CHARLES B. MARDER, DPM

PODIATRIC MEDICINE - FOOT & ANKLE SURGERY

BOARD CERTIFIED BY THE AMERICAN BOARD OF PODIATRIC SURGERY

CONFIDENTIAL PATIENT INFORMATION

NAME _____ BIRTHDATE _____ AGE _____

SOCIAL SECURITY # _____ SEX MALE _____ FEMALE _____

MARITAL STATUS MARRIED_____ SINGLE_____ WIDOW_____ DIVORCE_____

HOME ADDRESS _____

CITY _____ STATE_____ ZIP _____

EMAIL _____

HOME PHONE _____ WORK PHONE_____ CELL PHONE_____

OCCUPATION _____ EMPLOYER _____

NAME OF SPOUSE OR PARENT _____

SPOUSE OCCUPATION _____ EMPLOYER _____

SPOUSE WORK PHONE _____ CELL PHONE _____

IN CASE OF EMERGENCY, CONTACT _____

RELATIONSHIP _____ PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

NAME _____ ADDRESS_____

FAMILY DOCTOR _____ PHONE _____

HAVE YOU EVER BEEN TREATED BY A PODIATRIST BEFORE? YES _____ NO _____

PODIATRIST _____ PHONE _____

LAST VISIT DATE & REASON _____

MY FOOT PROBLEM IS _____

DO YOU USE TOBACCO? YES _____ NO _____ PACKS PER DAY _____ YEARS _____

DO YOU USE ALCOHOL? YES _____ NO _____ AMOUNT _____

LIST ANY STREET DRUGS OR SUBSTANCES YOU HAVE USED? _____ NONE _____

DO YOU HAVE ANY PROBLEMS WITH ANESTHESIA? YES_____ NO _____ EXPLAIN _____

FEMALES, COULD YOU BE PREGNANT? YES_____ NO _____ DATE OF LAST PERIOD _____

DO YOU HAVE ANY CULTURAL OR RELIGIOUS PRACTICES THAT WILL IMPACT YOUR HEALTH CARE?

YES _____ NO _____ IF YES, EXPLAIN _____

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NAME _____ BIRTHDATE _____

PLEASE CHECK ANY PROBLEMS YOU HAVE NOW OR EVER HAD IN THE PAST:

- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Chest Pain
- ☐ Angina
- ☐ Irregular Heart Beat
- ☐ Unable to Exercise
- ☐ Rheumatic Fever
- ☐ Leg Cramps or Pain
- ☐ Bleeding Tendency
- ☐ Hemophilia
- ☐ Easy Bruising
- ☐ Diabetes Type 1____ Type 2 ____
- ☐ Thyroid Problems
- ☐ Steroid Use
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Radiotherapy
- ☐ Liver Problems
- ☐ Hepatitis
- ☐ AIDS / HIV
- ☐ Anemia
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Chronic Cough
- ☐ Asthma
- ☐ Bronchitis
- ☐ Shortness of Breath
- ☐ Pneumonia
- ☐ Sinus Problems
- ☐ Recent Cold / Flu
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Jaundice
- ☐ Hiatal Hernia
- ☐ Frequent Heartburn
- ☐ Ulcers
- ☐ Kidney Problems
- ☐ Loose, Chipped Teeth
- ☐ False Teeth or Caps
- ☐ Neck Pain or Stiffness
- ☐ Blood Clots
- ☐ Stroke
- ☐ Fainting or Blackouts
- ☐ Seizure
- ☐ Mental Health Problems
- ☐ Migraine Headaches
- ☐ Nerve Injury
- ☐ Herniated Disc
- ☐ Paralysis
- ☐ Back Injury
- ☐ Neck Injury
- ☐ Weakness
- ☐ Arthritis
- ☐ Hoarseness
- ☐ Difficulty Opening Mouth
- ☐ Glaucoma
- ☐ Prosthetics
- ☐ Mitral Valve Prolapse
- ☐ Motion Sickness
- ☐ Hearing Loss
- ☐ Eye Problems
- ☐ GI / Colon Problems

LIST ANY MEDICAL PROBLEMS NOT LIST ABOVE:

_____

_____

LIST ALL PREVIOUS SURGERIES:

_____

_____

CURRENT MEDICATIONS (include non-prescriptions medicine, vitamins and herbal supplements)

	Name	Dose	Schedule	Last Taken
1.				
2.				
3.				
4.				
5.				
6.				
7.				

DO YOU HAVE ANY ALLEGIES to medications, foods, environmental substances, tape, latex, dye, etc.? ☐ YES ☐ NO

LIST:_____

_____

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NAME _____ BIRTHDATE__ _____

INSURANCE INFORMATION (Please allow receptionist to photocopy your insurance ID cards)

If someone other than patient is the insured part, please include date of birth for claims

PRIMARY INSURANCE

PLAN NAME _____ *INSURED NAME _____

INSURED'S SOCIAL SECURITY _____ INSURED'S DATE OF BIRTH _____

*POLICY / ID # _____ *GROUP ID # _____ EFF. DATE _____

CLAIMS ADDRESS _____ CITY_____ ST _____ ZIP _____

CLAIMS PHONE # _____

SECONDARY INSURANCE

PLAN NAME _____ *INSURED NAME _____

INSURED'S SOCIAL SECURITY _____ INSURED'S DATE OF BIRTH _____

*POLICY / ID # _____ *GROUP ID # _____ EFF. DATE _____

CLAIMS ADDRESS _____ CITY_____ ST _____ ZIP _____

CLAIMS PHONE # _____

GUARANTOR INFORMATION (List person or insured name responsible for bill – use full legal name – no nicknames)

RELATIONSHIP OF GUARANTOR TO PATIENT ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER

LAST NAME _____ FIRST NAME _____SOCIAL SECURITY _____

HOME ADDRESS _____ ZIP CODE _____

* EMPLOYER NAME _____ PHONE _____

FINANCIAL RESPONSIBILITY AGREEMENT

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any medical service or visit, preventative exam or physical, lab testing, x-ray, EKG, and any other screening service or diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility and not the responsibility of the physician or the physicians' staff to know if my insurance will pay for any medical service I receive.

I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network amounts, usual and customary limit, or any other type of benefit limitation for the medical services I receive.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out-of-pocket expense to me. I understand this and agree to be financially responsible for all charges.

I understand and agree it is my responsibility to know if my PCP (Primary Care Physician) choice has been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.

SIGNATURE _____ DATE _____

(PLEASE SIGN HERE – PATIENT OR RESPONSIBLE PARTY)

RESPONSIBLE PARTY NAME _____

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NAME _____ BIRTHDATE _____

PATIENT PRIVACY DIRECTIVE

In our efforts to comply with the Health Insurance Portability and Accountability Act (HIPPAA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers.

Please provide us with the phone number(s) that we or an automated service may leave messages regarding appointments:

_____

Please provide us with the phone number(s) that we or an automated service may leave messages regarding treatments and/or test results:

_____

Please provide us with the name(s) and phone number(s) that we may talk to regarding your appointments:

_____

Please provide us with the name(s) and phone number(s) that we may talk to regarding your treatments and/or test results:

_____

Please provide us with the name(s) and phone numbers(s) that we may talk to regarding your billing:

_____

Please provide an email address that this office may communicate health information to you with:

_____

Please provide a cell phone number that we may text health information to:

_____

Please provide us with the name and number of your emergency contact:

_____

You must inform us **in writing** of any changes in your directives.

I acknowledge that everything above is accurate.

SIGNATURE _____ DATE _____

PRINTED NAME _____

I acknowledge I have seen or been offered a copy of the "Notice of Privacy Practices".

SIGNATURE _____ DATE _____

PRINTED NAME _____

RELATIONSHIP IF PATIENT REPRESENTATIVE _____

PHYSICIAN'S OFFICE REPRESENTATIVE NAME _____

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PATIENT REGISTRATION FORM
DISCLOSURES & CONSENTS

PATIENT NAME _____ BIRTHDATE_____

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of my insurance benefits to Foot & Ankle Care of Texas, P.A. or the physician individually for services rendered to my dependents, or me, by the physician or those under his or her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-payment or balance due that Foot & Ankle Care of Texas, P.A. is unable to collect from my insurance carrier for whatever reason.

MEDICARE /MEDICAID/CHAMPUS INSURANCE BENEFITS:
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my, or my dependent's records that these programs my request. I hereby direct that payment of my, or my dependent's authorized benefits be made directly to Foot & Ankle Care of Texas, P.A. or the physician on my behalf.

AUTHORIZED TO RELEASE NON-PUBLIC PERSONAL INFORMATION:
I certify that I have read and been offered a copy of the Foot & Ankle Care of Texas, P.A., "HIPAA Notice of Privacy Practices". I hereby authorize Foot & Ankle Care of Texas, P.A. or the physician individually to release any of my, or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL, OR E-MAIL:
I understand that I have the right to rescind this authorization at any time by notifying Foot & Ankle Care of Texas, P.A. or my physician to that effect in writing. PLEASE REFER TO THE PATIENT PRIVACY DIRECTIVE ATTACHED.

LAB / X-RAY / DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-payment or balances due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:
I hereby consent to evaluation, testing, and treatment as directed by my Foot & Ankle Care of Texas, P.A. physician or those under his or her supervision.

This office is dedicated to the priniciples and ideals of offering, to all our patients, courteous and professional foot care of the highest standards. To obtain these objectives, our first obligation is to our patients. All patients are expected to pay their charges in full at the time that services are rendered. Arrangements may be made with the bookkeeper, in advance, if these policies create undue hardship. If my account becomes delinquent or is placed with an attorney for collection, I, the undersigned responsible party, agree to pay all attorney and collection fees.

High standards of professional service require the doctor to devote ample time to each patient to consider their individual problem. I understand that delays may occur in the doctor's carefully planned appointment schedule that may be unavoidable.

I hereby give my permission to Dr. Charles Marder and Associates to examine, administer treatment, offer consultation and perform such procedures as may be necessary in the diagnosis and treatment of my condition.

I have fully reviewed this questionnaire and answered truthfully and to the best of my knowledge. I am aware that my answers could affect my health care, or the care of the patient for whom I am responsible.

PATIENT SIGNATURE _____ DATE _____

GUARANTOR SIGNATURE _____ DATE _____

GUARANTOR NAME (PLEASE PRINT) _____

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DISCLOSURE REGARDING ANCILLARY SERVICES / RESEARCH PROGRAMS

ANCILLARY SERVICES

Your physician may refer you to one or more " Ancillary Services" in connection with your medical care. An "Ancillary Service" is a service relating to your medical care or treatment. The following types of services are Ancillary Services:

- Magnetic Resonance Imaging (MRI)
- Mammography
- Ultrasound
- Computer Tomography (CT)
- Position Emission Tomography (PET)
- X-Ray
- Infusion Therapy
- Bone Density Imaging
- Nuclear Imaging
- Laboratory
- Durable Medical Equipment (DME)
- Echo Cardiograph
- Sleep Therapy
- Audiology

Your physician may have an economic interest in or a business relationship with the company or person who provides the Ancillary Services. <u>You are not obligated to use</u> the provider that your physician refers you to. <u>You are free to use any provider you choose</u>.

RESEARCH PROGRAMS

Your physician may ask if you would like to participate in a clinical trial or other research program. These programs may be sponsored by a drug company or may be part of a governmental research program. **Your physician may be compensated for services rendered in connection with these programs. You are not obligated to participate in any research program and your permission will be obtained prior to your participating in a program your physician believes may be appropriate for you.**

Please feel free to ask your physician if you have any questions about a particular Ancillary Service or Research Program.

PRINTED PATIENT NAME _____

PATIENT SIGNATURE _____

DATE _____