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:** ☐ **Male** ☐ **Female** **Marital Status:** ☐ **Single** ☐ **Married** ☐ **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: ☐ Male ☐ Female **Relationship to Policy Holder:** ☐Self ☐Spouse ☐Child ☐Other	**Gender:** ☐ Male ☐ Female **Relationship to Policy Holder:** ☐Self ☐Spouse ☐Child ☐Other
Policy Holder's Address: ☐ **Same as patient**	**Policy Holder's Address:** ☐ **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? ☐ No ☐ Yes, Amt $_____	**Do you have a Co-pay?** ☐ No ☐ Yes, Amt $_____
Referral Required: ☐ **Yes** ☐ **No**	**Referral Required:** ☐ **Yes** ☐ **No**

Responsible Party Information – *Please complete if the party responsible for payment is not the Patient or the Policy Holder.*

Responsible Party's Name (Last / First): **Responsible Party's SSN:** **Relationship to Patient:** ☐Self ☐Spouse ☐Child ☐ Parent ☐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	☐Yes ☐No	Circulatory Problems	☐Yes ☐No	Phlebitis	☐Yes ☐No
Allergies to Anesthetics	☐Yes ☐No	Diabetes	☐Yes ☐No	Psychiatric Care	☐Yes ☐No
Allergies to Medicine or Drugs	☐Yes ☐No	Ear Problem	☐Yes ☐No	Radiation Treatment	☐Yes ☐No
Allergies to Latex	☐Yes ☐No	Epilepsy	☐Yes ☐No	Rash	☐Yes ☐No
Allergies to Penicillin	☐Yes ☐No	Eye Problem	☐Yes ☐No	Respiratory Disease	☐Yes ☐No
Anemia	☐Yes ☐No	Fainting	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Angina	☐Yes ☐No	Foot or Leg Cramps	☐Yes ☐No	Shortness of Breath	☐Yes ☐No
Arthritis	☐Yes ☐No	Gout	☐Yes ☐No	Sinus Problems	☐Yes ☐No
Artificial Heart Valves or Joints	☐Yes ☐No	Headaches	☐Yes ☐No	Special Diet	☐Yes ☐No
Asthma	☐Yes ☐No	Heart Disease	☐Yes ☐No	Stroke	☐Yes ☐No
Back Problems	☐Yes ☐No	Hemophilia	☐Yes ☐No	Swelling in Ankle, Feet	☐Yes ☐No
Bleeding Disorders	☐Yes ☐No	Hepatitis or Jaundice	☐Yes ☐No	Swollen Neck Glands	☐Yes ☐No
Cancer	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Tired Feet	☐Yes ☐No
Chemical Dependency	☐Yes ☐No	Kidney Problems	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Chest Pain	☐Yes ☐No	Liver Disease	☐Yes ☐No	Ulcers	☐Yes ☐No
Chronic Diarrhea	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No	Varicose Veins	☐Yes ☐No
Cigarette/Tobacco Use	☐Yes ☐No	Neuropathy	☐Yes ☐No	Venereal Disease	☐Yes ☐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
☐ Local Anesthetics
☐ Novocaine
☐ Seafoods
☐ Sulfa
☐ Other: _____

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

Tanglewood Foot Specialists

1011 Augusta Drive, Suite 202
Houston, TX 77057

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 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 deductibles must be paid at the time of service. A copayment is required for each office visit. 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. If your deductible or annual maximum out-of-pocket has not yet been met, an estimated patient responsibility with be collected at the time of service. After the insurance claim is processed, you may receive a statement for any amount still owed. If a credit balance results after insurance payment, you will receive a refund check within thirty days.

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 that when you visit a specialist such as ours, you must have 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 ours 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. Any outstanding balance must be paid in full prior to any further office visits.

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. Two statements will be sent by US mail and one by email, if we have a good email address on record. After the third and last notice, your account may be forwarded to collections. Please let the billing office know if you have any difficulties receiving your bill. Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check, Visa/Mastercard/American Express/ Discover. An additional $35 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 would forward it to our office to be applied to your balance. It is the patient's responsibility to notify the office of any changes to address, email, or any other contact information.

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 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 PRACTICES: I acknowledge that I was provided a copy of the Notice of Privacy Practices, and that I 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 and acknowledge I was provided with a copy of the Notice of Privacy Practices and understand and accept its terms:

PRINT Patient Name: _____ Signature: _____ Date:_____

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.