Advanced Podiatry Associates, PLLC

Dr. Asia Jackson
Foot and Ankle Specialist
Conservative and Surgical Care

750 Eureka Street
Suite C
Weatherford, Tx 76086

817.596.5077
apapodiatry@gmail.com

Today's Date:_____

PLEASE PROVIDE YOUR INSURANCE CARD(S) AND PHOTO ID

PATIENT'S LAST NAME: FIRST NAME:

PATIENT'S ADDRESS:

CITY: STATE: ZIP

HOME PHONE: CELL PHONE:

DATE OF BIRTH: SOCIAL SECURITY NUMBER:

GENDER: F M SHOE SIZE: HEIGHT: WEIGHT:

MARTIAL STATUS: SPOUSE'S or PARENT'S NAME:

MY FOOT PROBLEMS ARE:

HOW LONG HAVE YOU HAD THE PROBLEM(S): DAYS: WEEKS: YEARS:

INSURANCE INFORMATION

ARE YOU THE INSURED: Y N If NO - NAME OF INSURED:

PRIMARY INSURANCE: GROUP #

POLICY# EFFECTIVE DATE

SECONDARY INSURANCE: GROUP #

POLICY# EFFECTIVE DATE

COMPLETE THIS SECTION ONLY IF NAME OF INSURED IS DIFFERENT FROM PATIENT

LAST NAME: FIRST NAME: GENDER: F M

INSURED'S ADDRESS:

CITY: STATE ZIP

HOME PHONE: WORK PHONE:

INSURED'S DATE OF BIRTH: SOCIAL SECURITY NUMBER:

WHAT IS THE INSURED'S RELATIONSHIP TO THE PATIENT:

PLEASE COMPLETE THIS SECTION

Email Address: _____ **Pharmacy:** _____

PRIMARY CARE PHYSICIAN _____

ADDRESS: _____

CITY: _____ STATE _____ ZIP _____

PHONE: _____ DATE OF LAST VISIT: _____

X _____ _____

PATIENT SIGNATURE (OR PARENT/GUARDIAN SIGNATURE IF PT IS a MINOR) DATE:

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Due to Health Insurance Portability and Accountability Act (HIPPA) of 1996, the following information must be filled out by each patient annually.

I authorize Dr. Asia N. Jackson, DPM to release my medical or insurance information necessary to process my medical claims and coordinate or manage my healthcare.

YES NO

In the event a family member or caregiver attends your office visits and is the exam room at the time of your evaluation and/or treatment, I give Dr. Asia Jackson with Advanced Podiatry Associates and its physicians or employees my permission to discuss freely my condition, treatment, or diagnosis with that person.

YES NO

Does Dr. Asia N. Jackson, DPM have permission to send a copy of your treatment note to your Primary Care Physician per his/her discretion?

YES NO

Please provide the numbers below where we have consent to leave a message:

May we leave a message at your home? **YES** **NO** HOME PHONE: _____

May we leave a message at your work? **YES** **NO** WORK PHONE: _____

May we leave a message on your cell? **YES** **NO** CELL PHONE: _____

May we leave a message on your pager? **YES** **NO** PAGER: _____

With whom may we discuss or release information about your care, treatment or diagnosis?

NAME: _____ PHONE: _____ Relationship to you? _____

NAME: _____ PHONE: _____ Relationship to you? _____

NAME: _____ PHONE: _____ Relationship to you? _____

NAME: _____ PHONE: _____ Relationship to you? _____

How Did You Hear About Us or Whom May We Thank For Referring You

LAST NAME: _____ FIRST NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

Patient/Parent/Guardian Signature _____ **DATE SIGNED:** _____

PRINT PATIENT'S NAME: _____

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Patient Name: _____

History & Medical Information

1) Explain your foot/ankle problem: ☐ Right ☐ Left _____

_____

2) When did pain/discomfort begin (date): Days? _____ Weeks? _____ Months? _____

Describe your pain/discomfort: ☐ Burning ☐ Numbness ☐ Sharp ☐ Other _____

3) What makes the pain/discomfort better? _____

4) Have you had a physical trauma or an accident? ☐ No ☐ Yes _____

5) Occupation: _____ Is your problem work related? ☐ No ☐ Yes

6) Past Medical History

☐ Anemia	☐ Gout	☐ Thyroid Disorders	☐
☐ Bleeding Disorders	☐ Heart Disease	☐ Nerve Disorders	☐
☐ Cancer	☐ Hepatitis	☐ Neurological Disorders	☐
☐ Diabetes	☐ High Cholesterol	☐ Osteo Arthritis	☐
☐ Epilepsy	☐ HIV/AIDS	☐ Stroke	
	☐ High Blood Pressure	☐ Kidney Disease	

7) List all medications/herbs/vitamins: _____

_____

_____

8) Allergies: (Describe reaction) ☐ None

☐ Penicillin	☐ Codeine		
☐ Anesthesia	☐ Demerol		
☐ Aspirin	☐ Mycins		
☐ Sulfa	☐ Tape	☐ Other	_____

9) Surgical History: Have you had surgery? ☐ Yes ☐ No

10) Social History: (only check was is pertinent to you)

☐ Tobacco Use	☐ Alcohol Use	☐ Exercise Habits	_____
☐ Caffeine Use	☐ Drug Use		

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Financial Responsibility

Durable Medical Equipment, orthodics, in-office surgery (including injections) and physical therapy are often not covered by even the most comprehensive medical insurances, including secondary to Medicare. Unfortunately, this can result in out-of-pocket expenses for you or your family. It is our policy to communicate with your insurance company to help you avoid any circumstances where you would unknowingly have out-of-pocket expenses due to non-covered benefits, deductibles, copays and coinsurance. By signing below, you assume full responsibility for all allowable charges not covered by your medical insurance.

Please contact your insurance company in advance if you have any questions about what expenses you may incur. If your insurance will not allow a service provided by our office and you prefer not to pay out-of-pocket, please let us know so we can discuss other options.

_____ _____

Signature of Patient (or Parent/Guardian) **Date**

****

Advanced Podiatry Associates Signature Authorization

Information Release

I authorize the providers of Advanced Podiatry Associates, PLLC to release any information obtained in the course of my evaluation and/or treatment to my insurance company(ies), primary care physicians, and/or attorney(s). I further authorize any other medical provider of services to release full details of your condition to Advanced Podiatry Associates, PLLC for the purpose of medical treatment.

initials _____

Direct Payment

I authorize payment directly to Advanced Podiatry Associates, PLLC for the amount due in my pending claim for podiatry expenses payable under the terms of my insurance. I agree that I am responsible for any services or supplies that may not be covered by my insurance.

initials _____

Balance Payment

I agree that I am responsible for any balance not paid by my insurance, (including Medicare secondary insurance). I understand that if I fail to resolve any balance determined to be my responsibility, my account may be forwarded to collections.

initials _____

Photographic and Radiological Release - Clinical Records

I authorize the providers of Advanced Podiatry Associates, PLLC to take necessary clinical photographs and X-rays with the understanding that such records are for confidential clinical purposes only. If my insurance company requires medical records to process my claim, I authorize the release of my records for that purpose.

initials _____

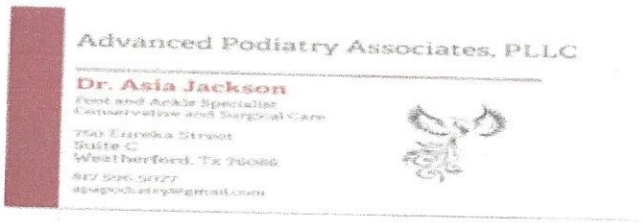
Change of Information

I will use best efforts to notify Advanced Podiatry Associates, PLLC of any change to my information (address, phone numbers, insurance company etc) in a timely manner. Should I fail to notify Woodly Foot and Ankle Specialists, PC of a change in my insurance carrier, I agree that I will be responsible for any charges not payable due to my failure to obtain any necessary referrals, authorizations, and/or coverage benefits. I realize that this is my responsibililty when seeking the care of a specialist.

initials _____

I have read and fully understand the above statements. *I agree that I am bound and hereby give my consent.*

Patient Signature (Parent or Guardian) Date



Statement of Financial Responsibility

Please read and sign

I understand that I am responsible for any charges incurred during any visit or treatment by the doctors and staff of Advanced Podiatry Associates, PLLC

initials _____

My insurance company may not cover my charges for the following reasons: My insurance company may not cover the service, my insurance may not be in effect, the charges may be applied to my deductible/co pay and/or coinsurance, I did not bring a referral for this care, the referral did not arrive in time for the visit or for any other reason deemed by my insurance.

initials _____

As a courtesy to me, the staff of Advanced Podiatry Associates, PLLC will make every effort to verify my insurance, its benefits and coverages, **however**, it is my responsibility to verify my plan's network, benefits and coverages for services provided by Advanced Podiatry Associates, **The doctors and staff of Advanced Podiatry Associates, PLLC will file my insurance when appropriate, but I will be ultimately responsible for all charges.**

initials _____

I understand that payment is due at the time of service. I understand that my account will be turned over to collections if payment is not made after 61 days of 1st bill from Advanced Podiatry Associates, PLLC.

initials _____

*****24 HOUR APPOINTMENT CANCELLATION NOTICE IS REQUIRED*****

I Understand that a Fee of $30.00 will be accessed to my account if I fail to provide a 24 hour cancellation notice resulting in a missed appointment.

initials _____

X_____ _____

Patient/Parent/Guardian Signature

Services will not be provided without a signed financial statement

Advanced Podiatry Associates, PLLC
Dr. Asia Jackson, DPM

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____