

Mark Sands, DPM

Jeffrey Baxter, DPM

Bernabe Canlas, DPM

Confidential information important for our files and your health...Please complete ALL pages.

Name (Last, First, MI): _____ Age: _____ Sex: M F

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ SSN: _____

DOB: _____ Type of Shoes Usually Worn: _____ Size: _____ Height: _____ Weight: _____

Email Address: _____

Employer: _____ Occupation: _____

Work Phone: _____ Work Email Address: _____

Primary Policy Holder (Guarantor) Information: Note to divorced parents – the parent or guardian who presents with child for treatment will be responsible for all charges incurred.

Name (Last, First, MI): _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Primary Insurance Carrier: _____ **ID #:** _____ **Group #:** _____

Secondary Ins Carrier: _____ **ID #:** _____ **Group #:** _____

Emergency Contact: _____ **Phone:** _____ **Relationship:** _____

Name of Local Pharmacy: _____ Phone: _____

Address/Location: _____ City: _____ Zip Code: _____

Who May We Thank for Referring You to Our Practice? _____

Doctor Referral _____

Service Payment Policy

I HEREBY AUTHORIZE South Texas Foot Specialist, PA or other providers to release any information acquired in the course of my treatment to my insurance company, employer, or third party payer as required for claims filed, quality assurance, health plan administration or complaints/grievances. I understand that the specific information to be released may include, but is limited to history, diagnosis and/or treatment of all related illnesses including HIV virus and Acquired Immune Deficiency Syndrome (AIDS). I authorize direct payment to be made to South Texas Foot Specialist, PA or other providers for any and all medical or surgical services/supplies rendered. I understand that if any services or charges are not covered, or if South Texas Foot Specialist, PA is unable to verify eligibility; I am responsible for all charges incurred for services rendered. I request that payment of government benefits either to myself or the party who accepts assignment. I have read all information and certify that it is true and correct to the best of my knowledge.

Patient/Parent/Guardian Signature

Date

Patient Medical History

CHIEF COMPLAINT

Current Complaint: _____ Duration: _____

Have you been treated for this before? Y N If so, when? _____ Was this an accident? Y N

If yes, date of accident/injury: _____ Place: _____

Brief description of accident/injury: _____

SOCIAL HISTORY

Tobacco: Y N Frequency: _____ Caffeine Y N Type: _____ Alcohol Y N Frequency: _____

MEDICAL HISTORY (Do you currently have or have had the following medical conditions)

- | | | |
|--|--|--|
| <ul style="list-style-type: none"> <input type="radio"/> ADD/ADHD <input type="radio"/> Allergies/Hay Fever <input type="radio"/> Anemia/Sickle Cell <input type="radio"/> Arthritis <input type="radio"/> Asthma/Bronchitis <input type="radio"/> Bleeding Disorders <input type="radio"/> Cancer Type: _____ <input type="radio"/> Charcot Foot <input type="radio"/> Chest Pain <input type="radio"/> Crohn's Disease <input type="radio"/> Circulation Problems | <ul style="list-style-type: none"> <input type="radio"/> Depression/Anxiety <input type="radio"/> Diabetes Type 1 Type 2 <input type="radio"/> Difficulty Healing <input type="radio"/> Epilepsy/Seizures <input type="radio"/> Fibromyalgia <input type="radio"/> Graves Disease <input type="radio"/> Gout <input type="radio"/> Headaches <input type="radio"/> Heart Disease/Heart Attack <input type="radio"/> Hepatitis A, B, C <input type="radio"/> High Blood Pressure | <ul style="list-style-type: none"> <input type="radio"/> Immune Disease (HIV, AIDS) <input type="radio"/> Kidney Stones <input type="radio"/> Liver Disease <input type="radio"/> Mitral Valve Prolapse <input type="radio"/> PVD <input type="radio"/> RSD <input type="radio"/> Shortness of Breath <input type="radio"/> Stroke <input type="radio"/> Thyroid Disease <input type="radio"/> Warts |
|--|--|--|

List any other medical problem not listed above: _____

FEMALES: Are you or might you be pregnant? Y N Have you had a hysterectomy: Y N

Diabetic Doctor/PCP: _____ **Phone:** _____ **Date Last Seen:** _____

MEDICATIONS (Please include dosage of each. Include vitamins and supplements)

- | | | |
|----------|----------|----------|
| 1. _____ | 3. _____ | 5. _____ |
| 2. _____ | 4. _____ | 6. _____ |

ALLERGIES: (Aspirin, sulfa drugs, Penicillin, Iodine, Novocain, latex, foods, etc)

- | | | |
|----------|----------|----------|
| 1. _____ | 3. _____ | 5. _____ |
| 2. _____ | 4. _____ | 6. _____ |

Have you ever had a reaction to local or general anesthesia? Y N

SURGERIES AND HOSPITALIZATIONS: (describe procedure, year and any complications)

- | | | |
|----------|----------|----------|
| 1. _____ | 3. _____ | 5. _____ |
| 2. _____ | 4. _____ | 6. _____ |

FAMILY HISTORY: (Please list any pertinent medical history such as diabetes, cancer, high blood pressure, etc)

Mother: Alive Deceased _____

Father: Alive Deceased _____

I hereby give South Texas Foot Specialist permission to diagnose and administer treatment for my foot and ankle condition and authorize any release of information obtained in the course of my treatment.

Patient/Parent/Guardian Signature

Date

HIPAA Notice of Privacy Practices

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you that relates to your past, present or future physical, mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, we would disclose your PHI as necessary to a home health agency that provides care to you or provide to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for a hospital stay may require that your relevant health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of an appointment. We may use or disclose your PHI in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight, Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses.

Your Rights: You have the right to inspect and have copied (at your expense) your PHI under federal law; however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. You have the right to request a restriction of our PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit and use disclosure of your PHI, your PHI will not be restricted. You have the right to use another healthcare professional. You have the right to request to receive confidential communications from us by alternative means or at an alternative location within reason. You have the right to obtain a paper copy of this notice from us, even if you have agreed to accept this notice alternatively, i.e. electronically. You may have the right to have your physician amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. We reserve the right to change the terms of this notice and will inform you at your next office visit following the change. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact. **We will not retaliate against you for filing a complaint.** This notice was published and became effective on/or before April 14, 2013 and updated on February 24, 2015.

Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 164.500.

Other Permitted and Required Uses and Disclosures: Will be made only with your written consent, authorization or opportunity to object unless required by law, this includes inquiries about your scheduled appointments. You may revoke this authorization in writing at any time, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Treatment of Minors: It is our policy that only a natural, adoptive parent or legal guardian is authorized to present a child for treatment UNLESS a written authorization is given on the form provided.

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my PHI. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operation such as quality assessments and physician certifications

I have been given the right to review the Notice of Privacy Practices prior to signing this acknowledgement. I understand that South Texas Foot Specialist reserves the right to change these policies at any time and I may contact this office for an updated copy at any time. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name/Signature

Date

Confidentiality Questionnaire

In order to comply with HIPAA guidelines, it is necessary for you to complete the following information:

List family and/or other people authorized to pick up your written prescriptions, test results, any forms, orthotics or sample medications. This also includes whom we may inform about your general medical condition, diagnosis, test results and treatment plan.

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

May we leave confidential (billing/medical condition) messages on your home answering machine or voicemail? Y N
May we leave confidential (billing/medical condition) messages on your cell phone/work voicemail? Y N

I understand that this consent will remain in effect until revoked in writing by myself, or my legal guardian/parent.

Signature: _____ Relation: _____ Date: _____

*****PLEASE NOTE*****

If you fail to notify our office *in writing* that you would like to have an individual removed from any of the above, that person **WILL** be able to obtain information about your care from our office

Thank you for choosing us for your podiatry needs. Our goal is to provide you with the highest quality care at an affordable cost. To make our services available to as many patients as possible on an affordable basis, we have adopted the financial collection policy outlined below. We ask that you read the policy carefully and sign prior to any treatment.

- WE MAY ACCEPT ANY ASSIGNABLE INSURANCE WITH APPLICABLE COVERAGE
- WE OFFER FINANCIAL ASSISTANCE (ACA DISCOUNT) UNDER OUR INDIGENCY POLICY TO ALL ELIGIBLE PATIENTS ON A CASE BY CASE BASIS
- FULL PAYMENT IS DUE AT TIME OF SERVICE UNLESS ARRANGED OTHERWISE
- WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS AND DISCOVER

Dishonored checks will be charged back to the patient's account with a service fee of \$30.00. Dishonored checks not redeemed within 20 working days of written notice to the maker will be referred to the prosecutor for collection. We do not accept post-dated checks.

Regarding Insurance

We accept assignment of most insurance benefits at our discretion. A valid insurance card, policy/plan number is needed to verify coverage. As a courtesy to our patients, verifiable and assignable insurance will be billed by our office. However, you will be personally responsible for your account balance regardless of whether or not if your insurance will pay for your total balance of your claims, unless you're eligible for discounts under our indigency policy pre-determined before the services are rendered. Your insurance policy/employee benefits plan is a contract between you and your insurance company/employee benefits plan. We are not a party to that contract.

Regarding Discount

If eligible, you may qualify for certain discounts, reduction or waiver of deductibles, coinsurance and co-pay to any eligible patients based on medical needs and ability to pay, on a case by case basis under our Corporate Indigency Policy in accordance with applicable federal and state laws. You may apply for financial indigency discount assistance by asking our staff to determine if you're eligible.

Regarding Surgeon and Facility Charges

We will disclose to every patient our charges as clearly as practically possible before your medical procedures if it is known to us. Please feel free to ask our staff if you have any questions about charges and your payment responsibilities. Please be advised, your insurance company requires us, your physician, to file services separately from the surgical facility/hospital where services are rendered along with the anesthesiologist, diagnostic labs, radiologists, pathologists and any other entity involved in your surgery. If you have any questions about your surgical facility bills, please direct them to that surgical facility or hospital. While we do not anticipate any unforeseeable circumstances, we have no control over any such event(s) that may arise. Should you require additional medical or surgical care in any event of the post-surgical complications and reactions, you may incur additional expenses at this facility or outside this facility, such as a hospital.

Regarding PPO and HMO Network Participation

You may have the choice to choose a physician or surgical facility with or without PPO or HMO participation under difference insurance coverage and benefits levels. We are dedicated to providing the highest quality care to every patient, however we have no power to change your insurance coverage or network limitations. Most health care plans or insurance policies may provide coverage to non-PPO providers and facilities, but at lower percentage of insurance reimbursement. Although it is your responsibility to verify your insurance coverage for non-PPO/HMO providers, we will always disclose to you as to our participation status with your insurance plan. We also provide financial assistance or discounts for high deductibles and co-insurance through our Corporate Indigency Policy in accordance with applicable federal and state laws, on a case by case basis.

Most health plans or insurance policies may have coverage for out of network providers or facilities, but at a different or lower percentage level of reimbursement rates.

We will verify your insurance coverage and obtain pre-certification if applicable for all services as a courtesy to you before your treatment.

Please understand that verification of insurance is not a guarantee of insurance payment

Diabetic Medicare Patients

In order to file your claim for routine foot care, we must have the date you last saw your diabetic doctor, which must be within six months.

HMO Patients

You are required to obtain your own referral from your primary care doctor prior to your visit.

Medical Records Release/Copying

Please allow 48 hours for requested medical records. We charge \$8.00 per x-ray sheet copies. We do not give out the original x-rays, they remain in your permanent medical record.

Disability/FMLA Forms

Due to the length and time to complete these forms, we charge \$25.00 for the first set of disability forms. There will be a \$10.00 charge for each additional request.

Refunds/Credits

Please notify us in the event that you have a true credit and we will send you a check for that amount. Checks are issued on the 15th and last day of each month. We do not refund, credit or take back any supply/durable medical equipment given. Unfortunately, every supply does not work for every patient.

Compliance & Disclosure under Texas Occupations Code – Section 102.006

In compliance with section 102.006 of the Texas Occupations Code, I consent that I have been informed of the following information: The choice of doctor or facility I am being referred to is solely based on the quality and safety of care, reputation and patient satisfaction. I recognized my rights with respect to in-network or out-of-network coverage. My attending doctor(s) and/or clinic (facility) have disclosed to me at the time of initial contact and at the time of referral: (A) his or her affiliation, if any, with the doctor or facility for whom I, the patient, am being referred and (B) that he/she will receive, directly or indirectly, remuneration for referral. It is my request to exercise my right of freedom of choice for the provider(s) and 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 the section of 102.006 of the Texas Occupations Code.

Dr. Mark Sands’ Facility(s) with affiliation and remuneration:

**Houston Physician’s Surgery Center
Houston Physician’s Hospital
Houston Physician’s Imaging Center**

Dr. Jeffrey Baxter’s Facility(s) with affiliation and remuneration:

**Houston Physician’s Surgery Center
Houston Physician’s Hospital
Houston Physician’s Imaging Center**

Dr. Bernabe Canlas’ Facility(s) with affiliation and remuneration:

South Shore Surgical Center

Your Responsibility for Cooperation

If we accept your insurance assignment as a form of payment for reimbursement, you agree to timely cooperate with your insurance company or health plan in the course of claim processing, such as insurance inquiries, requests for additional information, claims status verification or any inquiries for the purpose of your claim processing. You also agree to notify us immediately of any insurance inquiry or request for additional information and provide us with a copy of any documentation received from the insurance company or submitted to insurance company from you.

Payment for each visit is due at the time of the visit, unless otherwise discussed prior to treatment. We are committed to serving you with the highest quality of care possible at an affordable cost. Our staff is ready to help you. If you have any questions regarding our financial policies, please do not hesitate to ask. We thank you for your cooperation.

I have read the Financial Policy and I understand and agree to this Financial Policy.

Signature of Patient

Patient Name (Print)

Date