Bay Area Podiatry Associates, PA

Patient Demographic Information

Patient's Name:				Date:
DOB:		Age:		Sex: F M
Home Address:		Marital Status: □ Single □ Married □ Widow □ Divorced □ Separated		
City:	State:		Zip:	
Home Phone:	Cell Phone:		Work Phone:	
Emergency Contact:	Phone #:		Relationship:	
Email Address:		Primary Care Physician:		
Employer Name:		Position:		
Primary Language:		Ethnicity: □ Hispanic or Latino □ Non-Hispanic		
Race: □ American Indian or Alaska Native □ Asian □ Black or African American □ Native Hawaiian or Pacific Islander □ White				
Is this a work related injury? Yes No If you answered yes to the following question please inform the front desk. Please be aware that your private health insurance will not cover any work related injury.				

INSURANCE INFORMATION

Primary Insurance Co. Name:		Secondary Insurance Co. Name:	
Policy #:		Policy #:	
Subscriber's Name:	Relationship to Patient:	Subscriber's Name:	Relationship to Patient:
Subscriber's DOB:		Subscriber's DOB:	

PHARMACY INFORMATION

Pharmacy Name: Pharmacy Address:	Pharmacy Phone:

Bay Area Podiatry Associates, PA

The Physician's at Bay Area Podiatry Associates strive to provide the most up to date and personalized care for our patients, we have partnered with several institutions in the area which share that goal.

We are pleased to inform you of the following:

1. Kirk A Koepsel DPM and Matthew S Rockett DPM have an ownership interest in Houston Physicians Hospital.

2. Kirk A Koepsel, DPM is an investor in Pharma Select.

3. You have the right to choose the provider of your health care service. Therefore ,you have the option to use a healthcare facility other than Houston Physician's Hospital and also a compounding pharmacy other than Pharma Select.
.
4. You will not be treated differently by your physician if you choose to obtain healthcare services at a facility other than Houston Physician's Hospital and if you choose to use another compounding pharmacy other than Pharma Select

If you have any questions concerning this notice, please feel free to ask your physician or any representative of Houston Physicians Hospital and Pharma Select.

By Signing this Disclosure of Physician Ownership you acknowledge that you have read and understand the forgoing notice and hereby understand that your physician has an ownership and or interest in Houston Physician's Hospital and Pharma Select.

Signature: _____ Date: _____

Bay Area Podiatry Associates, PA

Name_____ Date of Birth_____Date_____

PODIATRIC HISTORY

Reason for your visit: _____
_____
_____

Describe Type of Pain:
□ Dull □ Sharp □Shooting
□ Burning □ Aching
□ Throbbing □ Tingling
□ Numbness □ Cramping
□Other: _____

Location: □ Right □ Left □ Both
□ Foot □ Ankle □ Leg

Height: _____
Weight: _____
Shoe Size: _____

Duration (How long have your symptoms been present):_____Days/ Weeks/ Months/ Years

Onset: □ Slow □ Sudden □ Traumatic

If Traumatic: □ Auto □ Worker's Comp □ Other

Has Pain Become: □ Better □ Worse □ Stayed the same

Symptoms are worse:□ Morning □ All Day □Evening □ Night

Please circle your pain level:

Previous Treatments: _____
_____

What aggravates the condition?
_____
_____

Who is your Primary Care Physician? Last time seen? _____
_____

May we contact physician regarding your care? □ YES □ NO

Bay Area Podiatry Associates, PA

MEDICATIONS

Please include prescriptions, over-the-counter medications, and vitamins or (Provide a list to be photocopied):

Name: _____ Dosage: _____ Reason: _____

Name: _____ Dosage: _____ Reason: _____

Name: _____ Dosage: _____ Reason: _____

Name: _____ Dosage: _____ Reason: _____

MEDICAL HISTORY

Please mark to indicate if you have or have been treated for any of the following:

Aids/HIV__
Acid Reflux__
Anemia__
Anxiety__
Arthritis__
Artificial Heart Valve__
Artificial Joint__
Asthma__
Back Problems__
Bleeding Problems__
Bipolar Disorder__
Blood Clot/DVT__
Cancer__
Type _____
Chemical Dependency__
Chest Pain/Angina__
Circulatory Problems__
Depression__
Diabetes__
Type__ How Long__
Emphysema__
Fibromyalgia__
Gout__
Headaches__
Heart Attack__
Heart Murmur__
Hepatitis__
High Blood Pressure__
Kidney Problems__
Liver Disease__
Low Blood Pressure__
Neuropathy__
Pacemaker__
Phlebitis__
Psoriasis__
Seizure Disorder__
Stroke or TIA__
Thyroid Problems__
Varicose Veins __
Other_____

Women, are you pregnant? Y N Breastfeeding Y N

MEDICATION ALLERGIES

Any allergies or adverse reaction to the following?

Local anesthesia __
Latex __
Penicillin __
Betadine __
Tetanus __
General anesthesia __
Anti-Inflammatory __
Iodine __
IVP dye __
Nickel __
Aspirin __
Tape/Adhesives __
Sulfa __
Codeine __

Other antibiotics (name) _____

Other medications (name) _____

SURGICAL AND HOSPITALIZATION HISTORY

Please list previous surgeries and hospitalizations with approximate dates (year):

Surgery/Hospitalization_____ Date: _____

Surgery/Hospitalization_____ Date: _____

Surgery/Hospitalization_____ Date: _____

Surgery/Hospitalization_____ Date: _____

Do you have any metal implants? Yes NO

If so what kind of implant: _____

Do you smoke Y N #of Cigarettes/day _____

Do you drink Alcohol Y N # of drinks/day_____ #drinks/wk _____

____ I have a Durable Power of Attorney or advance directive and the decision maker's name is

_____.

____ I do not wish to discuss an advanced care plan.

Signature: _____

Date: _____

Bay Area Podiatry Associates

Privacy Consent and Release

I have reviewed this office's 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 document.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Printed Name of Patient or Personal Representative If not self, description of Personal Representative

I understand that by signing this form, I give permission for my doctor to collect payment due from my insurance for services performed. I understand medical records remain confidential as described in the Notice of Privacy Practices.

Emergency Contact Name & Number _____

I allow release of medical information to the following: (Please check all that apply)

☐ No one except myself ☐ Spouse : _____ ☐ Other: _____

Financial Policy

Insurance

1) According to your insurance plan, you are responsible for any and all co-payments, deductibles, and co-insurances at the time of your visit.
2) It is your responsibility to keep us updated with your correct insurance information. If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.
3) It is your responsibility to understand your benefit plan with regard to, for instance, covered services and participating laboratories.
4) It is your responsibility to know if a written referral or authorizations is required to see specialists, whether prior authorization is required for a procedure, and what services are covered.

Payment

1) Self-pay patients are expected to pay for services in FULL at the time of the visit.
2) If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance for reimbursement.
3) Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within 10 business days of your receipt of your bill.
4) For scheduled appointments, prior balances must be paid prior to the visit.
5) We accept cash, checks, Visa, Master Card, Discover and American Express credit and debit.

Fees

1) If you are not able to keep an appointment, we require a 24 hour notice. There is a charge of $ 30.00 for missed office visit appointments.
2) Co-payments are due at the time of service. A $20.00 service fee will be charged in addition to your co-payment if the co-payment is not paid by the end of the next business day.
3) A $ 30.00 fee will be charged for any checks returned for insufficient funds.

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

_____ _____

Signature of Patient (Parent/Guardian) Date