

PATIENT NAME: _____

DATE OF BIRTH: ____/____/____

CONTRACT # _____ GROUP # _____

SECONDARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CONTRACT # _____ GROUP # _____

PATIENT NAME: _____

DATE OF BIRTH: ____/____/____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME	DOSE	HOW OFTEN DO YOU TAKE?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SOCIAL HISTORY

MARITAL STATUS: SINGLE MARRIED PARTNERED SEPARATED DIVORCED WIDOWED

USE OF ALCOHOL: NEVER NO LONGER USE HISTORY OF ALCOHOL ABUSE
 CURRENT USE - TYPE _____ RARE OCCASIONAL MODERATE DAILY

USE OF TOBACCO: NEVER QUIT - HOW LONG AGO? _____ SMOKE ___ PACKS/DAY FOR ___ YEARS

USE OF RECREATIONAL DRUGS: NEVER QUIT - HOW LONG AGO? _____ TYPE _____
 CURRENT USE - TYPE _____ RARE OCCASIONAL MODERATE DAILY

EMPLOYER: _____ OCCUPATION: _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? 10% 25% 50% 75% 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? CHILDREN-AGE(S) _____ PET(S)-WHAT KIND? _____
 ELDERLY OR DISABLED FAMILY MEMBER OTHER _____

EXERCISE: NEVER RARE OCCASIONAL WEEKLY SEVERAL TIMES A WEEK DAILY

TYPES OF EXERCISE: _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: DIABETES: TYPE 1 OR TYPE 2 CANCER HEART DISEASE
 HIGH BLOOD PRESSURE STROKE CORONARY ARTERY DISEASE THYROID DISEASE
 RHEUMATOID ARTHRITIS

PATIENT NAME: _____

DATE OF BIRTH: ____/____/____

OTHER _____

YOUR MEDICAL HISTORY

ALLERGIES: MEDICATIONS _____

ANESTHESIA _____ FOODS _____

TAPE LATEX SHELLFISH IODINE OTHER _____

NONE KNOWN

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

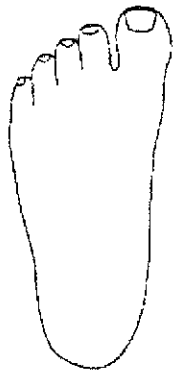
ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES: TYPE 1 OR TYPE 2 (CIRCLE)	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:								

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT



TOP OF FOOT



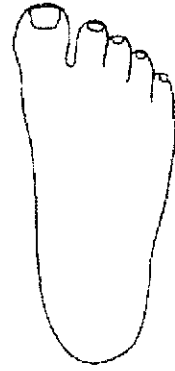
BOTTOM OF FOOT



RIGHT FOOT



BOTTOM OF FOOT



TOP OF FOOT



PATIENT NAME: _____

DATE OF BIRTH: ____/____/____

INSIDE OF FOOT

OUTSIDE OF FOOT

OUTSIDE OF FOOT

INSIDE OF FOOT

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: BEGIN ALL OF A SUDDEN GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? NO PAIN SHARP DULL ACHING BURNING
 RADIATING ITCHING STABBING OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN POSSIBLE)

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: STAYED THE SAME BECOME WORSE IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? WALKING STANDING DAILY ACTIVITIES
 RESTING DRESS SHOES HIGH HEELS FLAT SHOES ANY CLOSED TOE SHOE
 RUNNING OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? YES (DESCRIBE) _____ NO

IF YES, WAS IT A WORK-RELATED INJURY? YES NO

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

PRINT NAME OF PATIENT, PARENT OR GUARDIAN

SIGNATURE OF DOCTOR

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

DATE

SIGNATURE

DATE

Hunter Foot & Ankle Associates, PLLC
1600 Coit Rd. Suite 210
Plano, TX 75075
972-877-3939

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Hunter Foot & Ankle Associates, PLLC to disclose my protected health information as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it. I understand that I may revoke this authorization at any time by giving notice in writing at the address found above, but if I do it will not affect any actions taken before receipt of my revocation.

I understand that my treatment will not be conditioned on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Patient name: _____ Date of birth: _____
Persons/organizations to receive the information: _____

The specific information to be released/disclosed is specified below:

Complete Medical Record

Or specify one or more of the following:

- | | |
|--|--|
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> X-rays |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Billing and Claim Records |
| <input type="checkbox"/> Laboratory | <input type="checkbox"/> (Other - specify) _____ |

This information is to be used/disclosed for the following purposes(s) only: _____

(no purpose need be stated if the request is made by the patient and the patient does not wish to state the purpose).

This authorization will expire on _____ (state date or event).

SPECIFIC AUTHORIZATION

I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, unless I have crossed it out, and initialed it.

Yes No Initials _____

Signature of patient or patient's representative
(Form MUST be completed before signing.)

Date _____

Printed name of patient's representative (if applicable): _____
Relationship to the patient (if applicable): _____

*** YOU ARE ENTITLED TO A COPY OF THIS DOCUMENT**

Authorization for Release of Information

Name of Patient _____ Date of Birth ____/____/____

Hunter Foot & Ankle Associates, PLLC is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity To Receive Information. Check each person/entity that you approve to receive information.	Description of information to be released Check each that can be give to person/entity on the left in the same section.
<input type="checkbox"/> Voice Mail	<input type="checkbox"/> Results of lab tests/x-rays <input type="checkbox"/> Other _____
<input type="checkbox"/> Spouse _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows below: _____
<input type="checkbox"/> Parent (provide name) _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows below: _____
<input type="checkbox"/> Other (provide name) _____ _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows below: _____

Patient Information:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or discloses as a result of this authorization maybe subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. THIS AUTHORIZATION SHALL IN BE EFFECT UNTILL REVOKED BY PATIENT.

Date ____/____/____

 (Signature of Patient or Personal Representative)

Description of Personal Representative's Authority (attach necessary documentation)

Revised October 2009

Hunter Foot & Ankle Associates, PLLC
1600 Coit Rd. Suite 210
Plano, TX 75075
972-877-3939

**Consent for Photography, Videotaping, or Other Imaging
for Media or Educational Purposes**

Patient's Name: _____

Patient's Date of Birth: _____

I give my consent to have photographs, videotaped images, or other images made of [myself or patient's name]. I understand and agree that these images may be used by [name of practice] for the purpose outlined below.

_____ Teaching purposes, which includes being shown to other patients.

_____ Advertisements by [name of practice]

_____ Placement on [name of practice]'s website

_____ Other _____

Signature of patient/legal representative

If legal representative, relationship to patient

Date

Hunter Foot & Ankle Associates, PLLC
Dr. Roderick C. Hunter Jr., DPM
1600 Coit Rd. Suite 210
Plano, TX 75075
972-877-3939

Cancellation Policy/No Show Policy For Doctor Appointments and Surgery

1. Cancellation/ No Show Policy for Doctor Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty dollar (\$50) fee; this will not be covered by your insurance company.

2. Scheduled Appointments

We understand that delays can happen however we must try to keep the other patients and doctors on time.

If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

3. Cancellation/ No Show Policy for Surgery

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office.

If surgery is not cancelled at least 10 days in advance you will be charged a seventy five dollar (\$75) fee; this is will not be covered by your insurance company.

4. Account balances

We will require that patients with self pay balances do pay their account balances to zero (0) prior to receiving further services by our practice.

Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.

Patients with balances over \$100 must make payment arrangements prior to future appointments being made.

Print Name Patient

Signature Patient/Guardian

____/____/____
Date

Patient Account # _____
(Office Use Only)

A. Notifier:

B. Patient Name:

C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D. _____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. _____ listed above.
Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

- OPTION 1.** I want the D. _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- OPTION 2.** I want the D. _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**
- OPTION 3.** I don't want the D. _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:

J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

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