Hill Country Foot Specialist

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Please PRINT clearly and answer all questions to the best of your ability:

PATIENT INFORMATION

Name:_____

Date of Birth:_____

Gender
Male □
Female □

Martial Status
Single □
Married □
Other □

Address:_____

City:_____

State/Zip:_____

Home Phone:(_____)_____

Soc. Sec. #_____

DL#_____

Business/Work Phone:(_____)_____

Cell Phone:(_____)_____

Employed by:_____

Occupation:_____

How long? _____

INSURANCE INFORMATION

Primary Insurance: _____

Secondary Insurance: _____

Responsible Party (this is the person who is the primary insured on your insurance card or the parent/guardian of a child):

Name:_____

SSN#:_____

Relation:_____ Date of Birth: _____

Phone: (____)_____

EMERGENCY CONTACT INFORMATION

Spouse Name(if applicable):_____

Emergency Contact Name: _____

Relation:_____

Emergency Contact Number: (____)_____

REFERRAL INFORMATION

Referred by:_____

Primary Care Physician's Name: _____

Phone: (_____)_____

PODIATRIC HISTORY

CHIEF COMPLAINT

List the problems that have led you to seek Podiatric help now and approximately when each began:

Problem(s) Date of Onset

_____

_____

_____

Please indicate which foot problems you have or have had in the past:

Ulcers	□ Yes □ No
Amputations	□ Yes □ No
Ankle Pain	□ Yes □ No
Heel Pain	□ Yes □ No
Athlete's Foot	□ Yes □ No
Bunions	□ Yes □ No
Corns and Calluses	□ Yes □ No
Cramps or Numbness in Feet or Legs	□ Yes □ No
Foot or Leg Cramps	□ Yes □ No
Ingrown Toenails	□ Yes □ No
Warts	□ Yes □ No
Swelling in Ankles or Feet	□ Yes □ No
Venus Stasis	□ Yes □ No
Toenail Fungus / Discolored Nails	□ Yes □ No
Have you had foot surgery?	□ Yes □ No

If "Yes" what was the Foot Surgeons name: _____

DIABETIC INFORMATION *(if applicable)*

Are you a Diabetic? **□ Yes □ No**

Type 1 or Type 2? **□ Type 1 □ Type 2**

What is your average morning blood sugar reading?

_____

CONTINUE TO BACK SIDE…..

MEDICAL HISTORY

Please indicate if you have or had the following medical conditions:

Alcoholism	□ Yes □ No	Emphysema	□ Yes □ No	Phlebitis	□ Yes □ No
Anemia	□ Yes □ No	Epilepsy	□ Yes □ No	Pleurisy	□ Yes □ No
Angina Pectoris/*Chest Pain*	□ Yes □ No	Frequent headaches	□ Yes □ No	Pneumonia	□ Yes □ No
Asthma	□ Yes □ No	Gout	□ Yes □ No	Prostate Disease	□ Yes □ No
Arthritis	□ Yes □ No	Head Injury	□ Yes □ No	Respiratory Disease	□ Yes □ No
Back/Disk Problems	□ Yes □ No	Heart Attack	□ Yes □ No	Rheumatic Fever	□ Yes □ No
Bleeding Tendency	□ Yes □ No	Heart Disease	□ Yes □ No	Rheumatoid Arthritis	□ Yes □ No
Blood Disease	□ Yes □ No	Hepatitis or Jaundice	□ Yes □ No	Sciatica	□ Yes □ No
Cancer	□ Yes □ No	High Blood Pressure	□ Yes □ No	Severe Bronchitis	□ Yes □ No
Circulatory Problems	□ Yes □ No	High Cholesterol	□ Yes □ No	Shortness of Breath	□ Yes □ No
Chronic Bronchitis	□ Yes □ No	Liver Disease	□ Yes □ No	Stroke	□ Yes □ No
Convulsions or Seizures	□ Yes □ No	Low Blood Pressure	□ Yes □ No	Swollen Joints	□ Yes □ No
Difficulty in Coordination	□ Yes □ No	HIV/AIDS	□ Yes □ No	Tuberculosis	□ Yes □ No
Difficulty with Speaking	□ Yes □ No	Kidney Disease	□ Yes □ No	Ulcers	□ Yes □ No
Difficulty with Walking	□ Yes □ No	Neurological Disease	□ Yes □ No	Uncontrolled Movements	□ Yes □ No
Double Vision	□ Yes □ No	Neuropathy	□ Yes □ No	Unexplained Weight Loss/Gain	□ Yes □ No
Ear Problems	□ Yes □ No	Paralysis	□ Yes □ No	Venereal Disease	□ Yes □ No
Any obscure or unusual disease?		_____		X-Ray Treatment	□ Yes □ No

Please explain any of the selections you have made above: _____

_____

_____

List past surgeries and/or hospitalizations:

_____

_____

_____

Do you smoke? □ Yes □ No
If so how many a day: _____
Did you formerly smoke? □ Yes □ No
When did you quit: _____

ALLERGIES

Have you had an allergic reaction to any of the following?

□ Aspirin □ Codeine □ Demerol □ Iodine □Latex □Local Anesthetics □ Penicillin □ Novocaine □ Sulfa

Any other Allergies? _____

Have you ever had a bad reaction to penicillin or any other drug (e.g. rash, itching, swelling, ect.?) (If so give name of drug and kind of reaction.): _____

_____

CONSENT

Consent

I, hereby, being the patient, parent, or guardian, give permission to Dr. Robert D. Parker, DPM to examine perform diagnostic tests, and treat my feet and ankles medically, surgically, orthopedically, and for the administration of local anesthetics which are deemed advisable by the doctor. Although their occurrence is extremely rare, some risks have been reported to be associated with some surgical procedures. State and Federal law requires us to mention the possible risk of numbness, infection, swelling, bleeding, discoloration, nausea, vomiting, allergic reactions, brain damage, quadriplegia, the loss of function of any organ or limb, or disfiguring scars associated with such procedures. I understand and accept the complications may require hospitalization and may result in death. I, hereby, certify that I, or my dependent have insurance coverage and assign directly to Dr. Parker all insurance benefits, if any, otherwise payable to Dr. Parker for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I, hereby, authorize Dr. Parker to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions, and I authorize this signature to be used for the release of my medical records under the regulations of State and Federal Law via telephone, fax, mail, internet, or et al.

I have read and understand this consent and all questions have been answered. I understand that this consent will remain in effect until such time that I choose to terminate it, in writing.

Patient/Guardian Signature _____ Date _____

CURRENT MEDICATIONS

List all medications you are now taking. For each, give the name, the strength of each dose, how often taken, and when you began taking it. This list must be detailed, accurate, and complete; therefore, consult with your family, pharmacist, & primary care physician. Do not neglect aspirin and other pain medicines; hormones; contraceptive; water, diet, vitamins, nerve, or sleeping pills. If you need more space for your meds, please let our staff know and we'll gladly provide you with an extra list.

NAME OF MEDICINE STRENGTH OF DOSE HOW OFTEN TAKEN WHEN BEGAN TAKING

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

HCFS FINANCIAL POLICY & AGREEMENT

Welcome to our practice! Please know that our office is committed to your podiatric medical care and treatment being successful. We are here to assist you and make sure that your visit is thorough, informative, pleasant, and we strive to make you feel as comfortable as possible.

Please understand that the payment of your bill is considered part of your treatment. Our office is contracted with private and public insurance plans in an effort to provide the patient with podiatry specialty care. We are committed to providing you with comprehensive podiatric medical care. Every private and public health insurance plan is vastly different depending upon the enrollment contract the patient has selected. Please know that each insurance plan has different rules & stipulations regarding how often podiatry services may be provided to the patient. This agreement will provide you with an overview regarding our office and billing policies:

The provider will bill for the services rendered at the date and time the service was provided**. Please note that if the provider (Dr. Parker) uses a needle with or without a syringe for an injection, exploration, or another service and/or if Dr. Parker uses a scalpel blade for trimming, exploring, shaving, and/or debriding an area on your foot or ankle your insurance company considers this a SURGICAL PROCEDURE. Since your insurance plan considers this service a surgical procedure it may be applied or go toward your deductible.**

You, the patient, are responsible to know your individual plan including your deductible at the time the service is provided. **This office will not get into a dispute with you in person or on the phone regarding the billing process, protocol, or whether or not you feel it was or was not a surgical procedure.** It is the insurance company that deems it a surgical procedure, not Dr. Parker. Therefore, you may receive a statement in the mail from this office for this service that the insurance company has deemed a surgical procedure. If you have any

questions regarding your statement/account you may contact our billing company, **HEALTHY IMAGES BILLING at (512) 547-3501**.

The undersigned agrees, as the patient or an agent of the patient, that the patient is accepting financial responsibility for all services rendered and is obligated to pay the account balance in full. If there is verifiable medical insurance coverage or other verifiable financial coverage a claim will be filed as a convenience to the patient. However, it remains the responsibility of the patient/guarantor to follow-up with/his insurance company if the claim is not paid within 45 days. **Please note that Dr. Parker is a specialist provider and some insurance plans such as Superior Medicaid, Evercare, Blue Cross Blue Shield Health Select, et al require prior authorization before an office visit or any services are rendered by Dr. Parker. Referrals to see Dr. Parker, authorizations, and pre-certification are the responsibility of the patient/guarantor and should be secured prior to services.** F**ailure to obtain referrals/authorizations/pre-certification will result in charges to the patient.**

Payment for services that are not covered by the insurance or third party payer is the responsibility of the patient/guarantor. **Payment of co-pays and deductibles are required at the time the services are provided unless prior arrangements have been made with the Office Manager.** All patients are responsible for verifying that Dr. Parker is a participating provider in their plan. If you have an insurance plan that requires referrals and you are given a return or follow up appointment you may wish to contact your primary care physician to obtain more office visits. Failure to obtain more office visits if you have an insurance that requires referrals/preauthorization may result in the patient receiving a bill for the services provided by Dr. Parker. X-rays, MRIs, CTs, MRAs, pathology reports, special lab tests, and other laboratory procedures are the patient's responsibility. If your insurance carrier requires you to use special ancillary facilities (laboratories, x-ray facilities, etc.) you must inform Dr. Parker and his staff at each visit. Failure to do so may result in charges to you which your insurance company may not cover.

Any remaining balance after insurance payment is the patient's responsibility. No payment plans will be set up on the day of your treatment. Please be aware that although our office will file your claim with your insurance company, it is never a guarantee of payment. You, the patient, will be responsible for all amounts and debts that are not covered by your insurance company. Our office will send out 3 consecutive monthly statements after we receive the explanation of benefits from your insurance for the date the service was provided. If no payment or arrangements for the balance on the account have been received within 30 days after the billing company sends the final statement the account will be handed over to a collection company. **Our office will gladly assist you in any way that we can during this process but we will not get into a dispute with you regarding your claim, your insurance, your charges, and your account as all services rendered by Dr. Parker are done so in good faith.**

If you cannot keep your appointment please contact this office so that the reserved appointment time can be given to another patient that needs attention. Patient "no shows" or missed appointments are disruptive to the continuity and flow of the practice. **Due to an increase in patient "no shows" and missed appointments you may be billed $35 if you miss an appointment with out giving prior notification.** If you consistently miss appointments and do not contact this office then you will be discharged from this practice.

This office is committed to protecting your privacy. Your medical records are managed in a confidential manner and in compliance with the HIPAA Law. **No protected health information will be given out within the scope of the HIPAA law unless you sign a medical records release.**

Please note there are times when the provider must take photographs, audio & video of a patient's visit and foot/ankle condition or deformity for medical record keeping, diagnostic, and treatment purposes. By signing this agreement, I, the patient and/or patient's legal guardian, consent and give permission for the provider and whomever he may deem his assistant to take images, audio & video recordings for diagnostic and treatment purposes, and medical record keeping.

Your podiatric care is very important to this practice. We will do everything possible to make your office visit a satisfying experience. We care about you and your feet. Thank you for choosing us as your Podiatric medical specialists.

I have read and understand the office policy and financial agreement stated above and agree to accept full financial responsibility as described fully herein, and I authorize the release of any medical and/or other information necessary to process any insurance or other claims.

Patient/Guardian Signature:_____Date:_____