Next Step Foot & Ankle Clinic

Welcome to our practice! Our goal is to provide the best possible foot care for you. Please fill out this paperwork and **immediately return it to our office**. We ask that your also provide us with a current list of medications and any recent lab work. You can send it to our Universal City Office fax at 210.257.6931 or Pleasanton Office fax at 830.569.6833, email to: contactus@silvesterfc.com or drop it by during normal business hours. We appreciate your trust in us and we appreciate the opportunity to serve you.

Payment Policy: Payment for services is due at the time service is given. We accept cash, checks, and credit cards. Care Credit© may be available. If you have specific financial concerns, we will be happy to discuss payment options with you.

Assignment of Insurance Benefits: We will bill your insurance for you. Rarely does an insurance company cover an entire bill. We will do our best to estimate your deductible and the portion that will be covered by your insurer. **Co-payments and deductibles are due by you on the date you are seen.** In addition, any balance remaining after your insurance pays is your direct responsibility. This includes any non-covered services.
While we make every effort to determine your benefits ahead of time, it is ultimately your responsibility to know what your insurance plan covers.

Referrals: If your insurance requires a referral, please help us by making sure that referrals are sent by your primary care doctor prior to your visit. **Please call our office to check on your referral status before coming for your appointment. If you show up and a referral is not in place, we will ask you to reschedule or you can choose to pay for your visit.**

Appointments: Your time is valuable, and we strive to keep as close to your scheduled appointment time as possible. As with any medical setting, situations may occur that keep the doctor from seeing you at the scheduled time. If we are running late, we will inform you and give you the option of waiting, or rescheduling. Please call us if you are running late to see if accommodation can be made. If you are more than 15 minutes late, we may ask you to reschedule your appointment.

If you will miss an appointment, kindly let us know. A $10.00 fee will be assessed for no-shows. Please provide a current list of medications at each visit.

Please read and initial your consent to the following:

__ **X-rays and photos of your feet may be taken during your visit.** X-rays or photos of individual feet or portions of feet may be used for medical records to document wound healing, for educational or marketing purposes. If used for educational or marketing purposes, your identity will be kept confidential.

__ **E-Prescribing.** We participate in the governmentally mandated practice of e- prescribing, which means we electronically submit prescription requests to your choice of pharmacy. This process checks for potential adverse reactions by creating a history of medications prescribed.

__ **Electronic Communication.** With your provided email address, we will subscribe you to our Patient Portal. The Patient Portal will provide a secure method of communication between our clinic and you. You will receive your user name and password for the Patient Portal when you come to the clinic for your first visit.

If you have questions about our office procedures, please do not hesitate to ask us. We are here to help and look forward to being your first choice in foot care.

Signature _____ Date _____

Next Step Foot & Ankle Clinic Financial Policy and Privacy Policy

Thank you for choosing our office to provide your foot and ankle care. We are committed to serving you with skill and compassion. We strive to make our payment policy as clear as possible for our patients. The medical services provided by our offices are services you have elected to receive, which implies a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. If we do not participate with your insurance plan, payment in full is expected at each visit. If you are insured by a plan we participate in, but you do not have an up to date insurance card and we are unable to verify benefits, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE: We are a participating Medicare provider. We will bill Medicare and any secondary policy you have. However, that does not mean that all services are covered. Non-covered services will be identified as such, and you will have the choice to receive or not receive these services. You are responsible for paying your annual Medicare deductible. You are also responsible for any coinsurance, which is 20% of the Medicare allowed amount for an item or service. We do not participate in all Medicare replacement plans.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance after payment or explanation of benefits (EOB) is received from your primary insurance. We do not bill tertiary insurance plans.

COPAYS & DEDUCTIBLES: The co-pay and deductible arrangement is part of your agreement with your insurance company. All co-pays and unmet deductibles must be paid at time of service. Failure on our part to collect copayments and deductibles from patients can be considered fraud.

SELF-PAY: Payment in full is due at the time of service if you do not have health insurance, and for items not covered by insurance. We accept cash, money orders, check, Visa, MasterCard, Discover and Care Credit. A $35 NSF fee will be assessed for all bad checks.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or may not be considered reasonable/customary/necessary by Medicare or other insurers. You are responsible for payment for those services.

REFERRALS/AUTHORIZATIONS: Our practice does not require a referral to be seen UNLESS required by your insurance plan. If you arrive for an appointment and the necessary referral or auth is not in place, you will be given the option to reschedule or pay for those services at the time they are given. We will do all we can to help you get these in place, but ultimately it is your responsibility to understand your plan's referral/auth requirements.

CLAIMS SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. *Your insurance company may need you to supply certain information to them directly. It is your responsibility to get this information to them in a timely manner. Claim balances become patient responsibility if insurance requests are ignored.* Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays on your claim. Your insurance benefit is a contract between you and your insurance company.

PATIENT BILLING: Insured patients will be sent up to three "remainder" statements, showing what your insurance company has paid on your behalf, any amounts that we have adjusted off due to our contract with your insurance company, and what your remaining financial responsibility is. Please contact our billing office immediately upon discovering any error or if you are unable to make payment. The third statement for self-pay and insured patients is considered a Final Notice, and if no payment is received on your account, you may be sent to collections. If your insurance pays after you have paid on your account, a refund will be mailed to you within 30 days.

ASSIGNMENT OF BENEFITS

I, the undersigned patient or authorized representative, certify that I have coverage as presented, and assign directly to DJ Silvester, DPM, PA/Next Step Foot & Ankle Clinic all insurance benefits payable to me for services rendered. I understand that I am liable for payment of deductibles, copayments, and/or non-covered services. I authorize the release of medical information to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of my signature on all insurance submissions.

I understand that it is my responsibility to notify the doctor's office if there is any change to my insurance coverage.

I have read the above policy regarding My Financial Responsibility to Next Step Foot & Ankle Clinic/DJ Silvester DPM PA for medical services and products provided. I agree to pay Next Step Foot & Ankle Clinic/DJ Silvester DPM PA any balance unpaid by my insurance carrier for myself or the patient named below.

Print Patient Name _____ **Signature** _____

Date _____

If signature above is not Patient, relationship to Patient _____

PATIENT ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been given the opportunity to read a copy of Notice of Privacy Practices. This Notice of Privacy Practices is available in our office, and on our website: www.nextstepfoot.com.

Protected Health Information (PHI) may consist of items such as diagnoses, treatments, labs, prescriptions and appointments. **Who may we discuss your Protected Health Information with?**

___Spouse: Name and phone number_____

___ Child: Name and phone number_____

___ Other: Name and phone number_____

Print Patient Name _____ **Signature** _____

Date _____

If signature above is not Patient, relationship to Patient _____

----OR----

DOCUMENTATION of FAILURE TO OBTAIN SIGNED ACKNOWLEDGMENT:

On (date) _____NSFAC presented this Acknowledgment of Receipt of Privacy Practices form to _____. Patient or agent refused to provide a signature.

Employee Signature _____ Date_____

NEXT STEP FOOT AND ANKLE CLINIC Registration Form

☐ Pleasanton ☐ Floresville ☐ Universal City

Last Name _____ Legal First Name _____ Middle _____

DOB Age Gender: ☐ Male ☐ Female Weight Height Shoe Size

Address:	Apt:	City:	State:	Zip:

Home Phone ( ) Work Phone ( ) Cell Phone ( ) Email:

Circle Preferred Method of Call/Voicemail: Home Phone Work Phone Cell Phone

Circle Preferred Method of Written Correspondence (In addition to NSFAC's Secure Portal): Email US Mail

Emergency Contact Name Relationship Home Phone Cell Phone

Name person(s) who can access your records/PHI or pick up items for you:

Race: AmericanIndian/Alaska Native Asian Black/African American Hispanic Native Hawaiian White

Primary Language: Ethnicity: Hispanic/Latino Not Hispanic/Latino Patient Declined

PCP or Referring Physician (Full Name) _____ Phone _____

If Diabetic, full name of Diabetic Doctor _____ When did you see them last? _____

How did you hear about our office? Friend/Family Internet Search Website Facebook Mailing Book Offer Physician Other:

Reason for Visit with Us: Date Occurred:

Is your injury/condition (Circle) Work-Related Car Accident Related Other Liability Being Paid By Employer Self-Pay/Cash

Primary Insurance - Copy of Card Required		Secondary Insurance - Copy of Card Required	
Insurance Name	Eligibility Phone ( )	Insurance Name	Eligibility Phone ( )
Member ID#	Group#	Member ID #	Group #
Policyholder Name	Patient's Relationship to Policyholder	Policyholder Name	Patient's Relationship to Policyholder
Policyholder Date of Birth	Policyholder SS#	Policyholder Date of Birth	Policyholder SS#

CURRENT PROBLEM (Please Check all that Apply)

Location: (where)	☐ Top Of	☐ Bottom of	☐ Inside of	☐ Outside of	☐ In between	☐ Bilateral	☐ Left	☐ Right
Site: (what)	☐ Ankle	☐ Arch	☐ Ball of foot	☐ Calf	☐ Foot / Feet	☐ Heel	☐ Leg	☐ Toes
Quality: (Type of pain)	☐ Aching	☐ Bruised	☐ Burning / Itchy	☐ Cramping	☐ Deep	☐ Dull	☐ Improving	☐ Inflamed
	☐ Numb	☐ Pressure	☐ Sharp	☐ Swollen	☐ Tender	☐ Tight	☐ Tingling	☐ Other
How long has it bothered you?		☐ Today	☐ # of days	☐ # of weeks	☐ # of Months	☐ # of Years		
When does it bother you?	☐ At Night	☐ After Exercise	☐ Constant	☐ In Morning	☐ Off and on	☐ Recurrent	☐ Other	
What caused it?	☐ Fell	☐ Foot type	☐ Increased Activity	☐ Injury	☐ Running	☐ Unknown	☐ Other	
What makes it better?	☐ Ice / Heat	☐ Elevation	☐ Medication	☐ Compression	☐ Orthotics	☐ Shoes	☐ Rest	☐ Other
What makes it worse?	☐ Barefoot	☐ Pressure	☐ In Shoes	☐ Increase Activity	☐ Running	☐ Walking	☐ Other	
Also have:	☐ Back Pain	☐ Dementia	☐ Diabetes	☐ Overweight	☐ Headaches	☐ Infection	☐ Muscle Spasm	
	☐ Fatigue	☐ Swelling	☐ OTC Inserts	☐ Weakness	☐ Osteoporosis	☐ Numbness	☐ Other	

TODAY's Pain Scale: (Circle) 0 1 2 3 4 5 6 7 8 9 10 Worst TODAY's Severity: (Circle) Mild Moderate Severe

PAST MEDICAL HISTORY (Please Check All that Apply)

- ☐ No Known Problems
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ CAD
- ☐ Cancer
- ☐ Cholesterol
- ☐ CongHFail
- ☐ COPD/LungIssue
- ☐ DVT, Blood Clot
- ☐ Depression
- ☐ Dementia
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ GI, Ulcer
- ☐ Gerd, Acid Reflux
- ☐ Gout
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV
- ☐ Injury Legs/Feet
- ☐ Kidney disease
- ☐ Liver disease
- ☐ MI, myocardial
- ☐ MRSA
- ☐ Neuropathy
- ☐ Osteoporosis
- ☐ Pain in legs/feet
- ☐ RSD / CRPS
- ☐ Seizures
- ☐ Stroke
- ☐ Swelling of _____
- ☐ TB
- ☐ Thyroid

PREVIOUS PROCEDURES OR SURGERIES (Please Check All that Apply)

- ☐ No Surgical History
- ☐ Amputation of _____
- ☐ Angioplasty / Stent
- ☐ Appendectomy
- ☐ Blood Transfusion
- ☐ Bunion
- ☐ Coronary Bypass
- ☐ Foot or Ankle Surgery(Type _____)
- ☐ Gallbladder Surgery
- ☐ Gastric Banding
- ☐ Hip Surgery
- ☐ Kidney Transplant
- ☐ Knee Surgery
- ☐ Liver Transplant
- ☐ Lower Extremity Bypass
- ☐ Lower Extremity Stent
- ☐ Pacemaker
- ☐ Steroid Injection
- ☐ Other

FAMILY HISTORY (Check in box if present in family member's history)

	Unknown History	Alive & Well	Arthritis	Cancer (Type)	Kidney Disease	Hypertension	Stroke	Diabetes	Other
Father	☐	☐	☐	☐ ( )	☐	☐	☐	☐	
Mother	☐	☐	☐	☐ ( )	☐	☐	☐	☐	
Son	☐	☐	☐	☐ ( )	☐	☐	☐	☐	
Daughter	☐	☐	☐	☐ ( )	☐	☐	☐	☐	

SOCIAL HISTORY (Please Circle Response)

Do you drink alcohol Y N — If yes, do you drink Every Day Social Only

Do you smoke? Y N — If yes, how many years have you smoked? _____

Are you a former smoker? Y N — If yes, how many years did you smoke? _____ What year did you quit? _____

Recreational Drug Use (Circle) Never Used Have Used Currently Use Treated for Addiction (Year _____)

PHARMACY AND MEDICATIONS A Typed List of Medications, Dosage, & Frequency Would Be Greatly Appreciated

Pharmacy: _____
Street _____
City / Zip _____
Phone _____
Fax _____

Medication	Dose	Frequency	Medication	Dose	Frequency
1			6		
2			7		
3			8		
4			9		
5			10		

ALLERGIES (Please Check all that Apply)

- ☐ No Known Allergies
- ☐ Aspirin
- ☐ Egg
- ☐ Iodine
- ☐ Adhesive (tape)
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Milk
- ☐ General Anesthetic
- ☐ Oak
- ☐ Sulfa
- ☐ Penicillins
- ☐ Codeine
- ☐ Heparin
- ☐ Shellfish
- ☐ Other:

VACCINES (Indicate month and year last given)

Flu ( ) Pneumonia ( ) Tetanus ( )

ATTESTATION

I DO HEREBY ATTEST THAT THIS INFORMATION IS TRUE, ACCURATE, AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT ANY FALSIFICATIONS, OMISSIONS, OR CONCEALMENT OF ANY MATERIAL FACT MAY SUBJECT ME TO ALL FEES FOR SERVICES AND/OR OTHER LIABILITY. I ALSO UNDERSTAND THAT I AM TO NOTIFY NSFAC IMMEDIATELY OF ANY CHANGES TO THE ABOVE INFORMATION, AND I WILL BE ASKED TO DO AN ANNUAL UPDATE TO THIS REGISTRATION FORM ANNUALLY.

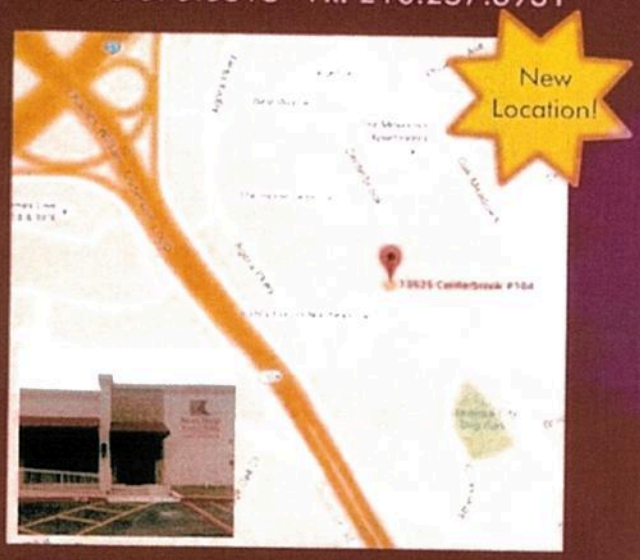
Print Name of Patient or Legally Authorized Representative _____ Relationship to Patient _____

Signature of Patient or Legally Authorized Representative _____ Date _____

Now Serving San Antonio and South Texas

Next Step Foot & Ankle Clinic - Universal City

13525 Centerbrook, Suite 104
Universal City, TX 78148
Ph: 210.375.3318 Fx: 210.257.6931



Next Step Foot & Ankle Clinic - Pleasanton

409 N. Bryant Street
Pleasanton, TX 78064
Ph: 830.569.FEET(3338) Fx: 830.569.6833

www.NextStepFoot.com

Directions to Our Universal City Office

We are located just off Pat Booker Road. Turn left on Athenian Drive, then left on Centerbrook. Between Kohl's and the Universal City Dog Park.

Directions to Our Pleasanton Office

Directions From the North (via I-37 S)

- Take I-37 S to Exit 109 toward TX-97/Pleasanton/Floresville
- Turn right onto E State Highway 97/TX-97
- Take slight right onto Commerce Street, which becomes E Bensdale Road
- Turn left onto North Bryant Street
- Our office is on the right between Stadium Drive and W Adams Street

Directions From the Northeast (Floresville Area)

- Take State Highway 97 W/TX-97 toward Pleasanton
- Take slight right onto Commerce Street, which becomes E Bensdale Road
- Turn left onto North Bryant Street
- Our office is on the right between Stadium Drive and W Adams Street
- Turn left on South Bryant Street
- Our office is on the left between W Adams Street and Stadium Drive