PATIENT DEMOGRAPHICS & INSURANCE INFORMATION

Name: _____ Sex: ☐ Male ☐ Female

Address: _____ Date of Birth: _____ Age: _____

City: _____ Social Security #: _____

State: _____ Zip Code: _____ Preferred Pharmacy: _____

Phone: _____ ☐ Home ☐ Work ☐ Other Referring Physician: _____

Phone: _____ ☐ Home ☐ Work ☐ Other Primary Care Physician: _____

E-Mail Address: _____

EMERGENCY CONTACT

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

ACCOUNT GUARANTOR

☐ **Same As Patient**

Name: _____ Sex: ☐ Male ☐ Female

Address: _____ Date of Birth: _____ Age: _____

City: _____ Social Security #: _____

State: _____ Zip Code: _____ Relation to Patient: _____

Phone: _____ ☐ Home ☐ Work ☐ Other Phone: _____ ☐ Home ☐ Work ☐ Other

PRIMARY INSURANCE & SUBSCRIBER

☐ **Same As Patient**

Name: _____ Sex: ☐ Male ☐ Female

Address: _____ Date of Birth: _____ Age: _____

City: _____ Social Security #: _____

State: _____ Zip Code: _____ Insurance Carrier: _____

Phone: _____ ☐ Home ☐ Work ☐ Other Patient's Identification #: _____

Phone: _____ ☐ Home ☐ Work ☐ Other Policy/Group #: _____

SECONDARY INSURANCE & SUBSCRIBER

☐ **Same As Patient**

Name: _____ Sex: ☐ Male ☐ Female

Address: _____ Date of Birth: _____ Age: _____

City: _____ Social Security #: _____

State: _____ Zip Code: _____ Insurance Carrier: _____

Phone: _____ ☐ Home ☐ Work ☐ Other Patient's Identification #: _____

Phone: _____ ☐ Home ☐ Work ☐ Other Policy/Group #: _____

TREATMENT OF MINORS, PATIENTS WITH A MEDICAL POWER OF ATTORNEY or THOSE REQUIRING A CARE GIVER

A minor is considered to be a person under the age of eighteen and must be accompanied by a parent, legal guardian or court appointed custodian at each visit. Individuals with an existing power of attorney, who are no longer able to make decisions for themselves are required to have their appointed agent present at each visit. Individuals who require a care giver or reside in a care facility are required to have a care giver present throughout each visit. These requirements have been established in an effort to maximize the benefits of the care we provide and the outcomes to our patients and to comply with State laws. In the event a patient meeting any of these criteria arrive for a scheduled appointment without the required individual, the appointment will be rescheduled.

ACCOUNT GUARANTOR AGREEMENT

I hereby authorize Waco Foot & Ankle, P.A. (WFA) to administer such treatment or procedures as are considered medically necessary on the basis of clinical findings. I request the assignment of any and all insurance benefits directly to WFA. I agree to pay any charges incurred and deemed patient responsibility and any charges not covered by insurance. I understand that the use of a check for payment is my acknowledgement and acceptance of the terms outlined in WFA's posted check acceptance policy.

Account Guarantor's Signature: _____ Date: _____

Waco Foot & Ankle, P.A.

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, Waco Foot & Ankle, P.A. creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations be restricted. I also understand that the Practice and I must:
agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and
agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

(PATIENT'S NAME PRINTED)	D.O.B.
PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR)	SOCIAL SECURITY NUMBER (FOR IDENTIFICATION PURPOSES ONLY)
WITNESS (Optional)	DATE

Waco Foot & Ankle, P.A.

FINANCIAL POLICY

Insurance Copays
Insured patients are expected to present an insurance card at each visit to determine any changes in insurance eligibility or copay assignments. All insurance copayments are due and payable upon arrival for your appointment.

Prepayment
The patient portion of financial responsibility is due prior to the scheduling of a surgery or procedure. This includes outstanding deductibles, coinsurance or any service exempted from your insurance coverage. We recognize that determining expected out-of-pocket expenses can be complicated in some insurance coverage packages and have personnel to assist you. Based on the information provided by your insurance carrier(s), we will determine the payment expectations. Once the carrier's responsibility has been determined to be satisfied, any credit on your account will be refunded from the carrier's final payment.

Patient Statements
Patient statements are generated and mailed each month on all accounts with an outstanding patient balance. All statement balances are due in full on or before the 20th of the following month unless a formal payment plan has been negotiated and signed. Partial payments will be applied to the patient's account; however, the acceptance of partial payments will not automatically establish a payment plan of any kind and may result in the initiation of our collections process.

Accepted Payment Types
We accept MasterCard, Visa, Discover and American Express as well as personal checks, money orders and cash.

Check Acceptance Policy
NSF checks are automatically reprocessed with the addition of a $25 + tax processing fee. In addition to the processing fee, the patient account will be charged with any additional bank charges as well as any additional administrative costs associated with the collection and processing of the returned check.

Monthly Payment Plan
Paying a potion of your balance each month will not constitute an acceptable monthly payment plan. To discuss the implementation of an acceptable payment plan, please call our business office during normal business hours. No agreement will be considered or activated without proper documentation and an original signature.

Referrals
If your insurance carrier requires that you be referred to a specialist by your primary care physician (PCP), it is your responsibility to have your PCP obtain the referral prior to your scheduled clinic visit. We will assist you by tracking your referrals, but request your participation and cooperation as necessary.

Medical Records
You can obtain a copy of your medical records for yourself at no charge for the first request. There will be a fee of $30 for each additional request. A Medical Records Release Form authorizing the release of your information must be signed prior to the release of information to a third party. Please allow 14 days for medical records to be prepared. Please refer to our Notice of Privacy Practices in compliance with HIPAA regulations for guidelines on how your personal health information is protected.

Non-Standard Insurance Forms
The completion and filing of personal insurance claims forms (FMLA, AFLAC,etc..) follows receipt of a $25 Form Completion Fee. Please allow 72 business hours for forms to be completed, signed and mailed after payment has been received. Each additional form request is treated and billed individually.

Collection Agency
We retain the service of an outside Collection Agency for recovery of delinquent balances. Balances that are more than 90-days old are considered delinquent. We reserve the right to attach all additional fees associated with any effort toward collecting the delinquent account balance in its entirety including, but not limited to, attorney fees, court costs and collection fees imposed by a collection agency (43% of original balance), associated with any effort .

Billing Questions
Patient statements are sent monthly and provide detail about dates of service and balances due. We are always happy to answer any questions or concerns about your billing or statements. Please call our business office at 254-776-6995.

This Financial Policy helps us provide quality, consistent care to our valued patients. If you have any question or need clarification of any of the above policies, please feel free to contact us. I have read and understood the above policy statement.

Account Guarantor Name	Account Guarantor Signature	Date

PATIENT ACCOUNT SECURITY

Credit Card On File Program

Waco Foot & Ankle, like many healthcare facilities, has been greatly impacted by the implementation of the Patient Protection and Affordable Care Act (PPACA). The PPACA has caused insurance deductibles to rise to extremely high levels as well as co-insurance coverage to drop. With these two changes we are seeing increasing amounts and higher percentages of our charges for services placed on our patients. We understand most patients have also seen changes in their insurance in the form of additional coverage limitations and higher monthly premiums. Unfortunately, many patients are finding it difficult to manage the increasing financial obligation imposed by their insurance leaving many bills unpaid, therefore we are asking patients to secure their account with a credit card. Our Credit Card on File Program is a safe and reliable mechanism that will help ensure that the negative impact of PPACA does not affect your credit worthiness or limit your healthcare choices in the future.

Co-Insurances and/or Deductibles – These amounts are determined after your insurance company has completed processing your claim. At that time, if a balance remains on your account, monthly statements will be sent. You will have 90 days to pay the charge using any method of payment you choose. If, after 90 days, the charge remains on your account, your credit card will be charged the portion of your balance that has aged beyond 90 days.

Our Credit Card on File Program is safe and secure. Once stored in a secure transaction vault, your credit card information will not be physically accessible and your account number will be exchanged for a token number that is only usable in our officce. This is safer than a standars credit card transaction. The program is designed to be a convenience for you to keep your account current and prevent you from being turned over to a collection agency.

This will not compromise your ability to dispute a charge or question your insurance company's determination of payment.

****PLEASE NOTE:** If the Credit Card provided expires, becomes invalid, or lacks sufficient funds, it will be required that you update your Credit Card on File information and/or pay your balance in full in order to reschedule with your provider.

If you have any questions about this payment method, do not hesitate to ask.

Authorization to Charge my Credit Card

Patient Name (printed): _____ Patient Date of Birth: : ____/_____/____

Until further notice, I authorize Waco Foot & Ankle, P. A. to charge balances that have aged beyond ninety (90) days on the

account of the above named patient to the following credit card:

Card Type (circle one): Visa Mastercard Discover American Express

Name on Card: _____ Card Holder Signature: _____ Date: ____/_____/____

Credit Card Number: xxxx-xxxx-xxxx-_____ Exp. Date (mm/yy):_____/_____ Billing Zip Code: _____
(Your card must be present.)

Email Address: _____

Please hand your credit card and valid state issued identification to the Receptionist when you check in. He or she will enter your card information into the secure transaction vault. Once stored, your credit card information will not be physically accessible. Thank you.

RESERVED FOR OFFICE USE

Card Holder's Driver's License Number: _____ Issuing State: ____ DOB: _____

WFA Representative: _____

Welcome to Waco Foot & Ankle, P.A.

Thank you for choosing us to assist you with your healthcare needs.
Please take a moment to answer the following questions so that we will have as much information as possible to give you the best healthcare.

INTAKE QUESTIONNAIRE - Page 1

PRINTED PATIENT'S NAME _____ DATE OF BIRTH _____ DATE COMPLETED _____

Please Answer All Questions In Detail As It Pertains To Your Current Complaint

Please describe in detail the reason for today's visit:

_____

_____

_____

_____

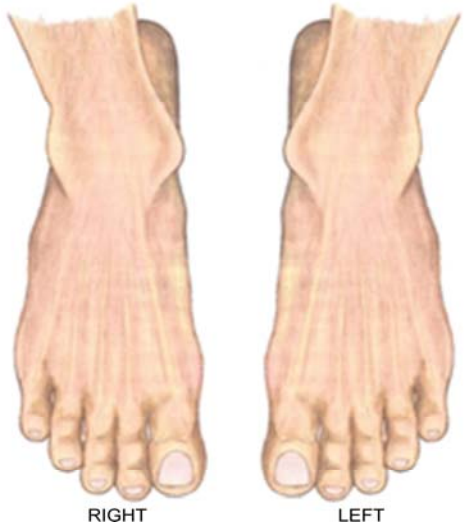
_____

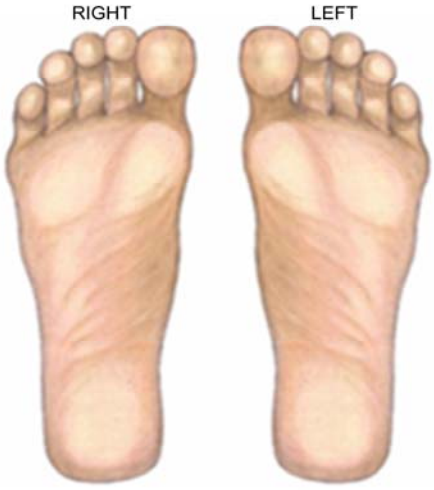
Circle the face that BEST describes your current pain level:

If you have pain, how would you describe the type of pain you are having today?

___ Burning ___ Tingling ___ Sharp ___ Throbbing ___ Aching ___ Dull ___ Stabbing ___ Radiating

On the diagrams below, please mark the problem and/or painful area(s):





When did you first notice pain and/or discomfort? _____

If this was the result of an injury, please describe the injury.

_____

_____

_____

Is your current condition the result of an on-the-job injury? ☐ Yes ☐ No

Since the onset/injury, the condition seems to be:

___ Unchanged ___ Intermittent (Comes & Goes) ___ Worsening ___ Improving ___ Constant

PRINTED PATIENT'S NAME _____ DATE OF BIRTH _____

What seems to aggravate your condition?

___ Walking ___ Certain Shoes ___ Exercise ___ Heat or Cold ___ Standing ___ Running

___ Other: _____

What forms of treatment have you tried for your current condition?

___ No Treatment ___ Physical Therapy ___ Custom Orthotics ___ Over-The-Counter Orthotics ___ Stretching

___ Ice ___ Heat ___ Over-The-Counter Medication ___ Prescription Medication ___ Shoes ___ Injections

___ Soaking ___ Resting ___ Elevation ___ Compression ___ Surgery ___ Other: _____

Please check any of the following conditions you have been *diagnosed* with: ___ **NONE**

___ Diabetes (Type: 1 or 2 ?) (Year Diagnosed: _____)

___ Neurological Disorder: _____

___ Anemia
___ Anxiety
___ Arthritis
___ Asthma
___ Bipolar Disorder
___ Bleeding Disorder
___ Blood Clot
___ Cancer: Type: _____
___ Chronic Urinary Tract Infection
___ Congestive Heart Failure
___ COPD/Emphysema
___ Dementia
___ Depression
___ Dialysis
___ Eye Problem: _____
___ Factor V Leiden Deficiency
___ Fibromyalgia
___ GI Bleed
___ Gout
___ Heart Attack-Year: _____
___ Heart Condition: _____
___ Hepatitis (A, B or C ?)
___ High Blood Pressure
___ High Cholesterol
___ HIV
___ Irritable Bowel Syndrome
___ Kidney Failure, Stage: _____
___ Liver Problems
___ Lupus
___ Migraines
___ Osteoporosis
___ Prior Diabetic Foot Complications
___ Pacemaker / Defibrillator
___ Peripheral Neuropathy
___ Peripheral Vascular Disease
___ Pregnancy/Possibly Pregnant
___ Psoriasis
___ Reflux/Indigestion
___ Restless Leg Syndrome
___ Rheumatoid Arthritis
___ Schizophrenia
___ Seasonal Allergies
___ Seizures
___ Sleep Apnea
___ Stroke
___ Thyroid Disorder: _____

___ Other medical condition(s) not listed: _____

Please list all surgeries you have had along with the year they were performed: ___ **NONE**

_____

_____

_____

Did you or any of your relatives have any anesthesia problems or surgical complications? If so, please describe:

_____

_____

PRINTED PATIENT'S NAME _____ DATE OF BIRTH _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Living Conditions: ☐ Alone ☐ With Spouse ☐ With Spouse & Children ☐ With Parents

☐ Nursing Facility or Assisted Living (_____) ☐ Other: _____

Name of Facility

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Disabled ☐ Unemployed ☐ Student

Employer: _____ **Type of work:** _____

Family Medical History: ☐ **NONE**

Grandfather:	☐ Bleeding Disorder/Blood Clots	☐ Cancer	☐ Diabetes	☐ Heart Problems	☐ Neurological
Grandmother:	☐ Bleeding Disorder/Blood Clots	☐ Cancer	☐ Diabetes	☐ Heart Problems	☐ Neurological
Father:	☐ Bleeding Disorder/Blood Clots	☐ Cancer	☐ Diabetes	☐ Heart Problems	☐ Neurological
Mother:	☐ Bleeding Disorder/Blood Clots	☐ Cancer	☐ Diabetes	☐ Heart Problems	☐ Neurological
Sibling:	☐ Bleeding Disorder/Blood Clots	☐ Cancer	☐ Diabetes	☐ Heart Problems	☐ Neurological

Tobacco Use: ☐ Never ☐ Former Smoker Year Quit: _____ ☐ Current Smoker ☐ Smokeless Tobacco

Illicit Drug Use: ☐ Never ☐ Former Drug User ☐ Current Drug User

What illicit drugs do/did you use: _____

Alcohol Use: ☐ Never ☐ Former Drinker ☐ 1-7 Drinks per week ☐ More then 7 drinks per week

Exercise: ☐ Never ☐ 1-3 timer per week ☐ More than 3 times per week ☐ Daily

What type(s) of exercise do you perform?

_____

_____

List any allergies you have to medications, foods or substances such as latex and the reaction caused: ☐ **NONE**

_____

_____

_____

Please list all medication you are currently taking, including vitamins and over-the-counter medications:

Medication Name	Dose	Frequency

Please use the back of this form if additional room is needed to list your medications.

Welcome to Waco Foot & Ankle, P.A.

INTAKE QUESTIONNAIRE - Page 4

PRINTED PATIENT'S NAME _____ DATE OF BIRTH _____

Do you currently have any of the following problems?

___ Chills	___ Wheezing	___ Numbness
___ Fatigue	___ Constipation	___ Seizures
___ Fever	___ Diarrhea	___ Tingling
___ Weight Loss	___ Nausea	___ Tremors
___ Blindness	___ Vomiting	___ Weakness
___ Contact Lenses	___ Frequent Urination	___ Anxiety
___ Glasses	___ Painful Urination	___ Depression
___ Difficulty Swallowing	___ Back Pain	___ Abnormal Bruising
___ Impaired Hearing	___ Joint Pain	___ Excessive Bleeding
___ Respiratory Congestion	___ Leg Cramps	___ Decreased Appetite
___ Chest Pain	___ Stiffness	___ Excessive Thirst
___ Fainting Spells	___ Difficulty Healing	___ Heat/Cold Intolerance
___ Irregular Heart Rate	___ Excessive Scarring	___ Increased Appetite
___ Leg Swelling	___ Itching	___ Weight Changes _____
___ Cough	___ Rashes	
___ Difficulty Breathing	___ Dizziness	
___ Shortness of Breath	___ Frequent Falls	

What type of shoes do you wear most of the time? _____

What is your shoe size? _____