North Central Texas Foot and Ankle

The Office of Dr. Childers, DPM

Welcome to NCTFA! Attached you will find the new patient paperwork for your upcoming visit. Please complete this **PRIOR** to your appointment in order to prevent delays in the check in process.

The following information is needed for your upcoming appointment:

- Insurance Card(s)
- Drivers' License/ ID Card
- Current Medication List
- If you have had an MRI or x-rays please be sure to bring either your images on a disc, or the report.

Please be aware, additional x-rays may be needed at the time of your visit with Dr. Childers.

Your appointment time is reserved exclusively for you, we ask if you are unable to make your appointment please call within 24 hours to cancel. If you arrive more than 15 minutes late to your appointment, please be aware that it may be rescheduled.

Not having the attached information completed in full may result in a delay at the time of your appointment.

Self-pay patients – Payment is due in full at the time of service. If you have questions regarding the approximate cost of your visit, please contact our office and we would be happy to provide you with an estimate. Please be aware this will only be an estimate, the actual amount due will depend on the services rendered by the physician.

Insurance patients – copays, deductibles and co-insurance will be collected at the time of service.

If you have questions, please call the office where your appointment is scheduled. The contact information, including our addresses is below.

We look forward to seeing you and becoming a part of your healthcare team.

North Central Texas Foot and Ankle

Decatur Office: 1713 S. FM 51 Ste. 103 Decatur, TX 76234 Phone: (940) 627-0993
Roanoke Office: 351 W. Byron Nelson Blvd. Ste. 100 Roanoke, TX 76262 Phone: (817) 674-7494

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PATIENT INFO

NAME: _____

(Last) (MI) (First)

ADDRESS: _____

(Street) (City) (State) (Zip)

Email Address: _____ DOB: _____

Soc. Sec. #: _____ Driver's License #: _____ State: _____

Employer: _____ Occupation: _____

Employer Address: _____

(Street) (City) (State) (Zip)

Marital Status: _____ Spouse's Name: _____

Referred by: _____ Primary Care Physician: _____

INSURANCE INFORMATION

Insurance Type: ☐Health ☐ Personal Pay ☐ Auto ☐ Worker's Comp ☐ Medicare

Insurance Name: _____ Member #: _____ Group #: _____

Insurer's Name: (If different from Patient) _____ Relationship to Patient: _____

Insurer's DOB: ____/____/____ Insurer's Soc. Sec. #: _____

Insurer's Employer: _____

Secondary Insurance: _____

Member #: _____ Group #: _____

Insurer's Name: (If different from patient): _____ Relationship to Patient: _____

I clearly understand and agree that all services rendered to me are charged directly to me and that I personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient/ Guardian Signature: _____ ***Date:*** _____

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Podiatry Patient History:

Patient Name: _____ Date: _____

Date of Birth: _____ Height:_____ Weight: _____

Marital Status: _____ Employment Status: _____ Occupation:_____

Primary Care Physician Name: _____

Date Last Seen & for what condition: _____

Chief Complaint/ Reason for this visit: _____

Date of Onset/ How long have you had this problem: _____

Using a scale from 0-10 (10 being the worst), how would you rate your problem/ pain?

(Please Circle) 0 1 2 3 4 5 6 7 8 9 10

How Would you describe the type of pain?

☐Sharp ☐Burning ☐Tingling ☐Stabbing

☐Dull ☐Throbbing ☐Catching ☐Other: _____

☐Swelling ☐Stiffness ☐Weakness

☐Shock ☐Numbness ☐Knots

Medical History:

☐Blood Clots ☐Liver Disease ☐Seizure Disorder ☐Hepatitis

☐Anxiety/ Depression ☐Lung Disease ☐Heart Problems ☐Stroke(s)

☐High Blood Pressure ☐Thyroid Disease ☐Tuberculosis ☐Bleeding Problems

☐GERD/ Acid Reflux ☐HIV ☐ADHD/ ADD ☐Diabetes

☐Hyperlipidemia/ High Cholesterol ☐Other: _____

Surgeries: (Please List Name and Date)_____

_____

_____

Social History:

Do you follow Special Diet? ☐Yes ☐No (If Yes, Please Explain) _____

Alcohol Use ☐None ☐Social ☐Mild ☐Moderate ☐Heavy

Current Smoker: ☐Yes ☐No How much? _____ How Many Years? _____

Electronic Cigarettes: ☐Yes ☐No How Long? _____ Substance Abuse: ☐Yes ☐No List: _____

Marital Status: _____ Children: ☐Yes ☐No How Many? _____ Ages: _____

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Family History:

Indicate if you have any immediate family members with any of the following. (Please indicate the relationship to you)

Illness	Mother	Father	Brother	Sister
Heart Disease				
Stroke				
Diabetes				
Neurological Problems				
Autoimmune Disease				
Rheumatoid Arthritis				
Cancer				
High Blood Pressure				
Asthma				
Other:				

Preferred Pharmacy:_____

List **ALL allergies AND reaction(s)** (Medications, food, seasonal, etc.) you may have:

_____

_____

_____

List ALL Medications Below:

Medication	Dosage	Reason for Taking

Could you be pregnant? ☐Yes ☐No

Have you had your Influenza (flu) Immunization within the active flu months or October- March? ☐Yes ☐No

Have you had your Pneumococcal (Pneumonia) Vaccine within the last 12 months? ☐Yes ☐No

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Office policies, RX refills, and phone messages

Patient Name (Print): (Last)_____ (First)_____

It is the patient's responsibility to know their insurance. Please call your insurance company if you have any questions regarding your policy.

General questions to keep in mind for your appointment:

- Is Dr. Childers a CONTRACTED PROVIDER with your insurance?
- Do you need PRIOR AUTHORIZATION for procedures/ visits?
- How much is your COPAY for a Specialist?
- Are X-rays and supplies included in your COPAY?
- Do you have a YEARLY DEDUCTABLE? If so, how much has been met?

Please allow 24-48 BUISINESS HOURS on refill requests

- Notify your pharmacy directly on refills.
- In order to be efficient, these are the set policies that are in effect regarding all prescriptions.

Protocol for Medical Records/ Form Request

- Please allow **7-10 BUISINESS DAYS** for medical forms to be ready.
- Please be aware, there is a **$25.00** charge for **EACH** request.

HIPAA Exceptions:

Please check ALL that apply:

☐ OK to have message left on answering machine

☐ OK to leave message with spouse

☐ OK to leave message with any adult who answers the phone.

☐ OK to leave message regarding appointments ONLY.

I have read and understand the above information regarding my INSURANCE POLICY, PRESCRIPTION REFILLS, and the HIPPA EXCEPTIONS.

Patient or Guardian Signature_____ **Date**_____

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Photo Consent & Release Form

I consent for a photograph to be made of me or my child (or person for whom I am a legal guardian). I understand that the information will only be used for identification purposes and will be stored securely on the medical record. Refusal to photograph will not affect my medical care. If I prefer not to be photographed, I will be asked to provide photo identification.

____I agree for a photograph to be made of me for identification purposes.

____I agree to the use of my or my child's picture for identification purposes.

____I prefer not to have a photo made of me, my child, or dependent.

I, the undersigned, do hereby6 agree to the following NCTFA or Staff member to take photos of my treatment and/ or treated areas to be used for the purpose of monitoring my progress.

If I have any questions or wish to withdraw my consent in the future, you may contact:

Roanoke Office: (817) 674-7494 Decatur Office: (940) 627-0993

Signature: _____ Date: _____

Name of Patient or Minor: _____

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I authorize the physicians at North Central Texas Foot and Ankle to examine me (or patient for I am legally responsible) and to do any x-rays or other tests that may ne needed to make a diagnosis and to provide treatment. I consent to necessary office or other outpatient treatment after being properly informed of alternatives, benefits, and risks.

Physician Ownership Disclosure Statement

The centers for Medicare and Medicaid Services (CMS) requires any physician-owned hospital to provide written notice disclosing the following information to you the patient.

Authorization for Release of Medical Information

I authorize Dr. Childers to release to any insurance company, health plan, or government agency such medical information that may be required to process my claim for payment of the medical bill. I also authorize Dr. Childers to release appropriate medical information to any doctor, hospital, or other health care facility that has or will participate in my (the patient's care). I authorize photocopy, facsimile, or other electronic transmission of the above assignments, authorizations, and releases to be used in place of the original until and unless I send written notice to the contrary to the offices of Dr. Childers. I further authorize any other doctor, hospital, or health care facility to release to Dr. Childers any medical information concerning my (the patient's) illness or injury.

Consent to Obtain Patient Medication History

Patient medication history is a list of prescription medicines that our practice providers, or other provers, have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of the history. The collected information is stored in the practice electronic medical record system (EHR/EMR) and becomes part of your personal medical records. Medication history is very important in helping healthcare providers treat your symptoms and/or illness properly and in avoiding potentially dangerous drug interactions. It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history might not include drugs purchased witho9ut using your health insurance. Also, over-the-counter drugs, supplements, or herbal remedies that patients take on their own may not be included.

Financial Agreement

I agree to pay all professional fees charged by Dr. Childers for my (the patient's) care, irrespective of any insurance benefits to which I may ne entitled, except if Dr. Childers has agreed to accept insurance benefits as full payment for covered series in accordance with federal or state la (e.g., Medicare, Medicaid) or by contract with a prepaid health plan or managed-care plan, and provided such insurance benefits are paid within 60 days of claims submission, and provided there is no recovery from a third-party negligence lawsuit (see injuries and third-party negligence below) Ultimately it is your responsibility to understand the coverage that you pay for in a monthly premium to your carrier.

If an employer or its carrier denies a claim for payment for a work-related injury, or if a prepaid health places, managed-care health plan, or Medicare considers certain services ineligible or uncovered services, then I shall pay for those services. I understand that claims for services remaining unpaid 60 days after claims submission shall be presumed ineligible for insurance reimbursement, and ZI shall pay for those services. I patient is a minor, the parent/ guardian who requests treatment for a child will be responsible for all fees.

Injuries and Third-Party Negligence

I understand and agree that Dr. Childers has grated discounts from its usual fees for any reason, including its participation in prepaid or managed-care health plans, and if I (the patient) recover(s) any monies as the result of any judgment, award, or settlement of any lawsuit arising from treated injuries or illness, then I shall a lien to Dr. Childers against such monetary recovery in the full amount of such discounts.

Delinquency

If my (the patient's) account becomes delinquent I understand that Dr. Childers, at its sole discretion, may refer toa collection agency, or an attorney as allowed by law.

Insurance Assignment

I authorize any insurance company or third-party payor to whom a claim for payment has been submitted to pay any eligible benefits directly to Dr. Childers I hereby authorize payment go directly to Dr. Childers of medical benefits payable by my insurance company and understand that I am responsible for any charge not covered by the terms of my insurance policy. I hereby assign Dr. Childers full rights to represent my (the patient's) interests in any complaints of appeals of denial of benefits or reimbursement to the Texas Department of Insurance (State Insurance Commissioner). I hereby authorize said assignee Dr. Childers to furnish these agencies such information as may be necessary to support such complaints or appeals. I agree I cannot revoke the FINANCIAL AGREEMENT or the INSURANCE ASSIGNMENT at any time while any portion of the medical bill remains unpaid.

I have read, understand, and do hereby agree to the terms of the forgoing Assignments, Authorizations, and Releases. I also certify that the PATIENT INFORMATION I have provided is true and accurate to the best of my knowledge.

_____ _____

Patient, Parent, or Legal Guardian Date

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North Central Texas Foot and Ankle

NOTICE OF PRIVACY PRACTICES

THIS NOCTICE DESCRIBES MEDICAL INFORMATION ABOUT YOU
THAT MAY BE USDED AND DISCLOSED
AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW THIS CAREFULLY

The Health Portability & Accountability Act of 1996 (HIPAA) is a federal program that requi8res that all medical records and other individual identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, be kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. You may request a copy of this notice at any time.

As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose the information.

We may use and disclose your medical records for each of the following purposes: treatment, payment, and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more providers. For example, if your provider refers you to a specialist, we will provide the appropriate medical information to that physician to facilitate your care.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for you visit to your insurance company for payment.

Health Care Operations include the business aspect of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer services. An example would be internal quality assessment review.

Disclosures that can be made WITHOUT your authorization

There are situations in which we are permitted by law to use your medical information without your written authorization or an opportunity to object. In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization in writing to stop future uses and disclosers. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

Public Health, Abuse, or Neglect, and Health Oversight
We may disclose your medical information for public health activities as authorized.

Legal Proceedings and Law Enforcement
We may disclose your medical information in the course of judicial or administrative proceedings, in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements much be met before the information is disclosed.

Workers Compensation
We may disclose your medical information as required by the Texas Workers Compensation Law.

Inmates
If you are an inmate, or under the custody of Law Enforcement, we may release your medical information to the correctional institution or law enforcement official.

Military, National Security, Intelligence Activities, Protection of the President
We may disclose your medical information to authorized government functions.
Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors
We may release your medical information to researchers for research purposes if authorized; to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation; to a coroner or medical examiner to identify a deceased or cause of death; or toa funeral director where4 such a disclosure is necessary for the director to carry out his duties.

Required by law
We may release medical information where the discloser is required by law. Any other uses and disclosers will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Your Rights Under Federal Privacy Regulations

Requested Restrictions
You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare operations. We do not have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances. To request a restriction, submit the following in writing: a) the information to be restricted, b) what kind of restriction you are requesting, and c) to whom the limits apply. You may also request that we limit disclosure to family members, other relatives, or personal friends that may or may not be involved in your care.

Right to Inspect and Copy
You have the right to inspect and request copies of health information that is within the designated record set, which is information that is used to make decisions about your care. You must submit your request in writing to the Privacy Officer, HIPPA permits us to charge a fee for copies of medical records. We can refuse to provide access to our copies of some information for certain reasons when we provide a review of our decision on your request. Another licensed health care provider who was not involved in the provider to deny access will make any such review. We are required to respond or provide copies within fifteen (15) days of your request.

Right to Amend Your Protected Health Information
You may request an amendment of your medical information in the in the designated record set. Request must be in writing using the designated North Central Texas Foot and Ankle (NCTFA) form and presented to the Privacy Officer of NCTFA. You must provide a reason that supports yo9ur request for amendment. We will respond within sixty (60) days of your request. We may refuse to allow the amendment in the following circumstances: a) is not a part of the designated record set, b) information was not created by health care providers in this practice, c) is not available for inspection because of an inappropriate denial, or d) if the information is accurate and complete. Even if we refuse to allow an amendment, you8 are permitted to include a patient statement about the information at issues in your medical record. If we refuse to allow amendment, we will inform you in writing. If we approve the amendment, we will also inform you in writing, allow the amendment to be made, and notify others involved in your health care.

Right to an Accounting of Disclosures
The HIPPA privacy regulations permit you to request, and us to provide an accounting of disclosures that are other than for treatment, payment, healthcare operations, or made via an authorization signed by you or your representative. Request must be submitted in writing on the designated NCTFA form and presented to the Privacy Officer. Your first request of accounting within a twelve (12) month period is free. For additional request within that period we may charge you for providing the list. We will notify you of the charge, and you may withdraw or modify your request before any costs are incurred.

Appointment Reminder, Treatment Alternatives, and Other Health Related Benefits
We may contact you by telephone, mail, or both to provide appointment reminders, information about treatment alternatives, or health related benefits and services that may be of interest to you.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of the Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make a new notice provision effective for all protected health information that we maintain. We will post it, and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections haven been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services Office of Civil Rights about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPPA or to file a complaint:

The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Privacy Officer
1713 S. FM 51 Ste. 103
Decatur, TX 76234
PH (940) 627-0993
Fax (877) 796-5356

HIPPA COMPLIANCY FORM

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have reviewed the Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

_____ _____
Patient's Printed Name Date of Birth

_____ _____
Signature of Patient/ Legal Representative Date

_____
If Legal Representative, Relationship

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Review of Symptoms

Please list any prior hospitalizations and dates:

_____

_____

_____

Check any below that apply to you right now:

☐Fever	☐Chills	☐Dizziness
☐Nausea	☐Rash	☐Constipation
☐Diarrhea	☐Stomach Pain	☐Chest Pain
☐Swelling	☐Palpitation	☐Bruising
☐Abrasions	☐Joint Pain	☐Neck Pain
☐Productive Cough	☐Shortness of Breath	☐Back Pain
☐Abnormal Discharge	☐Blood in Urine	☐Unintentional Weight Loss
☐Blood in Stool	☐Weak	☐Fatigue
☐Vomiting	☐Lacerations	☐Frequent Urination
☐Other_____		

Patient Signature:_____ Date:_____

For Office Use Only:

Shoe Size: Height: Weight: Temperature: Blood Pressure:	**Notes:**

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