

# Hill Country Advanced Foot & Ankle Center, PA

Welcome to Our Office.....

Thank you for selecting our office to serve your foot care needs. We will strive to provide you with the very best Podiatric care. The following information is needed to better serve you. Thank you for taking the time to provide us this information.

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex:  M  F How did you hear about our office? \_\_\_\_\_

Hill Country Advanced Foot & Ankle Center has a Patient Portal, this allows you to access your medical information, request an appointment and also request a prescription refill. Our easy to use Patient Portal is simple to sign up for, by releasing your email address you give us permission to send you a link to activate your account.

E-mail \_\_\_\_\_

Marital Status:  Married  Unmarried  Single  Widowed  Divorced

Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Name of Spouse or Parent \_\_\_\_\_ Date of Birth of Spouse or Parent \_\_\_\_\_

Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

In case of an Emergency notify \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Primary Care Doctor \_\_\_\_\_ Location \_\_\_\_\_ Last Visit \_\_\_\_\_

---

## Acknowledgement of Notice of Privacy Practices

I, (name of patient) \_\_\_\_\_, acknowledge and agree that I have reviewed a copy of Hill Country Advanced Foot & Ankle Center's Privacy Practices and have completed the forms to the best of my knowledge.

I also certify that the above information is accurate and complete. I hereby give permission to administer treatment, and to perform such procedures as may be deemed necessary in diagnosis and/or treatment of my foot conditions.

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

From time to time we will need to leave a message for you (as stated in our Notice of Privacy Practices) on your voice mail or with another individual in your absence. Is it OK to leave a message that includes details (such as diagnosis and medication information, appointment times) at the numbers you have provided below:

### Please check the best number to reach you

Home Number:  \_\_\_\_\_ YES or NO

Cell Number:  \_\_\_\_\_ YES or NO

### Release of Information

Persons who are involved in your care (family, 'spouses', friends, other doctors, etc.) may inquire about your treatment, lab results, prescriptions, appointment, etc. **IF THEY ARE NOT ON THIS LIST, WE CANNOT SPEAK WITH THEM REGARDING YOU.** Please let us know what person(s) we may share information with and list them below.

_____	_____
_____	_____
_____	_____
_____	_____

# Hill Country Advanced Foot & Ankle Center, PA

## Insurance/Billing/Collections Policies

We must emphasize that as healthcare providers, our relationship is with you, our patient, and **NOT** with your insurance company. As a courtesy to you and per our contract with your insurance company, we will bill them directly, assuming you have given us all your insurance information. We charge what is usual and customary for our area.

Please read and initial beside each paragraph.

\_\_\_\_ You're responsible for knowing what your insurance benefits are, with regards to what the insurance will and will not pay for. If you are in doubt, please contact your insurance carrier. Please understand that payment of your bill is considered part of your treatment.

\_\_\_\_ This is NOT a Worker's Compensation injury.

\_\_\_\_ There will be a \$15.00 charge for missed appointments or appointments not cancelled 24 hours in advance.

\_\_\_\_ I understand that HCAFA will file with my primary insurance company charges that incur on my initial visit, testing, procedures, and future visits. There will be no fee for filing these charges. I will promptly inform the office of a change in my medical insurance. I understand that I am responsible for the co-pay amount at each visit as directed by my insurance, and the patient portion amounts directed by my insurance for services rendered are due at time of service. I also agree to pay any remaining collectible balances as governed by my insurance plan. I understand that my release of direct payment of insurance benefits does not release me from responsibility for full payment services (if unpaid by my insurance) rendered by HCAFA. I request payment of authorized benefits be made to Hill Country Advanced Foot & Ankle Center PA for any services furnished to me by a physician from the group. I authorize any holder of medical information about me to release any information needed to determine these benefits or benefits for related services. If the physician is a participated provider for my insurance carrier, I understand the physician will accept the insurance carrier's allowable. If the physician is not a participating member, I understand I will be responsible for the difference between the amount billed by the physician and the amount paid by the insurance carrier. If my insurance carrier has not paid within 90 days, I understand I am responsible for payment at that time, and will be reimbursed appropriately when my insurance carrier makes payment.

We accept VISA, MasterCard, Discover, American Express, and Care Credit as well as debit cards, cash, and personal checks drawn on American funds. We do offer payment plans for outstanding balances due, not for co-pays. Please call our billing department to discuss and make payment arrangements.

**Any accounts sent to collections will be charged an additional 33-50% fee of the total balance.**

**\*\*IF YOU DO NOT HAVE INSURANCE, PAYMENT IS DUE IN FULL AT THE TIME SERVICES THAT ARE RENDERED.\*\***

*I understand these policies and agree to be bound by their terms. I also understand that such terms are subject to change or be amended and I will be notified of any such changes or amendments.*

\_\_\_\_\_  
Print

\_\_\_\_\_  
Sign

\_\_\_\_\_  
Date

## Children of divorced/separated parents

Unless you give us a signed, notarized court order to keep on file, the parent or guardian who brings the child in for their office visit will be considered ultimately financially responsible. We will entrust you to tell our billing department who the bill needs to be sent to for any remaining balance after your insurance pays.

We thank you for understanding our financial policies. This has become necessary in order to continue to accept your insurance plans without having to bill you at the time services are rendered. Our goal is to make your visit with us as pleasant and professional as we can. If you have any questions, feel free to ask or call our billing department for assistance. Thank you again for choosing us for your foot/ankle needs.

## Guarantor Information

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

# Hill Country Advanced Foot & Ankle Center, PA

## Insurance

Please fill out completely even if copies of your insurance cards were provided.

Primary Medical Insurance: \_\_\_\_\_ Subscriber:  Self  Other

If Subscriber is someone else other than patient: Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Subscriber's Date of Birth: \_\_\_\_\_ Subscriber's Social Security Number: \_\_\_\_\_

Secondary Medical Insurance: \_\_\_\_\_ Subscriber:  Self  Other

If Subscriber is someone else other than patient: Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Subscriber's Date of Birth: \_\_\_\_\_ Subscriber's Social Security Number: \_\_\_\_\_

\_\_\_\_\_  
Print Patient/Guardian Signature Date

## Medicare / Medicare Advantage Authorization

I, the undersigned, request that the payment of authorized Medicare benefits be made on my behalf directly to Hill Country Advanced Foot & Ankle Center PA for services rendered. I hereby authorize the doctor to release to the Center of Medicare and Medicaid Services (CMS) all information necessary to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other insurance indicated, my signature authorizes releasing of the information to the insurer of agency shown. In the Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-payment, and charges associated with non-covered services. Co-payments and deductibles are based upon the charger determination of the Medicare carrier. If you have a **PRIVATE SENIOR PLAN** (Medicare Advantage Plan), this replaces your Medicare and you are subject to a co-payment, every visit, which is due at the time of service.

Initials \_\_\_\_\_

If you have a SECONDARY insurance, we will file the claim as a **courtesy** to you. It is our office policy that if the secondary insurance has not been paid the 20% within 60 days of our filing the claim, the bill will be sent to you for immediate payment and you will be responsible for submitting to get reimbursement from your secondary insurance. *It is our policy that you pay any co-pay that your secondary insurance states you have. This is a contract that you have with them. Please be prepared to pay at the time services are rendered.*

Initials \_\_\_\_\_

# Hill Country Advanced Foot & Ankle Center, PA

## Patient History

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

What Pharmacy do you use? \_\_\_\_\_ City: \_\_\_\_\_

What is your Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe Size \_\_\_\_\_

### **MEDICAL HISTORY:** (Please check any of the following that you have been diagnosed with or treated for in the past):

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> None Apply                              | <input type="checkbox"/> High Blood Pressure            | <input type="checkbox"/> COPD               | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Diabetes – year: _____                  | <input type="checkbox"/> High Cholesterol               | <input type="checkbox"/> Asthma             | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Heart Problems – <b>CHF, CAD, A-Fib</b> | <input type="checkbox"/> Non-Healing Wound              | <input type="checkbox"/> Emphysema          | <input type="checkbox"/> Hepatitis        |
| <input type="checkbox"/> Heart Attack – year: _____              | <input type="checkbox"/> Osteoarthritis                 | <input type="checkbox"/> Gout               | <input type="checkbox"/> AIDS/HIV         |
| <input type="checkbox"/> Stroke – year: _____                    | <input type="checkbox"/> Rheumatoid Arthritis/Lupus     | <input type="checkbox"/> Cancer-type: _____ |   |
| <input type="checkbox"/> PAD (Peripheral Arterial Disease)       | <input type="checkbox"/> Bleeding Problem – type: _____ |   |   |
| <input type="checkbox"/> Other (please list): _____              |   |   |   |

### **SURGICAL HISTORY:** (Please check the following you have had):

- |  |   |  |                                       |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> None  | <input type="checkbox"/> Foot Surgery: _____    |  |                                       |
| <input type="checkbox"/> Heart Surgery – type: <b>Bypass, Pacemaker, Heart Valve, Stents</b> | <input type="checkbox"/> Tonsillectomy          | <input type="checkbox"/> Tubal Ligation            |                                       |
| <input type="checkbox"/> Arthroscopy – type: _____   | <input type="checkbox"/> Spine Surgery          | <input type="checkbox"/> Appendectomy              | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Hernia Repair   | <input type="checkbox"/> Removal of Gallbladder | <input type="checkbox"/> Repair of Fracture: _____ |                                       |
| <input type="checkbox"/> Cataract <b>Right /Left/Both</b>                                    | <input type="checkbox"/> Other: _____           |  |                                       |

### **MEDICATIONS TAKEN DAILY:** (List all and doses or provide list)

- |                               |  |                                     |                                   |                                  |                                  |
|-------------------------------|--|-------------------------------------|-----------------------------------|----------------------------------|----------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> See Attached List | Are you on a blood thinner – YES/NO | <input type="checkbox"/> Coumadin | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Plavix  |
| _____                         | _____                                      | _____                               | <input type="checkbox"/> Eliquis  | <input type="checkbox"/> Xerelto | <input type="checkbox"/> Pradaxa |
| _____                         | _____                                      | _____                               |                                   |                                  |                                  |

### **ALLERGIES:** Are you allergic to any of the following or any other medication? No Known Drug Allergies

- |  |                                     |  |  |
|--|-------------------------------------|--|--|
| <input type="checkbox"/> Novocain/Anesthetic | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Adhesive Tape | <input type="checkbox"/> Latex – type of reaction: _____ |
| <input type="checkbox"/> Others: _____       |                                     |  |  |

### **SOCIAL HISTORY:** (Please answer each of the following)

Smoke: YES or NO	Quit? Year: _____	Packs per day / # of years: _____
Chew Tobacco: YES or NO	Quit? Year: _____	Amount _____
Alcohol: YES or NO	Amount _____	

### **FAMILY HISTORY:** (Do any of your primary family members have any of the following problems?)

- |  |                                   |   |                                       |
|--|-----------------------------------|---|---------------------------------------|
| <input type="checkbox"/> None Apply          |                                   |   |                                       |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bleeding Problems          | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart Problems      | <input type="checkbox"/> Cancer   | <input type="checkbox"/> Rheumatoid Arthritis/Lupus |                                       |
| <input type="checkbox"/> Strokes             | <input type="checkbox"/> Gout     | <input type="checkbox"/> Osteoarthritis             |                                       |

### **REVIEW OF SYMPTOMS:** (Are you currently suffering from any of the following?)

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> None                           | <input type="checkbox"/> Stomach/Abdominal Pain | <input type="checkbox"/> Fever/Chills          | <input type="checkbox"/> Rashes             |
| <input type="checkbox"/> Numbness/Tingling in legs/feet | <input type="checkbox"/> Heart Palpitations     | <input type="checkbox"/> Nausea/Vomiting       | <input type="checkbox"/> Trouble w/ Vision  |
| <input type="checkbox"/> Joint Pain (hips, knees, etc.) | <input type="checkbox"/> Shortness of Breath    | <input type="checkbox"/> Night Sweats          | <input type="checkbox"/> Difficulty Hearing |
| <input type="checkbox"/> Back Pain                      | <input type="checkbox"/> Coughing up Blood      | <input type="checkbox"/> Blood in Stools       | <input type="checkbox"/> Memory Loss        |
| <input type="checkbox"/> Muscle Aches                   | <input type="checkbox"/> Bleeding Problems      | <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Depression         |
| <input type="checkbox"/> Swollen Ankles                 | <input type="checkbox"/> Frequent Nose Bleeds   | <input type="checkbox"/> Trouble Urinating     | <input type="checkbox"/> Headaches          |
| <input type="checkbox"/> Pain in calf with activity     | <input type="checkbox"/> Phlebitis/Blood Clots  | <input type="checkbox"/> Frequent Urination    | <input type="checkbox"/> Chest Pain         |

\_\_\_\_\_  
Patient Name (PRINT)

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date