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:

Bay Area Podiatry Associates, PA

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_____

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: _____

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: _____

Insurance Coverage Disclaimer/Clinic Financial Policy

Due to changes within the insurance industry, effective immediately **Bay Area Podiatry Associates** is requesting all patients to verify and be familiar with their insurance benefits prior to being seen in our office. **As a courtesy, our staff will continue to verify and bill your insurance, but we cannot guarantee coverage or that the information we have received from your carrier and conveyed to you is accurate or complete.** Please read and sign that you have received and understand the following:

I understand that **Bay Area Podiatry Associates** will bill most insurance carriers and that all co-pay and deductible amounts are expected to be paid at the time of my appointment unless other arrangements have been made in advance. Should I have a balance for any reason after my insurance has processed the claim, a statement will be sent to me. **It will be my financial responsibility to pay this balance due**.

_____ Patients Initials

I understand that if my insurance company requires a referral, preauthorization or prescription, it is my responsibility to obtain this referral from my medical doctor prior to my appointment. I accept full responsibility of keeping track of the number of visits allowed and the number of visits used.

_____Patients Initials

I have read and understand that if my insurance does not pay in full for the services provided by the health care providers in this clinic, I assume liability for the allowed unpaid portion within the confines of my policy.

_____Patients Initials

I authorize the release of any medical records that might be necessary to facilitate payment of services and authorize the insurance company to make payments directly to the clinic and /or provider. It is understood that the providers within this office have access to each other's records without further authorization, and that may records may be released to other physicians directly involved in my care.

_____Patients Initials

I also understand that it is my responsibility to fully understand my insurance benefits and that the benefits quoted to me by this office are based on information provided to **Bay Area Podiatry Associates** by my insurance carrier. I understand that **Bay Area Podiatry Associates** must abide by the rules governing my insurance coverage, but ultimately coverage is based upon, my contractual agreement with my insurance carrier. **All services are subject to medical necessity**. I further acknowledge that if it is requested of me, that I agree to assist my provider in obtaining the proper documentation and/or referrals from my primary medical provider to substantiate the medical necessity of my treatment in this office.

_____ Patients Initials

Signed: _____ Date: _____