New Patient Forms

Today's Date _____

Patient Details

Patient Name _____

☐ Male ☐ Female Social Security # _____

Date of Birth _____ Age _____

Address _____

City/State _____ Zip _____

Phone 1 _____ ☐ home ☐ cell ☐ work

Phone 2 _____ ☐ home ☐ cell ☐ work

Email _____

Occupation _____

How did you hear about us? _____

Responsible Party/Billing Contact *(if different from above)*

Name _____

Date of Birth _____ Social Security # _____

Address _____

City/State _____ Zip _____

Phone _____ ☐ home ☐ cell ☐ work

Please describe the reason for today's visit:

_____

_____

_____

How long has it been bothering you? _____

Have you been treated for this problem? ☐ Yes ☐ No
If yes, please describe treatment:

_____

_____

_____

Have you had any previous foot or ankle surgery? ☐ Yes ☐ No
If yes, please list type and dates:

_____

_____

_____

ARCH FOOT & ANKLE

PLEASE COMPLETE ALL SECTIONS

In Case of Emergency, Please Contact:

Name _____

Relationship _____

Phone _____

Primary Care Physician:

Name _____

Phone _____

Date of Last Visit _____

Preferred Pharmacy & Location:

_____

_____

Medical Insurance

Primary Policy

Company _____

Policy/ID # _____

Group # _____

Secondary Policy

Company _____

Policy/ID # _____

Group # _____

(Optional) ☐ I prefer not to share this info

Primary Language: _____

CHECK ALL THAT APPLY:

☐ Hispanic ☐ Non-Hispanic
☐ White
☐ Black or African American
☐ Asian
☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander

New Patient Forms

PLEASE COMPLETE ALL SECTIONS.
If you have any of the following information already printed, we will be happy to make a copy.

Patient Name:_____ **Date**_____

Current Height_____ **Current Weight**_____ **Current Shoe Size**_____

Allergies

Have you experienced any allergic reactions or adverse effects from the following?

☐ **NO KNOWN DRUG ALLERGIES**

☐ Aspirin ☐ Penicillin
☐ Codeine ☐ Cortisone
☐ Iodine/Betadine ☐ Novocain/Lidocaine
☐ Sulfa Drugs ☐ Latex ☐ Tape

Other:

Medical & Family History

Please check if either ***you or a family member*** has experienced any of the following conditions:

MOTHER	FATHER	PATIENT	
☐	☐	☐	Anemia
☐	☐	☐	Arthritis
☐	☐	☐	Asthma
☐	☐	☐	Bleeding Disorder
☐	☐	☐	Breathing Problems
☐	☐	☐	Cancer- type:
☐	☐	☐	Congestive Heart Failure
		☐	COVID-19 *date:*
☐	☐	☐	Diabetes - Insulin Dependent
☐	☐	☐	Diabetes - Non-Insulin Dependent
☐	☐	☐	Gout
☐	☐	☐	Heart Disease
		☐	Hepatitis
☐	☐	☐	High Cholesterol
☐	☐	☐	High Blood Pressure
		☐	HIV
		☐	Joint Replacement: Hip (☐ Right ☐ Left) Knee (☐ Right ☐ Left)
☐	☐	☐	Kidney Disease
☐	☐	☐	Liver Disease
☐	☐	☐	Mitral Valve Prolapse
☐	☐	☐	Neuropathy
☐	☐	☐	Phlebitis (blood clots)
☐	☐	☐	Stomach Problems
☐	☐	☐	Thyroid Disorder
☐	☐	☐	Other:
☐	☐	☐	Other:
☐	☐	☐	Other:

Social History

Do you smoke? ☐ No
☐ Yes, every day ☐ Yes, occasionally
If Yes, how many years?_____
☐ I **previously smoked** for _____years
When did you quit?_____

Do you drink alcohol? ☐ No
☐ Occasional/social ☐ Mild ☐ Moderate ☐ Heavy

Medications

List all prescription medications as well as over the counter medications, vitamins & dietary supplements:

_____ (INITIAL) If available, I authorize Arch Foot & Ankle to obtain my current medication list from my pharmacy.

Surgical History

Please list any major surgeries:

Patient Financial Responsibility Policy

Thank you for choosing Arch Foot & Ankle for your podiatric care needs. We are committed to providing you with the highest quality care. Every patient must be thoroughly informed of their treatment options and the financial obligations for a particular service. Please carefully read and then sign this form to acknowledge your understanding of your financial obligations related to your treatment. If you should have any questions regarding our financial policies, please ask our office staff before signing this document.

The following is our payment policy, which we require you to read and sign prior to your visit(s).

The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for his/her treatment and care.

Patients have many different types of insurance and payment options for services rendered. Also, not all podiatrists in the practice accept the same type of insurance. To ensure that we have accurate information to process your claim, we will make a copy of your insurance identification card at the time of your appointment.

You are required to inform us immediately of any changes in demographic information or insurance information. Patients without insurance are required to pay in full at the time of service.

However, we understand that financial hardships may affect your ability to pay in full. We will always do everything we can to work with you. Please ask to speak to our Practice Manager, (281) 980-3668 to discuss a satisfactory arrangement.

Participating Plans: You must present your insurance card when requested and if applicable, your insurance referral form, at every visit. We will submit your medical claim directly to your insurance company for payment on your behalf. Full payment at the time of service is expected for all patients without insurance or those covered under plans which we do not participate in.

Non-Covered Services: If your provider does not participate in your insurance plan or your services are not covered by your insurance plan, you are responsible for payment of all charges at the time of service.

Copayments or Deductibles: All co-pays, co-insurance, deductibles, and non-covered services will be collected at the time of service.

Cancellations and Missed appointments: Our Policy is to charge for missed appointments not canceled within 24 hours of your appointment. The missed appointment fee of $50.00 will be your responsibility and billed directly to you.

Returned Checks: Will incur a $35.00 service charge.

Nonpayment: If your account is over 60 days past due, you will receive a statement stating that you have 30 days to pay your account in full. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency, and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative podiatric care. During those 30 days, we will only be able to treat you on an emergency basis.

Payment: For your convenience, the following payment methods are accepted cash, personal check, Visa, MasterCard, American Express, and Discover.

I authorize payments to be made directly to the Arch Foot & Ankle and fully understand that I am the responsible party for all charges incurred by me or my dependents at this facility. I also authorize the release of any and all information required to collect and process my medical insurance claims. I have read the "Financial Policy"; I understand and agree with it. By my signature below, I hereby authorize the assignment of financial benefits directly to Arch Foot & Ankle for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.

I understand that Arch Foot & Ankle and its physicians are not ultimately responsible for collecting from my insurance or negotiating settlement of claims. I understand the financial policies and accept responsibility for payment of any balance owed on my account. I understand that I am financially responsible for all charges whether or not paid by insurance.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Policy:

Patient Name	Responsibility Party Name (if different)	Signature of Responsible Party	Date

Patient Financial Policy Effective as of 7/19/2021

NOTICE OF PRIVACY PRACTICES

I hereby give my consent for Arch Foot & Ankle to use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and healthcare Operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Arch Foot & Ankle reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Arch Foot & Ankle, Privacy Officer, 3143 Hwy. 6, Sugar Land, TX 77478.

With this consent, Arch Foot & Ankle may call my home or other alternative location and **leave a message on voice mail or in person** in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. However, our policy is not to leave detailed messages regarding Protected Health Information or anything related to treatment, payment or healthcare operations.

With this consent, Arch Foot & Ankle may **mail to my home or other alternative location** any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Arch Foot & Ankle may **e-mail to my home or other alternative location** any items that assist the practice in carrying out TOP, such as appointment reminder cards and patient statements.

I have the right to request that Arch Foot & Ankle restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Arch Foot & Ankle may decline to provide treatment.

I acknowledge that I was provided a copy of the Notice of Privacy Practices. I have read and understand the notice. By signing this form, I am consenting to Arch Foot & Ankle disclosure of my Personal Health Information (PHI) to carry out Treatment, Payment and healthcare Operations (TPO).

Patient Name	**Responsibility Party Name (if different)**	**Signature of Responsible Party**	**Date**

Notice of Privacy Practices Effective as of 7/19/2021