



The Center For Foot & Ankle Surgery
 1015 E. 32ND St Suite 212
 Austin, TX 78705
 Phone: 512-477-8853 Fax 512-477-2592

PATIENT INFORMATION SHEET

Today's Date: _____

First Name: _____ Middle Name: _____
 Last Name: _____ Social Security #: _____
 Date of Birth: _____ Gender: _____

Home Address & Phone

Street: _____ Apt # _____ City & Zip: _____
 Home Phone: _____ Work Phone: _____
 Cellular: _____ E-Mail Add: _____
 Shoe Size: _____ Marital Status: _____ Fax: _____

Pharmacy Name: _____ **Phone #:** _____
Address: _____

INSURANCE INFORMATION - MUST FILL OUT THIS SECTION

Primary Insurance: _____
Insured Party Name: _____ **DOB** _____
 Social Security # _____ **ID #** _____
 Group # _____ **Effective Date:** _____
 Relationship to Patient (self, spouse, parent): _____

Secondary Insurance: _____
Insured Party Name: _____ **DOB** _____
 Social Security # _____ **ID #** _____
 Group # _____ **Effective Date:** _____
 Relationship to Patient (self, spouse, parent): _____

Was this an accident? Yes No If yes, date of accident: _____
 Place accident occurred: _____
 Brief Description of Accident: _____

Is there an attorney involved? Name & Phone: _____

Was this work comp? What body part: _____

Referred by: _____ Employer: _____

Work comp insurance: _____

Date of Injury: _____ Claim #: _____

Nurse Manager Name & Phone: _____

Adjuster Name & Phone: _____



The Center For Foot & Ankle Surgery
 1015 E. 32ND St Suite 212
 Austin, TX 78705
 Phone: 512-477-8853 Fax 512-477-2592

Primary Care Doctor: _____ Phone # _____
 Fax # _____ Address: _____
 City: _____ Zip: _____
 Date of LAST visit: _____

MEDICARE PATIENTS: *In compliance with new Medicare guidelines, you MUST be current (seen within the last 6 months) with your PCP and/or Endocrinologist*

Where did you hear about us? _____
 (web page, yellow pages, ad, relative, friend)

Patient or Legal Guardian (must be at least 18 years of age)

The undersigned hereby authorizes the release of any information and submittal of claims for services rendered for all benefits submitted on behalf of myself and/or dependents. I further acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered or for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature.

Please remember that insurance is considered a method of reimbursing the doctor for services rendered and not a substitute for payment. Some insurance companies pay fixed allowances for certain procedures and other insurance companies pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, out of network percentage and/or any other balance not paid by your insurance company.

 Print Name of Patient

 Print Name of Guardian

 Signature of Patient / Guardian

 Date

Guarantor or Legal Guardian if patient is under the age of 18:

(Notice to divorced parents – The parent or guardian who presents with child for treatment will be responsible for all charges incurred.)

Last Name: _____ First Name: _____ MI: _____
 Relationship: _____ SS #: _____ DOB: _____
 Home #: _____ Work #: _____ Cell #: _____
 Address: _____ Apt # _____
 City, State & Zip: _____
Emergency Contact Name: _____ Phone #: _____
 Relationship to Patient: _____

HEALTH HISTORY QUESTIONNAIRE

Center for Foot & Ankle Surgery

Charles Jason Hubbard, DPM

Trinity M. Mereau, DPM

Steven A. Walters, DPM

Original
Date:

Dates
Revised:

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.):

M

F

DOB:

Age

REVIEW OF SYSTEMS

Please check if you have recently been experiencing any of the following:

General	<input type="checkbox"/> change in appetite	<input type="checkbox"/> chills/ fever	<input type="checkbox"/> fatigue	<input type="checkbox"/> other
Skin	<input type="checkbox"/> rash	<input type="checkbox"/> Itching	<input type="checkbox"/> lesion/ lumps/ sores	<input type="checkbox"/> other
Head	<input type="checkbox"/> deformity	<input type="checkbox"/> Head injury	<input type="checkbox"/> headache	<input type="checkbox"/> other
Eyes	<input type="checkbox"/> blurred vision	<input type="checkbox"/> change in vision	<input type="checkbox"/> cataracts	<input type="checkbox"/> other
Ears	<input type="checkbox"/> Deaf	<input type="checkbox"/> Decreased hearing	<input type="checkbox"/> dizziness	<input type="checkbox"/> other
Nose & Sinuses	<input type="checkbox"/> Loss of smell	<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> other
Mouth & Throat	<input type="checkbox"/> Dry mouth	<input type="checkbox"/> Sores on tongue	<input type="checkbox"/> toothache	<input type="checkbox"/> other
Neck	<input type="checkbox"/> Enlarged thyroid	<input type="checkbox"/> Neck mass	<input type="checkbox"/> Neck pain	<input type="checkbox"/> other
Respiratory	<input type="checkbox"/> shortness of breath	<input type="checkbox"/> cough	<input type="checkbox"/> clubbing of fingers	<input type="checkbox"/> other
Cardiovascular	<input type="checkbox"/> chest pain	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> edema	<input type="checkbox"/> other
Gastrointestinal	<input type="checkbox"/> nausea	<input type="checkbox"/> vomiting	<input type="checkbox"/> abdominal pain	<input type="checkbox"/> other
Genitourinary	<input type="checkbox"/> frequency	<input type="checkbox"/> incontinence	<input type="checkbox"/> infection	<input type="checkbox"/> other
Musculoskeletal	<input type="checkbox"/> limitation motion	<input type="checkbox"/> muscle cramps	<input type="checkbox"/> stiffness	<input type="checkbox"/> other
P Vascular	<input type="checkbox"/> calf pain	<input type="checkbox"/> leg cramp	<input type="checkbox"/> rest pain	<input type="checkbox"/> other
Neurologic	<input type="checkbox"/> numbness	<input type="checkbox"/> seizures	<input type="checkbox"/> memory loss	<input type="checkbox"/> other
Psych	<input type="checkbox"/> anxiety	<input type="checkbox"/> depression	<input type="checkbox"/> insomnia	<input type="checkbox"/> other
Endocrine	<input type="checkbox"/> excessive thirst	<input type="checkbox"/> excessive urination	<input type="checkbox"/> thyroid problems	<input type="checkbox"/> other
Hematologic	<input type="checkbox"/> anemia	<input type="checkbox"/> easy bruising	<input type="checkbox"/> blood transfusion	<input type="checkbox"/> other

MEDICAL HISTORY

List and check all medical problems that other doctors have diagnosed:

Cancer

Location :

OB/ Gyn

Skin

Scleroderma

Steven Johnson

Head, Eyes, Ears

Cartaracts

Macular Degeneration

Retinal Detachment

Blind

Deaf

Respiratory Disease

Asthma

COPD

Pulmonary Embolism

sleep apnea

Cardiac problems

Congestive heart failure

Coronary artery ds

Blood clot

High cholesterol

Hypertension

Mitral Valve Prolapse

Murmur

Stroke

Gastrointestinal

Gastro-esophageal reflux

Hepatitis

IBS

Peptic ulcer

Urinary

Renal Failure

Dialysis

Musculoskeletal

Back pain

Osteoarthritis (Arthritis)

Osteoporosis

Raynaud's

Chronic Regional pain syndrome (RSD)

Neuro

Alzheimer's

Multiple sclerosis

Neuropathy

Parkinson

Seizures

Psych

Alcoholism

Anxiety

Attention Deficit

Depression

Drug abuse

Hematologic/ Lymph

Anemia

Sickle Cell

Endocrine

Diabetes

Hyperthyroidism

Hypothyroidism

Obesity

Allergy/ Immunology

Infectious Disease

AIDS

HIV

Osteomyelitis

Rheumatology

Ankylosing spondylitis

Fibromyalgia

Gout

Reiter's

Rhuematoid arthritis

Trauma

Motor vehicle accident

Fractures/ Broken bones: Location _____

Please add or explain any other medical conditions:



The Center For Foot & Ankle Surgery
1015 E. 32ND St Suite 212
Austin, TX 78705
Phone: 512-477-8853 Fax 512-477-2592

Financial Policy

Our primary goal is to provide excellent health care to all our patients. It is necessary to establish policies to avoid misunderstandings. We would like to clarify the following policies that are followed by our practice:

Insurance Coverage: We participate in many insurance plans. We do not file automobile or other third party liability claims (accident policies, litigations, etc.) If you are not insured we will do business with a payment in full collected at each visit. Knowing your insurance benefits is your responsibility. You are responsible for the portion of your charges that are not covered. Please contact your insurance company with any questions about coverage or claims processing.

Proof of Insurance: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current, valid proof of insurance. If you do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. If you fail to provide us with the correct insurance information in a timely manner, you must notify us **before** your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Co-Payments & Balances: Co-payments are due at the time you check in. This arrangement is part of your contract with your insurance company. Please note that the Center for Foot & Ankle Surgery physicians are specialty physicians and higher co-pays may apply. If you cannot pay your co-payment, you might have to reschedule your appointment. Unpaid deductibles, co-insurance percentages, and other outstanding balances are also due upon checking in with our front office. If payment is unable to be made in full, financing options are available through Care Credit.

Referrals: It is your responsibility to obtain valid referrals from your primary care physician (PCP) if your insurance company requires them. If you do not have your referral at the time of your appointment, you will need to re-schedule your appointment or pay for the visit before you see the doctor.

Work Related Injuries: You must tell our office if your injury/condition is work related. We must verify your claim **before** your appointment. If you work for an employer who is covered under provision of the Texas Workers' Compensation and the claim is found to be fraudulent or non-compensable, you will be fully responsible for all charges.

Non-Payment: Statements are due and payable in full upon receipt. In the event that your bank returns payment made by a personal check, a service fee of \$25.00 will be billed to your account. If any balance is outstanding, we may refer your account to a collection agency and you may be discharged from this practice. If this office must take action to collect an outstanding balance on your account, you will be responsible for payment of all costs of such collection efforts.

I have read and understand the financial policies and agree to abide by all guidelines.

Signature of Responsible Party/Patient

Printed Name/Relationship

Date



The Center For Foot & Ankle Surgery
1015 E. 32ND St Suite 212
Austin, TX 78705
Phone: 512-477-8853 Fax 512-477-2592

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have been given the right to review the Notice of Privacy Practices prior to signing this acknowledgement. I understand that *The Center for Foot & Ankle Surgery* reserves the right to change these policies at any time and I may contact this office for an update copy at any time.

I understand that I may request in writing that you restrict how my private information is used or disclose to carry our treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patients Name

Signature

Date



The Center for Foot & Ankle Surgery
1015 E. 32ND St Suite 212
Austin, TX 78705
Phone: 512-477-8853 Fax 512-477-2592

Consent to Release Personal Medical Information

I, _____, give my consent to the Staff and Physicians with The Center for Foot & Ankle Surgery, P.A. to release any medical information pertaining to me to the following people:

Name (please print) Phone Number: (____) _____ - _____

Name (please print) Phone Number: (____) _____ - _____

Name (please print) Phone Number: (____) _____ - _____

Name (please print) Phone Number: (____) _____ - _____

Patient Signature

Date