



Welcome to Our Office

Patient Name _____ Patient Date of Birth _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell _____ Guarantor Social Security # _____
Email Address _____
Driver's License # _____ Marital Status (circle) M S W D
Patient Employed By _____ Occupation _____
Company Address _____ Zip _____ Work Phone # _____
Sex: M / F Injury Date: _____

INSURANCE INFORMATION

Policy Holder's Name _____ Relationship _____
Address _____ Phone _____
Social Security # _____ Date of Birth _____
Primary Insurance _____ Group # _____ ID# _____
Secondary Insurance _____ Group # _____ ID# _____
Medicare # _____ Medicaid # _____
Referred By _____ Phone _____

MEDICARE ASSIGNMENT FOR COVERED SERVICES

I CERTIFY THE INFORMATION GIVEN IN APPLYING FOR PAYMENT IS CORRECT AND REQUEST PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF.

ASSIGNMENT OF INSURANCE BENEFITS

I HEREBY AUTHORIZE PAYMENT TO ED DAVIS, DPM, FACFAS FOR MEDICAL SERVICES. I REPRESENT THAT I HAVE INSURANCE COVERAGE AND DO HEREBY AUTHORIZE ED DAVIS, DPM, FACFAS TO RELEASE AND OBTAIN ALL INFORMATION NECESSARY TO SECURE PAYMENT OF SAID BENEFITS. IF MY INSURANCE FAILS TO PAY ED DAVIS, DPM, FACFAS FOR ANY REASON, I AGREE TO PAY ALL UNPAID BALANCES.

I HAVE READ AND UNDERSTAND MEDICAL PRODUCT DISCLOSURE, MEDICARE ASSIGNMENT, AND ASSIGNMENT OF INSURANCE BENEFITS AND AGREE TO ALL TERMS STATED.

SIGNATURE _____ DATE _____

PATIENT HISTORY FORM

Patient Name _____ Patient Date of Birth _____

Date you are filling out this form _____

Who is the physician or provider referring you to us? Dr. _____

What type of complaint or disease is the reason for requesting this visit?

TELL US ABOUT YOURSELF

Home Situation (circle, or add in writing):

Single Married (How long? _____) Divorced (How long? _____) Widowed (How long? _____)

Domestic Partnership Children? yes _____ no _____ Are they healthy? _____

EMPLOYMENT

Status: full-time _____ part-time _____ retired _____ disabled _____ homemaker _____

Occupation/type of work/jobs: _____

Habits: Do you smoke? No _____ Yes _____ If yes, how many packs per day? _____

If you have quit, how long ago? _____

Do you use alcohol? No _____ Yes _____ If yes, how often do you drink? _____

If you quit, how long ago? _____

Do family or friends worry about your alcohol intake? _____

MEDICAL HISTORY

Please list other diseases from which you **currently** suffer (heart, lung, etc.):

Please list other medical conditions from which you have suffered in the **past**:

Please list any surgeries (operations), reason for the surgery, and date of surgery:

SYMPTOM REVIEW

Gastrointestinal

- poor appetite
- abdominal pain
- indigestion
- trouble swallowing
- diarrhea
- constipation
- change in bowel habits
- nausea or vomiting
- rectal bleeding
- history of liver disease or abnormal liver tests

Cardiovascular

- chest pain
- history of angina or heart attack
- history of high blood pressure
- history of irregular beat
- history of poor circulation

Pulmonary/lungs

- shortness of breath
- persistent cough
- coughing up blood
- asthma or wheezing

Muscle/joint/bone

- swelling of ankles or legs, pain, weakness or numbness in:
 - arms or hands
 - back or hips
 - legs or feet
 - neck or shoulders

Neurologic

- history of stroke
- blackouts or loss of consciousness

Anything else?

- Are you experiencing an unusually stressful situation?
- Are there any specific personal issues you would like to bring up at the time of your visit?

Immunizations: If yes, give approximate year given

- | | | |
|-----------------------|----------|-----------|
| Pneumococcal | No _____ | Yes _____ |
| Hepatitis A | No _____ | Yes _____ |
| Hepatitis B | No _____ | Yes _____ |
| Tetanus | No _____ | Yes _____ |
| Do you use seatbelts? | No _____ | Yes _____ |

General

- weight gain/loss of 10+ lbs during last 6 months
- poor sleep
- fever
- headache
- depression

Eyes, ears, nose, throat

- blurred vision
- other change in vision
- history of glaucoma or cataracts
- loss of hearing
- ringing in ears
- sinus problems
- hoarseness

Genitourinary

- frequent or painful urination
- blood in urine

Skin

- itching
- easy bruising
- change in moles

Endocrine

- history of diabetes
- history of thyroid disease
- change in tolerance to hot or cold weather
- excessive thirst

Women only

- abnormal Pap smear
- bleeding between periods
- date of last mammogram _____

Men only

- PSA

Transfusions: Have you ever received a blood transfusion? No _____ Yes _____ When? _____

HIPPA PATIENT QUESTIONNAIRE

Please list family member and/or person, if any, whom we may inform about your general medical condition, your diagnosis and any billing question (including treatment, payment and healthcare operations).

As a reminder, these will be the ONLY people we will be able to speak to or release any information to regarding your account.

Name: _____ Phone: _____

Name: _____ Phone: _____

Can confidential messages (i.e. appointment reminders) be left on your telephone answering machine or voicemail? Yes _____ or No _____

Please indicate if we may mail your appointment reminder/lab/x-ray results.

Yes _____ or No _____

This form will remain in effect until you make any changes in writing.

Patient Signature

Date

FINANCIAL POLICY

Eddie Davis, DPM, FACFAS 109 Gallery Circle, Suite 119 San Antonio, TX 78258

As insurance coverage decreases and the patient's financial responsibility increases, we understand the need for clear communication of our financial policies. To better serve the needs of our patients, we have added valuable tools to help you meet your increased medical expenses.

*****NOTICE: WE DO NOT FILE TO SECONDARY INSURANCE CARRIERS****

- 1) **All coinsurance, copay, deductible and out of pocket amounts listed under your insurance carrier are due at the time of service. You may file with your secondary insurance carrier upon receipt of the explanation of payment from your primary insurance carrier.**
- 2) We will continue to look to insurance companies for their payment and assist you in receiving proper reimbursement for our services. Unfortunately, most insurances no longer cover services fully and most current insurance plans chosen by our patients require significant out-of-pocket expenses to be paid by the patient. Dr. Davis feels that it is important to recommend treatments based on their effectiveness and the best interest of the patient, not based on insurance coverage.
- 3) It is your responsibility to verify that all requirements of your insurance plan are met. We will assist you with pre-certification for procedures ordered by our office, but it is ultimately your responsibility to verify whether any care you receive is covered by your insurance. With continuous changes in coverage, it is important for you to verify your benefits and be aware of all restrictions and expenses of your plan.
- 4) In accordance with the requirements of most insurance contracts, we will require payment of office co-payments, deductible and non-covered services at the time of service. Certain services may or may not be covered and insurance companies only will make decisions after the service has been performed and submitted for payment, so it is necessary for us to collect a deposit under such circumstances. Insurance companies may take anywhere from 3 to several months to adjudicate claims and, based in Texas Administrative Code, Paragraph 3.70-3C, have up to 180 days after patient care has been completed. Patient refunds for overpayments, should that occur, will be issued by our office at 180 days after completion of patient care.
- 5) If we are a contracted provider on your primary insurance plan, we will file a claim with your carrier, and you will be billed after they have responded to our claim. Upon receipt of their response, payment or denial, you will receive a statement for the amount your insurance company notifies us is your responsibility. The State of Texas has a "prompt pay statute", 28TAC Section 21.2815 which requires health insurance companies to respond to an electronically filed claim within days. Keep in mind that the regulation requires a response, not payment. As providers we have no means to compel insurance companies to follow this regulation but encourage patients to contact their insurance companies and request a response.
- 6) If our doctor is not a contracted provider for your insurance plan, we will file a claim with the information you provide and will be billed for the entire amount. You will receive monthly statements and will look to you for payment. You will be responsible for working with your insurance company to insure prompt payment.
- 7) If you do not have your insurance card with you, you will be billed for the entire amount and asked for payment at the time of service. It is your responsibility to give us your card at each visit (if required) and inform us of any policy changes that may have occurred. We will not be able to file your insurance without a copy of your insurance card and your social security number. New patients are also required to show a photo id which helps prevent misuse of an insurance card.
- 8) If you have an insurance plan that requires a referral, we will require that the referral be here before we can see you. We do our best to assist you in obtaining a referral, but to expedite matters, it is best for you to contact your primary care physician and have them fax the referral to us or bring the referral with you.
- 9) Pre-certification for prescription drugs. Our office, as do most physicians' offices, write several prescriptions per day. We do not write letters to insurance companies/pharmacies nor fill out forms for drug pre-certification for generic drugs.
- 10) **We require New Patient appointment cancellations and surgery cancellations with our office to be made no less than 48 hours prior to your appointment/surgery time. There will be a \$50.00 fee for New patient office visit no shows and late cancellations. There will be a \$25.00 fee for established patient office visit no shows and late cancellation. A \$100.00 fee will be charged for surgery reschedule/cancellation. A \$500.00 fee will be charged for surgery day no show.**
- 11) **Any Durable Medical Equipment is non-returnable/refundable.**

Patient's signature: _____

Date: _____