Associated
FOOT & ANKLE SPECIALISTS
of San Antonio, P.A.

DATE: _____

**PATIENT INFO:**

Name: _____ SS#: _____ DOB: _____

Address: _____ City/State: _____ Zip: _____

Sex: ( ) Male ( ) Female Home Phone: _____ Cell Phone: _____

Occupation:_____ Employer: _____ Phone: _____

**IF MINOR:** Parent Name: _____ SS#: _____ DOB: _____

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**INSURANCE INFO:** Please list in order of coverage. We will also make copies of your card(s).

Insurance Name: _____ ID# _____ Group# _____

Insurance Name: _____ ID# _____ Group# _____

Insurance Name: _____ ID# _____ Group# _____

Is the patient the insured? YES NO If no, please provide name, ss# and dob of insured.

Name: SS#: DOB: Relation:

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What is the reason for your visit today? _____

Have you seen a podiatrist before? YES NO If yes, who/when? _____

Who is your primary care physician? _____ Date of last visit? _____

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**CONSENT:** I certify that the above information is true to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

**ASSIGNMENT AND RELEASE:** I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to ***Richard Adam, DPM PA*** all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all the charges whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____ Date: _____

# MEDICAL HISTORY:

**Patient:** _____

**DOB:** _____

What is your main concern about your feet/ankles? _____

How long have you had the problem? _____ Do you wear orthotics? _____

What have you done to treat the problem? _____

What is your approximate Height? _____ Weight? _____ Age? _____

Who referred you? _____

**CURRENT MEDICATIONS:** Prescriptions, over the counter and vitamins/herbal supplements. If you have prepared list of medications please provide. Otherwise please include dosage and frequency.

| Name | Dosage, Frequency | Name | Dosage, Frequency |
|---|---|---|---|
| Name | Dosage, Frequency | Name | Dosage, Frequency |
| Name | Dosage, Frequency | Name | Dosage, Frequency |
| Name | Dosage, Frequency | Name | Dosage, Frequency |
| Name | Dosage, Frequency | Name | Dosage, Frequency |
| Name | Dosage, Frequency | Name | Dosage, Frequency |

**ALLERGIES TO MEDICATIONS:** Please list medication and reaction.

_____

_____

Are you pregnant or nursing? _____

Have you ever smoked? _____

Do you currently use any tobacco products _____ if yes, type/amount/length _____

Do you use illegal drugs? _____ if yes, type/amount/length _____

Do you consume alcohol? _____ if yes, type/amount/length _____

Check any of the following podiatry conditions you have had:

| | | | | | |
|---|---|---|---|---|---|
| Flat Feet | | Neuroma | | Athlete's Foot | |
| Ankle Problems | | Fungus | | Itching | |
| Bunions | | Plantar Warts | | Foot Odor | |
| Hammer Toes | | Ingrown Toenail | | Swelling | |
| Ulcers | | Callouses | | Fracture | |
| Heel Pain | | | | | |

**(CONTINUED ON BACK)**

Check any of the following medical conditions/problems you have had:

| | | | | | |
|---|---|---|---|---|---|
| Anemia | | Chronic Cough | | AIDS/HIV | |
| Angina | | Dry Throat/Mouth | | Hepititis | |
| Bleeding Disorders | | Frequent Colds/Sore Throat | | Tuberculosis | |
| High Blood Pressure | | Chronic Bronchitis | | Stroke | |
| Heart Disease | | Emphysema | | Cancer/Tumors | |
| Chest Pain | | Asthma | | Liver Disease | |
| Blood Clots | | Headaches | | Skin Disease | |
| Varicose veins | | Migraines | | Bone Disease | |
| Keloid (scar) Formation | | Seizures | | Nervous Disorder | |
| Diabetes | | Diarrhea | | Arthritis | |
| Pneumonia | | Constipation | | Gout | |
| Allergies/Hay Fever | | Rheumatoid Arthritis | | Fever | |
| Sinus Congestion | | Muscle Pain | | Weight Loss/Gain | |
| Runny Nose | | Joint Pain | | Epilepsy | |
| Post-Nasal Drip | | Thyroid/Other Glands | | | |

Is there any other medical condition or diagnosis not listed above that the podiatrist should be aware of?

_____

_____

_____

**Family Medical History:**

Please note any family history (Parents, Grandparents, Children, Siblings, Living or Deceased)

| **Disease/Condition** | **Yes / No** | **Relationship To You** |
|---|---|---|
| Bunions | | |
| Flat Feet | | |
| Hammertoes | | |
| High Arches | | |
| Skin Disease | | |
| Varicose Veins | | |
| Arthritis | | |
| Cancer/Tumor | | |
| Diabetes | | |
| Heart Trouble | | |
| High/Low Blood Pressure | | |
| Kidney Disease | | |
| Lupus | | |
| Thyroid Disease | | |
| Other: | | |

X_____

Sign Date

# Associated Foot Specialists of San Antonio, P.A.
## Acknowledgment Form

I understand that as part of my healthcare, Associated Foot Specialists of San Antonio, P.A. originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- *A basis for planning my care and treatment*
- *A means of communication among the many health professionals who contribute to my care*
- *A source of information for applying my diagnosis and surgical information to my bill*
- *A means by which a third-party payer can verify that services billed were actually provided*
- *And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals*

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of protected health information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices prior to signing this acknowledgement. I understand that Associated Foot Specialists of San Antonio, P.A. reserves the right to change its practices and to make the new provisions effective for all protected health information maintained by Associated Foot Specialists of San Antonio, P.A.

I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Associated Foot Specialists of San Antonio, P.A. is not required to agree to the restrictions requested Associated Foot Specialists of San Antonio, P.A. will not use or disclose your health information without your authorization, except as described in the Notice of Privacy Practices.

Associated Foot Specialists of San Antonio, P.A. records may contain information created by an entity other than Associated Foot Specialists of San Antonio, P.A. Associated Foot Specialists of San Antonio, P.A. is not responsible for the information contained therein (including the accuracy, completeness, relevance, legibility or lack thereof of such incorporated records). Patient expressly requests release of all records maintained by Associated Foot Specialists of San Antonio, P.A. concerning patient, including incorporated records. Patient acknowledges that Associated Foot Specialists of San Antonio, P.A. has no and assumes no duty to patient regarding the content of or omissions from such incorporated records.

_____ _____

Signature of Patient or Legal Representative | Date Signed by Patient or Legal Representative

_____ _____

Signature of Associated Foot Specialists of SA Witness | Date

Associated Foot Specialists of San Antonio, P.A. was unable to obtain acknowledgment/consent because:

__Emergency __Patient Sedated

__Patient Non-Responsive __ Patient Refused — Reason_____

__Patient Confused/Disoriented

ASAP PRINTING CENTER 210 341 405

Associated
FOOT & ANKLE SPECIALISTS
of San Antonio, P.A.

Richard C. Adam, D.P.M.
Diplomate, American Board of Podiatric Surgery
Fellow, American College of Foot Surgeons

# Cancellation/ No-Show/ Financial Policy

We strive to provide you with the best care possible and in return we ask that you assist us not only in monitoring your health care but also by paying for our services in a responsible and timely manner.

- **Missed Appointments:** Our policy is to charge for missed appointments; those appointments that are not cancelled at least 24-hours in advance, the charge is $25. Please help us serve you better by keeping all scheduled appointments.

The following is a statement of our financial policy. Our office requires that each patient read and sign a copy of this policy before we provide any treatment. Therefore, please read through this statement and feel free to ask us any questions you may have relating to our policy. *Then sign the statement at the bottom of this form.*

- **Your Bill is Your Responsibility:** If your insurance company or other benefit program doesn't cover the entire bill, it's your responsibility to pay the balance. Unless you are on an extended payment plan, we expect payment in full within 45 days of being notified of any balance due.

We do require that your co-payment or deductible be made at the time of service. In the event that we do not accept assignment of benefits from a particular insurance company, HMO or PPO, we require that you pay your bill in full at the time of each visit or be pre-approved on our extended payment plan.

**Acceptable Payment Methods:**

We accept Cash, Checks, Visa, MasterCard, Discover Card and American Express. Under certain circumstances, with an approved credit card, we do offer extended payment plans. If you need additional information on that, please talk to our billing staff.

**I certify that I have read and understand the "Financial Policy" and agree to all terms and conditions as stated above. I understand it is my sole responsibility to verify my medical coverage with the insurance company, HMO or PPO, Medicare/Medicaid or other benefit programs and that I am ultimately responsible for payment in full for any outstanding balances incurred.**

_____ _____

Patient Signature Date

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website:www.DrRichardAdam.com