewood Foot Specialists Duties:

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the **Privacy Officer**.

Complaints & Contact Person

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

The Privacy Officer
1011 Augusta Drive, Suite 202
Houston, TX 77057

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Patient Name *(Please Print)*

Patient Signature

Date: _____

This Notice is effective on or after April 15, 2003

FINANCIAL POLICY FOR TANGLEWOOD FOOT SPECIALISTS

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. 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 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.

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.

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.

COPAYMENTS AND DEDUCTIBLES: All co-payments and deductible must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

SELF PAY: Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment of these services.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of this visit. If you do not have a referral from your primary care physician at the time of a visit, you will be financially responsible for all services received due in full upon completion of the visit. Full credit will be given if a referral is presented to our office within 48 hours of this visit. You will also be given the option to reschedule your appointment.

CLAIM 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.

PATIENT BILLING: You will be sent up to three notices for your financial responsibility (co-insurance, deductible) 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 the billing office know if you have 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/American Express/Discover. An additional \$25.00 will be added to your statement if the 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 would forward it to our office to be applied to your balance.

I have read the above policy regarding my *financial responsibility* to Tanglewood Foot Specialists for medical services provided. I agree to pay Tanglewood Foot Specialists 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 ACKNOWLEDGE OF NOTICE OF PRIVACY PRACTICES: By subscribing 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 **Tanglewood Foot Specialists** 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 the use of 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 insurance 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: _____

Our Patient's Bill of Rights

As patient and physician, ours is more than a relationship, it's a partnership. To ensure this, we have lived by the following principles:

- A patient has the right to know what his or her condition is and what trouble it is likely to cause.
- A patient has a right to have the condition explained in real terms, not medical terms.
- A patient has the right to know our qualifications and experiences.
- A patient has the right to consult other doctors without us being insulted or angry that the patient wants another opinion.
- A patient has a right to understand our fees.
- We will spend a patient's money wisely as possible. We will look for and recommend the most cost effective way of solving our patient's problems.
- We will not recommend surgery unless the patient needs help that only surgery can provide.
- If a patient feels that we have not provided them with our best efforts, please make this known. We can not guarantee results of treatment, but we can guarantee you our best efforts to treat you honestly and fairly.
- If a patient has financial problems, our office is committed to making arrangements so proper, necessary care is always provided.
- Considerate, respectful care at all times and under all circumstances with recognition of your personal dignity.
- Personal and informational privacy, within the law.
- Confidentiality of records and disclosures. Except when required by law, you have the right to approve or refuse the release of records.
- The opportunity to participate in decisions involving your health care, unless contraindicated by concerns about your health.
- Impartial access to treatment regardless of race, color, sex, national origin, religion, handicap or disability.
- Know the identity and professional status of individuals providing service to you.

Office Policies Regarding Managed Care Insurance Plans

We understand that the many changes in the health care system have made it quite confusing for our patients. The following are guidelines that have been established by the insurance companies to allow reimbursement for services we provide:

- You are responsible for obtaining and bringing referrals at the time service is rendered.
- Be aware that referrals may be for one visit or more. This is clearly indicated on the referral form.
- Referrals do expire. Most are good for either sixty or ninety days. This is also indicated on the referral form.
- A consultation report will be sent to your primary care doctor after the first visit and follow-up reports will be provided as necessary.
- You are responsible for your co-pay at the time your treatment is rendered.
- If you do not have a referral for a visit, you are responsible for full payment.
- Primary care physicians have indicated that they can not be called with a patient in the office for a referral for that particular visit. Referrals must be obtained before your visit to our office. Primary care physicians often need several days to provide you with a referral.

We are always available to help you with any questions regarding your insurance and treatment in our office. Thank you.

Podiatric Pain Analysis Survey

Tanglewood Foot Specialists

PODIATRIC MEDICINE • FOOT SURGERY • SPORTS MEDICINE

Dr. Andrew J. Schneider

1011 Augusta Dr • Suite 202 • Houston, TX 77057

Name: _____ Date: _____ Age: _____

Please check any of the following conditions you are currently experiencing or suffering from:

- | | |
|---|--|
| <input type="checkbox"/> Flat Feet | <input type="checkbox"/> Pain in feet getting out of bed |
| <input type="checkbox"/> Poor coordination | <input type="checkbox"/> "Toe-in" or "Toe-out" gait (walking) |
| <input type="checkbox"/> Heel or Arch Pain | <input type="checkbox"/> Pain or fatigue of feet or legs in activity |
| <input type="checkbox"/> Leg pain (shin splints) | <input type="checkbox"/> Ankle instability (easy twisting injuries) |
| <input type="checkbox"/> Achilles tendon pain | <input type="checkbox"/> Difficulty/Pain with brisk walking or running |
| <input type="checkbox"/> Discoloration of toes/foot | <input type="checkbox"/> Pain in legs occurs at the same distance every time |
| <input type="checkbox"/> Ankle swelling or stiffness | <input type="checkbox"/> Coldness in legs or feet that is uncomfortable |
| <input type="checkbox"/> Pain in feet or legs with exercise | <input type="checkbox"/> Non/Poorly healing sore on the leg or foot |
| <input type="checkbox"/> Foot/Toes/Legs Burn | <input type="checkbox"/> Feet/Toes feel numb |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Neck Pain |

Please answer the following about the above conditions:

Do the above conditions disrupt your lifestyle and activities of daily living? Yes / No

Is this condition causing or are you suffering with any of the following:

- | Tingling/Numbness in: | Pain radiating into: | Weakness of the: | Difficulty with: | |
|--------------------------------------|--------------------------------------|--------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Legs R / L | <input type="checkbox"/> Ankle R / L | <input type="checkbox"/> Legs R / L | <input type="checkbox"/> Standing | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Ankle R / L | <input type="checkbox"/> Feet R / L | <input type="checkbox"/> Ankle R / L | <input type="checkbox"/> Sitting | <input type="checkbox"/> Bending |
| <input type="checkbox"/> Feet R / L | <input type="checkbox"/> Toes R / L | <input type="checkbox"/> Foot R / L | <input type="checkbox"/> Lifting | <input type="checkbox"/> Kneeling |

How long have you been suffering with this condition? Days / Weeks / Months / Longer

Is this condition affecting your ability to perform daily tasks? Yes / No

Would you like to get rid of or reduce this problem? Yes No

There may be treatment options or solutions for the pain you are experiencing. Please let us know what you would like to do today.

I would like to discuss the above conditions with the Doctor so I can make an educated decision about my health.

If it were available, I would be interested in receiving treatment for this condition in this office

If available, I would be open to have a medical test to further evaluate my problem

Patient Signature

Physician Signature