Bay Area Podiatry Associates, PA

Patient Demographic Information			
Patient's Name:			Date:
SS#:	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:		Referral Source:	
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			

REFERRING PHYSICIAN INFORMATION	
Primary Care Physician's Name:	Phone #:

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 SS#:	Subscriber's DOB:	Subscriber's SS#:	Subscriber's DOB:

PHARMACY INFORMATION	
Pharmacy Name:	Pharmacy Phone:

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Guarantor Information	
Guarantor Name:	Relationship to Patient:
Guarantor Address:	Guarantor Phone:
Is this a work related Injury: □ YES	□ NO
WORKERS COMP ACCIDENT INFORMATION	
Date of Accident:	Claim #:
Worker's Compensation Insurance Company:	
Claim Adjuster's Name:	Adjuster's Phone:
Employer's Name:	Employer's Phone:

The Physicians at Bay Area Podiatry Associates strive to provide the most up to date and personalized care for our patients, and 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 Physician's Hospital.
2. Kirk A Koepsel DPM and Matthew S Rockett DPM are investors in Healthscripts.
3. Kirk A Koepsel DPM is an investor in ICON RX
4. You have the right to choose the provider of your health care services. Therefore, you have the option to use a health care facility other than Houston Physician's Hospital and also use a compounding pharmacy other than Healthscripts or ICON RX.
5. You will not be treated differently by your physician if you choose to obtain health care services at a facility other than Houston Physician's Hospital and if you choose to use another compounding pharmacy than Healthscripts or ICON RX.

If you have any questions concerning this notice, please feel free to ask your physician or any representative of Houston Physician's Hospital, ICON RX, or Healthscripts. We welcome you as a patient and value our relationship with you.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership and or interest in Houston Physician's Hospital, Healthscripts and ICON RX.

Signature: _____ Date_____

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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: _____

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

Previous Treatments: _____
_____

What aggravates the condition?
_____
_____

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

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

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 circle to indicate if you have had 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
Circulatory Problems
Depression
Diabetes
Type_____ How Long_____
Emphysema
Fibromyalgia
Foot Cramps
Gout
Headaches
Heart Attack
Heart Murmur
Heart Failure
Hepatitis
High Blood Pressure
Kidney Problems
Leg Cramps
Liver Disease
Lower Blood Pressure
Neuropathy
Pacemaker
Phlebitis
Psoriasis
Shortness of Breath
Stroke
Thyroid Problems
Tuberculosis
Varicose Veins
Wt Loss, Unexplained

Women, are you pregnant? Y N Breastfeeding? Y N

Other medical problem we should be aware of :_____

_____

ALLERGIES

Any allergies or adverse reaction to the following?

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

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: _____

Printed Name: _____

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