PATIENT REGISTRATION FORM

Metroplex Foot & Ankle Center

Patient Information *(please use full legal name, no nicknames, circle all that apply*

First Name _____MI _____Last Name _____

Social Security_____-____-_____Birth date _____Gender M F Nickname_____

Address_____City _____State_____Zip _____

Home Phone_____Work _____Cell_____

Preferred Phone _____E-mail: _____Mailing Address_____

Race (circle one): American Indian/Alaskan Native Asian Black/African American More than one race Native Hawaiian Pacific Islander White/Caucasian **Preferred Language:** English Spanish Other_____

Ethnicity (circle one): Non-Hispanic/Latino Cuban Mexican/Mexican American Other Hispanic/Latino Puerto Rican

Marital Status: S M W D Employer name and address: _____

Referring Physician _____ Phone _____

Primary Physician (if different from referring) _____ Phone _____

Pharmacy (general location and phone): _____

Pharmacy: Albertsons CVS Kroger Savon TomThumb Walgreens Wal-mart Other: _____

Primary Insured Information *(Primary Policy Holder)*

Relationship to Patient: Self Spouse Parent Other: _____

Last name _____First Name _____MI _____

Address_____City _____State_____Zip _____

Phone: _____Social Security_____-____-_____ Birth date _____

Insurance Information *(Also, please allow receptionist to photocopy your insurance ID card)*

Primary insurance: _____HMO PPO POS

Policy ID number: _____Group number _____

Secondary insurance: _____HMO PPO POS

Policy ID number: _____Group number _____

Medicare/Secure Horizons Patients

Are you a resident of a ☐ Skilled Nursing Facility or ☐ Rehab Facility Admit Date: _____

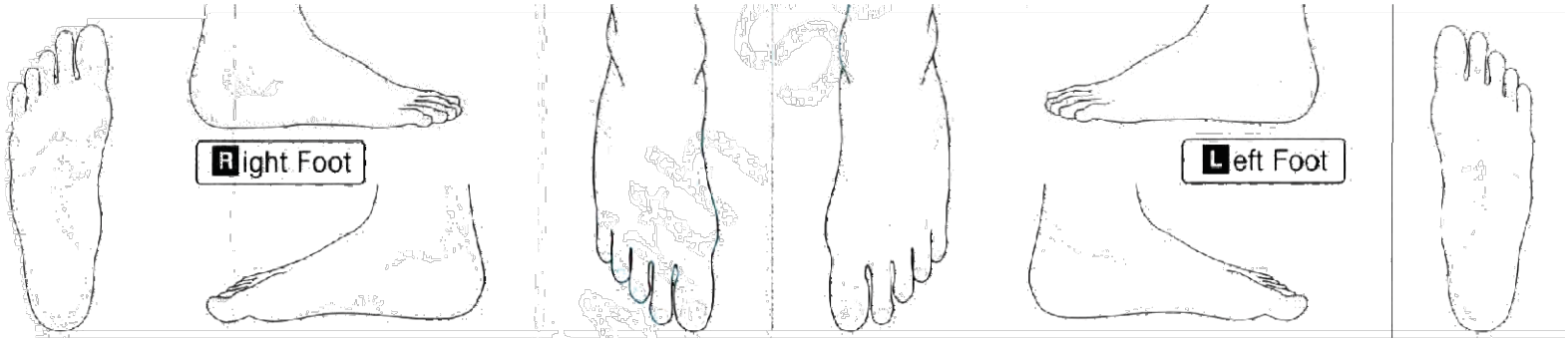
Name of Facility: _____ Phone # _____

Patient name: _____ DOB: _____

What is the main reason for your visit: ☐ Diabetic Exam ☐ Nail Problem ☐ Numbness ☐ Pain ☐ Skin Problem
☐ Stiffness ☐ Swelling ☐ Weakness ☐ Other

Did you bring x-rays? ☐Yes ☐ No

Please indicate below where your problem is:



In this section, check the ONE BOX which best describes how your problem started. Then answer the questions below the box you checked. Use as much space to the right as needed.

☐ NO INJURY (Onset was: ☐ Gradual or ☐ Sudden
Why do you think it started?

☐ INJURY (☐ Sport ☐ Accident – NOT Auto or Work)
Date _____Where and how did it happen?
What sport? _____

☐ INJURY AT WORK Date _____
Briefly describe _____ _____

☐ AUTO ACCIDENT Date _____

COMMENTS
_____
_____
_____
_____
_____
_____
_____

On a scale of 0-10 (10 is the worst), how severe is your pain?
(circle) 0 1 2 3 4 5 6 7 8 9 10

How long ago did it start? _____ Days _____Weeks _____Months _____ Years

Have you had a problem like this before? ☐ Yes ☐ No

What is the quality of the pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning
☐ Numb ☐ Other _____

This pain is ☐ Constant ☐ Comes and goes. Does your pain wake you from sleep? ☐ Y ☐ N

Since my problem started, it is: ☐ Getting better ☐ Getting worse ☐ Unchanged

What makes your symptoms worse? ☐ 1st step in morning ☐ Standing ☐ Walking ☐ Lifting ☐ Exercise
☐ Stairs ☐ Sitting ☐ Twisting ☐ Other _____

What makes your symptoms better? ☐ Rest ☐ Elevation ☐ Ice ☐ Heat ☐ Other _____

What have you done to treat this? _____

ALLERGIES Do you have any ALLERGIES to any medications? ☐Yes ☐No If yes, list below:

MEDICATION:	REACTION:

Patient name: _____ DOB: _____

PAST MEDICAL HISTORY:

WHAT MEDICATIONS DO YOU TAKE? ☐ None ☐ See list

MEDICATION	DOSE	HOW OFTEN

PAST SURGICAL HISTORY: (List complications if any)

Surgery/ Year

FAMILY HISTORY: List relationship of family member with the following:

☐ Reaction of Anesthesia _____ ☐ Heart Disease _____ ☐ Diabetes _____

☐ Lung Disease _____ ☐ Kidney Disease _____ ☐ Rheumatoid arthritis _____ ☐ Bleeding Disorder _____ ☐ Cancer _____ ☐ Liver Disease _____

Social History:

☐ Single ☐ Married ☐ Live alone ☐ Assisted living ☐ Other _____

Smoking ☐ Never # packs per day ____How long _____ When quit _____

Alcohol ☐ Never ☐ Social ☐ Daily ☐ Frequently

Illicit Drugs ☐ Yes ☐ No What type? _____

Occupation: _____ ☐ Student

PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS

☐ Anemia
☐ Anxiety
☐ Asthma
☐ Atrial Fibrillation
☐ Blood Clots in Veins
☐ Broken Bones
☐ Bronchitis
☐ Cancer
☐ Cataracts
☐ Change in skin
☐ Chest Pain
☐ Chills
☐ Chronic Back Pain
☐ Chronic Neck Pain
☐ Colon Polyps
☐ Congestive Heart Failure
☐ Coughing Blood
☐ Degenerative Arthritis
☐ Depression
☐ Diabetes _____
☐ Diarrhea
☐ Double Vision
☐ Eczema
☐ Emphysema
☐ Eye Pain
☐ Fever
☐ Fibromyalgia
☐ Frequent Urinary Infection
☐ Gallstones
☐ Glaucoma
☐ Gout
☐ Heart Attack
☐ Heart Murmur
☐ Heart Valve Disease
☐ Hemorrhoids
☐ Hepatitis
☐ Hernia
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV infection
☐ Incontinence
☐ Irritable Bowel Syndrome
☐ Joint Pain
☐ Joint Swelling
☐ Kidney Disease
☐ Kidney Stones
☐ Liver Disease
☐ Lupus
☐ Memory Loss
☐ Migraine Headache
☐ Multiple Sclerosis
☐ Muscle Weakness
☐ Nausea/Vomiting
☐ Neuropathy _____
☐ Night Sweats
☐ Numbness Tingling
☐ Osteoporosis
☐ Pneumonia
☐ Previous Ankle Surgery
☐ Previous Foot Surgery
☐ Psoriatic Arthritis
☐ Rash
☐ Rectal Bleeding
☐ Rheumatoid Arthritis
☐ Sciatica
☐ Seizures
☐ Serious Infection
Where _____
☐ Shortness of breath
☐ Skin Cancer
☐ Stomach Ulcer
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis
☐ Ulceration
☐ Unexplained weight loss
☐ Vascular Grafts
☐ Weight loss
☐ Wheezing

PLEASE SIGN: The information is accurate to the best of my knowledge. _____

DISCLOSURE AND CONSENT FORM

Patient Last Name _____First Name _____ DOB: _____

Authorization for Medical Treatment:

I authorize the physicians in charge of the care of this patient to administer any treatment as may be necessary or advisable in the diagnosis and treatment of this patient. This authorization includes but is not limited to routine diagnostic procedures, laboratory tests, rehabilitation therapy and x-rays. I acknowledge that no guarantees have been made to be as to results of my treatments, tests or procedures. I also authorize copies of the medical records to be released to other physicians and health care facilities as deemed necessary by any physician whose care the patient is under.

Assignment of Benefits

I assign all benefits to and authorize direct payment of benefits to Metroplex Foot and Ankle Center, PLLC, all insurance benefits and or Medicare/Medicaid benefits to which I may be entitled. This assignment specifically included, but is not limited to, major medical and disability insurance proceeds and benefits. It also specifically includes proceeds and benefits accruing under any settlement, structured or otherwise or awarded in judgment for personal injuries caused by a third party. A photocopy of this assignment shall be as valid as the original.

Non-covered Medicare/Medicaid Services:

Medicare/Medicaid have certain outpatient procedures that are excluded from coverage, including but not limited to those of routing diagnostic workups or routine physical examinations. If the patient's medical chart indicates that the patient's treatment is one for which no Medicare/Medicaid benefits are allowable, I understand that all charges incurred during treatment will be the patient's own financial responsibility. There are other limitations and charges for which the patient may be responsible; the patient will be provided additional information with regard to these charges and limitations on a separate written form.

Authorization to Release information to Insurance Company/Third Party Payer:

I authorize Metroplex Foot and Ankle Center, PLLC and any physician, therapist, practitioner, pharmacist or other person, any hospital including Veterans Administration or government hospital, any medical service organization, any insurance company, or any other institution or organization to release any medical information about the patient necessary to determine any benefits which may be payable for this treatment.

Personal Valuables:

Metroplex Foot and Ankle Center, PLLC, shall not be liable for the loss of or damage to any personal property.

Surgical Facility Interest Disclosure:

Texas law requires physicians and other health care providers to make certain disclosures to a patient at the time of initial contact and at the time of the referral when they refer a patient to another health care provider or facility from which the physician will receive remuneration. Should it be determined that surgery is required, a facility, Parkway Surgical Hospital, is made available to you. However, Dr. Lund and Dr. Rousseau would like you to know they have ownership interest in this facility and if a compounded cream prescription is required Dr. Lund and Dr. Rousseau have ownership in MedOC Compounding Pharmacy. If you do not wish to use them, for any reason, we will be happy to schedule your surgery or send your prescription to another facility. Your ongoing care is not conditioned on accepting the recommended referral.

Consent for E-Prescribing & Medication History:

I authorize Metroplex Foot & Ankle Center and it's providers to view my external prescription history via Surescripts prescription service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years. I understand this will allow my providers to better coordinate my care and medication history to maximize the effectiveness and safety of my treatment plan.

The undersigned certified that he or she has read the foregoing or is the guarantor/guardian and is duly authorized by or on behalf of the patient to execute the above and accept its terms.

Patient or Guarantor Signature _____ Date: _____

Guarantor name (if different from above): _____

FINANCIAL RESPONSIBILITY FORM

It is your responsibility to provide us with your most current insurance information.

If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered. We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company. We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company.

You are financially responsible for services not covered by your insurance company.

Before receiving services, you must verify that we are participating providers for your insurance company. In the event we are not participating providers, we will file the initial claim as a courtesy. Payment, however, is due in full at the time of service. We charge the usual and customary fees for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Copayments, coinsurance and/or deductibles are due at the time of service. We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim regardless of our estimation.

Statement of Responsibility

I understand that I am financially responsible to Metroplex Foot and Ankle Center, PLLC as the patient, guardian, conservator, or insured for all charges not covered by the above assignment, which charges may include any medical insurance deductibles and co-insurance. I understand that to sign as a guarantor means that if the patient does not pay for all charges, I, as guarantor will be responsible for such payment.

It is your responsibility to provide us with your most current billing information. [a]

You must provide your most current billing address, all available telephone numbers and any other important contact information. If your address or contact information changes, it is your responsibility to contact us with the updated information. We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30 days after receipt of the initial statement. You can call (817) 595-1310.

Payment in full is due upon receipt of the statement.

Patient balances not paid in full within 30 days of the statement issue date are deemed past due. Past due accounts may be subject to a $5.00 monthly late fee and/or a 1.5% monthly interest fee and may be referred to a professional collection agency and/or attorney for further collection activity. You will be responsible to pay all collection costs incurred, including attorney's fees and court costs if applicable.

If you are not able to pay the balance due in full, you must arrange a payment schedule. Any late fees already incurred on past due balances will be included in any mutually agreed upon arrangements. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney. You will be responsible for all collection costs incurred, including attorney's fees and court costs if applicable.

In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add $25.00 to your original balance. In addition, we may seek all additional legal remedies provided to us under Texas law. We may charge you a "No Show" fee of $35.00 if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date.

Failure to keep your account balance current may require us to cancel or reschedule your appointment.

Patient or Guarantor Signature _____ Date: _____

Guarantor name: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that Metroplex Foot and Ankle Center, PLLC, reserves the right to change their Notice of Privacy Practices and prior to implementation will post a copy in the physician office. I may request a copy of the updated Notice of Privacy Practices by calling the physician's office or requesting a copy in person at my appointment.

Patient or Guardian Signature _____ Date: _____

Guardian name (if different from above): _____

The following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for Metroplex Foot and Ankle Center, PLLC. to share my protected health information with:

Name _____ Relationship: _____

Name _____ Relationship: _____

Name _____ Relationship: _____

Emergency contact _____ Emergency phone number_____