Welcome to Houston Foot and Ankle

THIS INFORMATION IS IMPORTANT FOR OUR RECORDS AND YOUR HEALTH

SO PLEASE FILL THIS FORM OUT COMPLETELY

NAME OF PATIENT_____
SOCIAL SECURITY # _____
ADDRESS_____
CITY_____ STATE_____ZIP_____
SEX: M F AGE:_____ BIRTHDATE_____
MARITAL STATUS: S M D W
HOME PHONE_____CELL_____
E-MAIL ADDRESS_____
EMPLOYER_____
OCCUPATION_____
ADDRESS_____
CITY_____STATE_____ZIP_____
OFFICE PHONE_____

PERSON RESPONSIBLE FOR ACCOUNT_____
STREET_____
CITY_____STATE_____ZIP_____
EMPLOYER_____
ADDRESS_____
CITY_____STATE_____ZIP_____
PHONE_____
RELATIONSHIP TO PATIENT_____
BIRTHDATE_____

WHOM MAY WE THANK FOR REFERRING YOU TO US?

EMERGENCY CONTACT_____

RELATIONSHIP_____PHONE_____

MEDICAL INFORMATION

NAME:_____ DATE:_____

Welcome to our office. This information is important for our medical records and your health. Please fill this information out as completely as possible.

CHIEF COMPLAINT – What is your main foot or ankle problem (please specify left or right)?

Please list any other foot or ankle problems that need attention:

Have you seen another podiatrist or other physician for your current condition(s)? If so, please list physician(s)'s name and when evaluation/treatment took place.

Do you wear custom insoles, orthotics, or braces? Yes No

What is your height?_____ Weight?_____

What is your shoe size?_____ Width?_____

Family Physician or Internist Name:_____ Date Last Seen:_____

Specialty Physicians? Type:_____ Name:_____

Type:_____ Name:_____

Pharmacy Name:_____ Phone Number:_____

MEDICATIONS – Please list the names and dosages of all medications (both prescription and over the counter) that you are currently taking.
( ) Please check this box if you currently take NO medications.

MEDICAL HISTORY

Have you had any serious illnesses? If yes, please explain:

Circle if you have (or had) a problem with any of the following:

Diabetes	Lungs	Asthma	Blood Clots	Heart	Liver
Stroke	Kidneys	Thyroid	Stomach Ulcer	Phlebitis	Arthritis
Cancer	T.B.	Murmur	Hypertension	Bladder	AIDS/HIV
Skin	Anemia	Gout	Psychological	Epilepsy	Circulation
ADHD	RA	Psoriasis	Depression	Crohns/IBS	Fibromyalgia

For women: Are you pregnant or breast feeding? Yes No

ALLERGIES

Are you allergic or sensitive to any of the following (Please circle)? Please explain the reaction you get to the offending substance.

( ) Please check this box if you have NO KNOWN DRUG ALLERGIES

Penicillin	Morphine	Tape	Sulfa	Novocaine	Latex
Aspirin	Codeine	Iodine	Neosporin	Betadine	"-mycins"

Others (please list):_____

SURGERIES—Please list all surgeries/procedures that you have had. Please include when, where, and what surgical procedures. ( ) Please check this box if you have never had surgery

Have you ever had a reaction or complication from anesthesia or surgery? If so please explain.
( ) Please check this box if you have NOT had complications from anesthesia or surgery

Do you have bad reactions to any metals, jewelry, or an allergy/sensitivity to nickel? Y N

TRAUMATIC HISTORY – Have you ever had any SERIOUS injuries, accidents, or broken bones? If so, please list when, your treatment, and outcome.

HOSPITALIZATIONS – Have you ever been hospitalized for any reason? If so, please list when, where and for what reason. ( ) Please check this box if you have never been hospitalized

FAMILY HISTORY – Please circle if any of your family members have (or had) any of the following:

Diabetes	Cancer	Heart Disease	Hypertension	Foot Problems
RA	Psoriasis	Gout	Arthritis	Charcot Marie Tooth

SOCIAL HISTORY

Your occupation:_____

Marital Status:_____ # of Children:_____

Do you smoke? Yes No # of packs per day:_____ # of years:_____

Previously Smoked? Yes No # of packs per day:_____ # of years:_____ Year Quit_____

Do you use smokeless tobacco or chewing tobacco? Yes No frequency/qty_____

Do you drink alcohol? Yes No

How would you describe your drinking? Circle those that apply:

Social Light Moderate Heavy Binge Rarely Never

Do you use recreational/illicit drugs? Yes No Type:_____

Do you have a history of substance abuse or substance abuse treatment? Yes No

Are you involved in a sport or exercise program? Yes No Please explain below:

Due to recent mandated regulations at both the state and federal levels, we are required to collect the race, ethnic background, and preferred language(s) of all patients. This information will go into your electronic chart and will remain strictly confidential.

Please check the category which most closely represents your race:
____ American Indian or Alaskan Native
____ Asian
____ Black or African American
____ Native Hawaiian or Other Pacific Islander
____ Other Race or Multiple Races
____ White

Please check your ethnic background:
____ Hispanic or Latino
____ Non-hispanic/Latino

What is your preferred language(s): _____

We are dedicated to providing the best possible care and service to you. An essential element of your care and treatment is understanding your financial responsibilities. If you have any questions about the policies, please discuss them with our office manager and/or front office staff.

Health Insurance
We are contracted with most insurance plans to accept assignment of benefits. Our office will file your visit with the insurance company and will only collect your co-pay, deductible, and/or coinsurance when it applies. Please note: Our contract with your insurance carrier requires us to collect your co-pay at each visit.
If you have insurance coverage with a plan that we do not have a prior agreement with, the charge for your care and treatment are due at the time of service. In the event your health plan determines a service to be "non-covered", you will be responsible for the complete charge. Payment is due upon receipt of statement from this office.

Referrals
It is your responsibility to obtain a valid referral from your primary care physician when required by your insurance company.

Disability, Insurance Forms, Medical Records, and Copies of X-rays
There is a $25.00 per form charge to fill out disability and insurance forms. Please mail, email, or leave them at the front desk along with your payment. Forms will not be completed until payment is received. Please allow at least 3-5 working days for processing. We will call you once we have completed your request. There is a $25.00 fee for copying x-rays and $10.00 fee for medical records.

Medication Refills

Refills for medication prescribed by your doctor should be obtained by calling your pharmacy to request the refill. Please do not call the office, as this will only result in additional phone calls for you. Refills are not approved after normal business hours, weekends, or holidays, so please call in your refill request in time for the pharmacy to contact our office.

Cancellation Policy

Our office will make every attempt to confirm your scheduled appointment, but it is ultimately your responsibility to cancel or reschedule when necessary. Our office reserves the right to charge a $25.00 fee for failure to inform our office of appointment cancellation 24 hours prior to the appointment.

I have read and understand the office policies, and I agree to be bound by their terms. I also understand and agree that such terms may be amended from time to time by the practice.

_____ _____

Signature Date

Printed Name

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE SERVICES THAT I RECEIVE. PAYMENT IS EXPECTED AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. I UNDERSTAND THAT THERE WILL BE A $30.00 NSF FEE FOR ANY RETURNED CHECKS.

SIGNATURE_____DATE_____

FOR PATIENTS WITH INSURANCE COVERAGE, PLEASE READ AND SIGN:

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION AND REQUEST THAT BENEFITS BE PAID DIRECTLY TO HOUSTON FOOT AND ANKLE FOR SERVICES RENDERED. I UNDERSTAND THAT HOUSTON FOOT AND ANKLE IS FILING MY CLAIM AS A COURTESY AND THAT THIS DOES NOT RELIEVE ME OF FINANCIAL RESPONSIBILITY OF NON-COVERED SERVICES OR SUPPLIES.

SIGNATURE_____DATE_____

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I ACKNOWLEDGE THAT THE NOTICE OF PRIVACY PRACTICES AND HIPAA WAS AVAILABLE AND THAT I HAVE READ (OR HAD THE OPPORTUNITY TO READ IF I CHOOSE) AND UNDERSTAND THE NOTICE.

_____ _____

PATIENT NAME (PLEASE PRINT) DATE

_____

PARENT OR AUTHORIZED REPRESENTATIVE (IF APPLICABLE)

_____

SIGNATURE

Please read and sign this form. This form will help us receive insurance payment for your visit/services and allow us to communicate with insurance companies:

I assign the right to payment for medical benefits directly to Houston Foot and Ankle/Jason C. Miller, DPM, PA in consideration for medical services and supplies provided to me pursuant to my health insurance plan.

In the event that my health insurance plan refuses to pay for medically reasonable and necessary services provided, I also assign all my ERISA* rights to Houston Foot and Ankle/Jason C. Miller, DPM, PA for a full and fair review of any and all denied claims, including any penalties that may be assessed against the insurance company for claims-processing violations. This ERISA assignment is in consideration for the unpaid services provided, in consideration for my insurance plan's reduced fee schedule, and in consideration for the continued willingness of Houston Foot and Ankle/Jason C. Miller, DPM, PA to see patients, including me, on an insurance assignment basis. I understand that if my treating doctor prevails in any payment dispute, I may be liable for any applicable co-payment for contested services.

I consent to release medical information to Houston Foot and Ankle/Jason C. Miller, DPM, PA. I consent to Houston Foot and Ankle/Jason C. Miller, DPM, PA releasing medical information to other health care providers for the purpose of treatment when necessary for my care. I consent to Houston Foot and Ankle/Jason C. Miller, DPM, PA sending all necessary medical information to my insurance plan.

*ERISA is an acronym for the Employee Retirement Income Security Act, which includes federal laws requiring insurance companies to process submitted insurance claims and appealed (denied) insurance claims according to ERISA regulations. The failure to process submitted insurance claims and appealed (denied) insurance claims according to ERISA regulations may result in fines charged to the insurance company in amounts of up to $110 a day for each infraction.

Patient's Printed Name:_____

Patient's Signature:_____

Date:_____

I understand that HIPAA protects my medical records and confidentiality. It also restricts medical practices from sharing medical information regarding me and my care in many situations (often including sharing information with my family/friends). I hereby give my consent to share information regarding my medical care by Houston Foot and Ankle to the following individuals and/or organizations (please list any and all people that you give use permission to give information on your care, your test/lab results, and/or condition):

_____

_____

_____

_____

_____ _____

Patient Signature Date Signed

I consent to evaluation and treatment by Houston Foot and Ankle. I understand that Houston Foot and Ankle and the doctors at Houston Foot and Ankle may refer me to other doctors, vendors, or facilities that may be in or out of my insurance network. I understand that Houston Foot and Ankle cannot know with certainty which doctors and facilities are in or out of network with my insurance. I understand that use of in or out of network referrals are my choice and responsibility. Furthermore, I affirm that Houston Foot and Ankle has not forced me to use any certain facility, doctor, nor vendor regardless of insurance network status.

Patient Signature _____ Date Signed _____

Exclusive Forum Selection and Choice of Law Agreement

By signing this form (the "Agreement"), I, as the patient or representative of the patient, agree to all of the following on behalf of the patient and all of the patient's heirs and beneficiaries:

1. I agree that all health care rendered (or not rendered) to the patient by the Houston Foot and Ankle/Jason C. Miller, DPM, PA (including all employees, contractors, and representatives) shall be governed exclusively by Texas law, and not by the law of any other state or foreign nation. In no event shall the law of any other state or any foreign nation apply to the health care rendered (or not rendered).
2. I agree that any dispute, lawsuit, cause of action, or other claim that relates in any way to the health care rendered (or not rendered) to the patient shall be brought only in a Texas court in the county or district in which all or substantially all of the health care services were rendered (or should have been rendered).
3. I agree not to file in the courts of any other state any dispute, lawsuit, cause of action, or other claim that relates to health care rendered (or not rendered)
4. I understand that this Agreement applies to all claims arising out of or relating to the health care rendered (or not rendered) to the patient by Houston Foot and Ankle/Jason C. Miller, DPM, PA including all its employees, contractors, and representatives, whether the claim is brought by me or by someone else.
5. I understand that the choice of law and forum selection provisions of this Agreement are mandatory, not permissive.

Patient Printed Name _____ Patient Date of Birth _____

Patient Signature _____ Date of Signature _____

Signature and Name of Person Completing Form (if not patient) _____ Relationship to Patient _____

Disclosures

In compliance with Section 102.006 of Texas Occupations Code in connection with my informed consent and personal choice of doctors and facilities solely based on the quality and safety of care, reputation of patient satisfaction, and my knowledge in my decision-making in exercising my rights with respect to the in-network or out-of-network coverage and cost sharing, my attending doctor(s) and/or clinic/facility have disclosed to me at the time of initial contact and at the time of referral with respect to the choice of a doctor or facility solely in the interest of my healthcare quality and safety. As a result of my informed consent and personal choice of doctors and facilities: (A) his/her affiliation, if any, with the doctor or facility for whom the patient is referred and (B) that he/she will may receive, directly or indirectly, remuneration for referring upon my such request and exercising my rights of freedom of choice for the provider(s) and/or facility under the in-network or out-of-network coverage as provided by my health plan, in compliance with all applicable federal and state laws, Medicare, ERISA, PPACA, and Section 102.006 of the Texas Occupations Code. The Texas Medical Board's disciplinary guidelines consider a licensee's failure to disclose an ownership interest in health care facilities to which the licensee is referring his/her patients to be unprofessional conduct, but it does not provide specific guidance on how the physicians should make such disclosures. 22 Tex. Admin Code 190.8(2)(H). The Texas Medical Association has also expressed sensitivity to the potential conflicts of interest inherent in such arrangements and has encouraged physicians to disclose ownership interests in health care facilities to their patients. (A) physician my own or operate a healthcare facility (ie pharmacy, surgical facility, etc) if there are no resulting exploitation of patients. Furthermore, any remuneration or return on investment should be based on the physician's percentage of capital investment and not on utilization, or the volume or value of referrals of patients to a particular facility. It is not unethical for a physician to recover his/her investment in such a facility and earn a reasonable rate of return (See Texas Medical Association, Board of Councilors Current Opinions, "Heath Facility Ownership, Incentive Payments, and Conflicts of Interest" Fall 2012). The Texas Medical Association has recommended that the following guidelines be followed by physicians who have ownership interests in health care facilities: The physician has an affirmative ethical obligation to disclose his/her ownership of a health facility to his patient, prior to admission or utilization. Upon request, a physician should give the patient a list of alternative facilities, if such are available, and inform the patient that they have the options to use one of the alternative facilities.
The following lists our doctors' current investments/ownership or consulting agreements in health related facilities or companies:

Dr. Jason Miller: Houston Foot and Ankle/Jason C. Miller, DPM, PA, Memorial Hermann Surgical Hospital Kingwood, Alliance/Capital Imaging, Roo Enterprises, LLC, Healthcare Solutions Holdings, Inc., TX PMPP Trust, Vascular Institute, VIP Conroe Surgery Center

Dr. Laura Richards: Healthcare Solutions Holding, Inc.

Dr. Roxanne Toole: No disclosures

Dr. Margaret McLean: No disclosures

Dr. Spencer Mathews: No disclosures

I certify that I was informed of the doctors' investments/ownership and/or consulting agreements in healthcare related facilities mentioned above. I was informed of the effective alternative resources and facilities available at the time of my decision making and my option to choose an alternative resource/facility (including in and out of network facilities). I certify that I have read and fully understand this Disclosure and may make copies of this form should I chose to do so.

Signature of Patient _____ Date _____