AUSTIN
FOOT & ANKLE CENTER

***Please place a Check next to the Office Location***

_____***North:*** 9012 Research Blvd C-13, Austin, TX 78758 // *512.450.0101 Fax: 512.450.0086*

_____***Northwest:*** 11824 Jollyville Rd Ste 101, Austin, TX 78759 // *512.335.1800 Fax: 512.335.8353*

_____***South:*** 5200 Davis Ln Ste 120, Austin, TX 78749 // 512.336-8909 Fax: 512.450.0086

## 1. PATIENT INFORMATION

DATE:_____

Patient's NAME: _____

Contact Information:

MOBILE PHONE: _____

*OK to TEXT?* ___YES or ___ NO

Email Address: _____

Address: _____

_____
City State Zip

Sex: ☐M ☐F Age ____ Birthdate _____
☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

## 2. INSURANCE

Who is responsible for this account? _____
Relationship to Patient _____
Insurance Co. _____
Group #_____
Is patient covered by additional insurance? ☐Yes ☐No
Subscriber Name _____
Birthdate _____
Relationship to Patient _____
Insurance Co. _____
Group #_____

### ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

**MEDICARE AUTHORIZATION**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Austin Foot and Ankle Center for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed 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 health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In 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, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Relationship Date

## 3. Other Contact Information:

*Additional Phone #'s* _____

**IN CASE OF EMERGENCY, CONTACT**

Name _____ Relationship_____

Home Phone _____Work Phone _____

## 4. MEDICAL HISTORY

*Medical Allergies & Other Allergies:*

_____

_____

_____

*Are you Diabetic? ___ Yes ___ No*
*if NO, is there a family history of Diabetes?*
*___ Yes or ___ No*

*Are you CURRENTLY or HAVE you taken any of the followings types of medications in the past 6 months? (check any that apply)*

*__ Blood Thinners*

*__ Immunosuppressive Medications*

*Have you ever suffered from a Blood Clot?*
*___ Yes ___ No*

*Have you ever, or are you currently being treated for any of the following? (mark all that apply)*

*___ HIV/AIDS* *___ Hepatitis*

*___ Nerve Pain* *___ Knee Pain*

*___ Arthritis* *___ Back Pain*

*NEXT PAGE.....*

## 5. MEDICAL HISTORY

*Please describe your Foot &/or Ankle problem that we will be treating today?*

*Please LIST all previous FOOT & ANKLE surgeries if any:*

*Please LIST all OTHER surgical procedures, if any:*

*Please list your Primary Care Doctor &/or Referring Doctor if applicable:*

## *6. MEDICATIONS*

*Please list a pharmacy you would like us to keep on file :*

*Please LIST all current medications, include both prescription and non-prescription drugs. [include vitamin supplements, etc.]*

## CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's Signature _____ Date_____

AUSTIN
FOOT & ANKLE CENTER

***North:*** 9012 Research Blvd C-13, Austin, TX 78758 // 512.450.0101 Fax: 512.450.0086
***Northwest:*** 11824 Jollyville Rd Ste 101, Austin, TX 78759 // 512.335.1800 Fax: 512.335.8353
***South:*** 5200 Davis Ln Ste 120, Austin, TX 78749 // 512.336.512) 336-8909

# Financial Responsibility

1. We are dedicated to providing the best possible care and service to you with regard to your complete understanding of your financial responsibilities as an essential element of your care. The following is a statement of our financial policy in order to reduce confusion and misunderstanding between our patients and practice, which we require you to read and sign prior to any treatment. If you have any questions regarding these policies, please discuss them with our office manager.
2. Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at time of service. For your convenience we accept Visa, Master Card, Discover, & AMEX.
3. We have made prior arrangements with many insurers and health plans to accept and assignment of benefits. This means that we will bill those plans for which we have an agreement, and will only require you to pay the authorized co-pay, deductibles, and/or coinsurance at the time of service.
4. If your insurance is one that we have an agreement with, but you do not present your insurance card at the time of service or we cannot verify your coverage, we will require payment in full at the time of service. If we do not have an agreement with your insurance company, all charges are due in full at time of service.
5. If it is discovered, after the fact, that you did not present the current, or correct insurance ID card at the time of service, he will be responsible for the charges if denied by your current insurance company as “pass the filing deadline”
6. As a courtesy to our patients when able, we will file with your secondary insurance plans.
7. You are responsible for any services that are not covered on your insurance plan. Payment is due upon receipt of a statement from our office. If you disagree with your insurance company’s determination, you must contact the insurance company directly.
8. HMOs and some other insurance plans require an official referral or authorization number and/or form. It is your responsibility to know whether or not your insurance company requires this or if your current referral is expired. If the patient presents without this referral or authorization form and we have not received this in our office, full payment at the time of service will be expected.
9. In the event of default on the patient’s balance, for any reason, the patient and guardian will be responsible for a collection agency fee in the amount of $50. The patient will be charged $25 for each return check, and $50 for missed appointments.
10. Minor Patients: For all services rendered to minor patient’s, we will look to the adult accompanying the minor for payment. Payment arrangements must be made in advance for unaccompanied minors

**Thank you for understanding our financial policy**

***I have read and understand the financial policy of the practice and I agreed to be found by its terms. I also understand and agree that such statements may be amended from time to time by the practice.***

_____ _____ _____

Printed Name of Patient | Signature of Patient/Guardian | Date

AUSTIN
FOOT & ANKLE CENTER

***North:*** 9012 Research Blvd C-13, Austin, TX 78758 // 512.450.0101 Fax: 512.450.0086
***Northwest:*** 11824 Jollyville Rd Ste 101, Austin, TX 78759 // 512.335.1800 Fax: 512.335.8353
***South:*** 5200 Davis Ln Ste 120, Austin, TX 78749 // 512.336.512) 336-8909

# Acknowledgment of Review of : *Notice of Privacy Practices*

Patient Name:_____

_____ (**Initial)** -- I have reviewed this offices ***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 documented on request.

**Check (1) of the below options:**

_____ I give permission to leave a message on my **voice mail** concerning my personal health information at the

following phone number:_____

_____ I **do not** give permission to leave a message on my voice mail concerning my personal health information.

## Disclosure to Families & Loved Ones

I authorize Dr. Patel and/or his staff to disclose information to my family and/or friends ONLY with my personal request. For example, you may prefer a family member or friend to be present in the exam room with you, or you may want to allow someone such as: your spouse, parent, or child to have the ability to discuss your health care with us.

******Without authorization, NO information will be shared******

***I request that my personal health information be shared with the following people:***

| Name | Relationship | Phone # |
|---|---|---|

| Name | Relationship | Phone # |
|---|---|---|

AUSTIN
FOOT & ANKLE CENTER

***North:*** 9012 Research Blvd C-13, Austin, TX 78758 // 512.450.0101 Fax: 512.450.0086
***Northwest:*** 11824 Jollyville Rd Ste 101, Austin, TX 78759 // 512.335.1800 Fax: 512.335.8353
***South:*** 5200 Davis Ln Ste 120, Austin, TX 78749 // 512.336.512) 336-8909

# Office Policy on Durable Medical Equipment (DME)

Our office aims at a goal of the highest level of medical care, at times it is extremely difficult to balance your needs as a patient along with the requirements and stipulations in healthcare. We pride ourselves on doing everything possible to work within the guidelines of insurance carriers and managed health plans while providing that higher level of care. Durable medical equipment costs continued to rise and subsequently insurance carriers have taken action to protect themselves from fraud and other abuses of insurance benefits. This makes it necessary for you to know your coverage. Often these products fall under the exclusionary clauses and unmet deductibles. It then becomes a problem for our billing department to collect, what in some cases is a large sum of money, for equipment that cannot be returned and will not be covered by your insurance carrier.

Most times this equipment is patients specific and could not be recycled or reused. For example, in the case of a custom molded shoe orthotics, this equipment cannot be used by anyone but that person.

Our staff will extend themselves at great lengths to help deal with these situations, but no insurance carrier will guarantee your benefits until claims are received. Most often these claims are not given attention until sometime after your office visit. As a result of the rising costs for durable medical equipment and individual requirements of insurance plans regarding durable medical equipment, and has become necessary for this office to collect for these products at the time that they are dispensed.

I have read and understand the above stated office policy and agreed to accept responsibility as described.

Patient Name_____ Date_____

Social Security_____

Patient's signature_____

AUSTIN
FOOT & ANKLE CENTER

***North:*** 9012 Research Blvd C-13, Austin, TX 78758 // 512.450.0101  Fax: 512.450.0086
***Northwest:*** 11824 Jollyville Rd Ste 101, Austin, TX 78759 // 512.335.1800  Fax: 512.335.8353
***South:*** 5200 Davis Ln Ste 120, Austin, TX 78749 // 512.336.512) 336-8909

**Acknowledgment of Review of : *Insurance coverage***

Patient Name:_____

_____ **(Initial) --** I have reviewed my insurance policy and understand that many new plans now require ***large DEDUCTIBLES be met BEFORE*** my insurance company begins to cover my medical costs. I understand that I may inquire about charges that may be billed during my visit and should ask if I have any concerns regarding the potential costs.

***AS MUCH AS WE WOULD LIKE TO TAKE TIME DURING YOUR VISIT TO DISCUSS THIS WITH YOU, IT TAKES AWAY FROM THE PATIENT CARE PROCESS AND CAN CAUSE LARGE DELAYS DURING OFFICE VISITS. PLEASE DON'T HESITATE TO ASK QUESTIONS REGUARDING CHARGES AT ANYTIME DURING YOUR VISIT***