



WOODYLY FOOT AND ANKLE SPECIALISTS, PC
www.woodylyfootandankle.com
 Dr. Charlton Woodyly, DPM ~ Dr. Asia N. Jackson, DPM

7208 Glenview Dr.
 Richland Hills, TX 76180
 817-284-8271 (o)
 817-284-2940 (f)

750 Eureka St. Ste. C
 Weatherford, TX 76086
 817-596-5077 (o)
 817-598-0673 (f)

TODAY'S DATE: _____

PLEASE PROVIDE YOUR
 INSURANCE CARD(S) AND
 PHOTO ID

PATIENT'S LAST NAME: _____ FIRST NAME: _____

PATIENT'S ADDRESS: _____

CITY: _____ STATE: _____ ZIP _____

HOME PHONE: _____ CELL PHONE: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

GENDER: _____ F _____ M _____ SHOE SIZE: _____ HEIGHT: _____ WEIGHT: _____

MARTIAL STATUS: _____ SPOUSE'S OR PARENT'S NAME: _____

MY FOOT PROBLEMS ARE: _____

HOW LONG HAVE YOU HAD THE PROBLEM(S): _____ DAYS: _____ WEEKS: _____ YEARS: _____

INSURANCE INFORMATION

ARE YOU THE INSURED: Y N IF NO - NAME OF INSURED: _____

PRIMARY INSURANCE: _____ GROUP # _____

POLICY# _____ EFFECTIVE DATE _____

SECONDARY INSURANCE: _____ GROUP # _____

POLICY# _____ EFFECTIVE DATE _____

COMPLETE THIS SECTION ONLY IF NAME OF INSURED IS DIFFERENT FROM PATIENT

LAST NAME: _____ FIRST NAME: _____ GENDER: F M

INSURED'S ADDRESS: _____

CITY: _____ STATE _____ ZIP _____

HOME PHONE: _____ WORK PHONE: _____

INSURED'S DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

WHAT IS THE INSURED'S RELATIONSHIP TO THE PATIENT: _____

PLEASE COMPLETE THIS SECTION

EMAIL ADDRESS: _____ PHARMACY: _____

PRIMARY CARE PHYSICIAN _____

ADDRESS: _____

CITY: _____ STATE _____ ZIP _____

PHONE: _____ DATE OF LAST VISIT: _____

X
 PATIENT SIGNATURE (OR PARENT/GUARDIAN SIGNATURE IF PT IS A MINOR) _____ DATE: _____



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Due to Health Insurance Portability and Accountability Act (HIPPA) of 1996, the following information must be filled out by each patient annually.

I authorize Charlton G. Woodly, DPM and/or Dr. Asia N. Jackson, DPM to release my medical or insurance information necessary to process my medical claims and coordinate or manage my healthcare.

YES NO

In the event a family member or caregiver attends your office visits and is the exam room at the time of your evaluation and/or treatment, I give Dr. Charlton G. Woodly, DPM of Woodly Foot and Ankle Specialists, and its physicians or employees my permission to discuss freely my condition, treatment, or diagnosis with that person.

YES NO

Does Dr. Charlton G. Woodly, DPM and/or Dr. Asja N. Jackson, DPM have permission to send a copy of your treatment note to your Primary Care Physician per his/her discretion?

YES NO

Please provide the numbers below where we have consent to leave a message:

May we leave a message at your home? **YES NO** HOME PHONE: _____

May we leave a message at your work? **YES NO** WORK PHONE: _____

May we leave a message on your cell? **YES NO** CELL PHONE: _____

May we leave a message on your pager? **YES NO** PAGER: _____

With whom may we discuss or release information about your care, treatment or diagnosis?

NAME: _____ PHONE: _____ Relationship to you? _____

NAME: _____ PHONE: _____ Relationship to you? _____

NAME: _____ PHONE: _____ Relationship to you? _____

NAME: _____ PHONE: _____ Relationship to you? _____

*****How Did You Hear About Us or Whom May We Thank For Referring You*****

LAST NAME: _____ FIRST NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

Patient/Parent/Guardian Signature _____ DATE SIGNED: _____

PRINT PATIENT'S NAME: _____



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Financial Responsibility

Durable Medical Equipment, orthotics, in-office surgery (including injections) and physical therapy are often not covered by even the most comprehensive medical insurances, including secondary to Medicare. Unfortunately, this can result in out-of-pocket expenses for you or your family. It is our policy to communicate with your insurance company to help you avoid any circumstances where you would unknowingly have out-of-pocket expenses due to non-covered benefits, deductibles, copays and coinsurance. By signing below, you assume full responsibility for all allowable charges not covered by your medical insurance.

Please contact your insurance company in advance if you have any questions about what expenses you may incur. If your insurance will not allow a service provided by our office and you prefer not to pay out-of-pocket, please let us know so we can discuss other options.

Signature of Patient (or Parent/Guardian)

Date

Woodly Foot and Ankle Specialists Signature Authorization

Information Release

I authorize the providers of Woodly Foot and Ankle Specialists, PC to release any information obtained in the course of my evaluation and/or treatment to my insurance company(ies), primary care physicians, and/or attorney(s). I further authorize any other medical provider of services to release full details of your condition to Woodly Foot and Ankle Specialists, PC for the purpose of medical treatment.

initials _____

Direct Payment

I authorize payment directly to Woodly Foot and Ankle Specialists, PC for the amount due in my pending claim for podiatry expenses payable under the terms of my insurance. I agree that I am responsible for any services or supplies that may not be covered by my insurance.

initials _____

Balance Payment

I agree that I am responsible for any balance not paid by my insurance, (including Medicare secondary insurance). I understand that if I fail to resolve any balance determined to be my responsibility, my account may be forwarded to collections.

initials _____

Photographic and Radiological Release - Clinical Records

I authorize the providers of Woodly Foot and Ankle Specialists, PC to take necessary clinical photographs and X-rays with the understanding that such records are for confidential clinical purposes only. If my insurance company requires medical records to process my claim, I authorize the release of my records for that purpose.

initials _____

Change of Information

I will use best efforts to notify Woodly Foot and Ankle Specialists PC of any change to my information (address, phone numbers, insurance company etc) in a timely manner. Should I fail to notify Woodly Foot and Ankle Specialists, PC of a change in my insurance carrier, I agree that I will be responsible for any charges not payable due to my failure to obtain any necessary referrals, authorizations, and/or coverage benefits. I realize that this is my responsibility when seeking the care of a specialist.

initials _____

I have read and fully understand the above statements. I agree that I am bound and hereby give my consent.

 Patient Signature (Parent or Guardian)

 Date



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STATEMENT OF FINANCIAL RESPONSIBILITY

PLEASE READ AND SIGN

I understand that I am responsible for any charges incurred during any visit or treatment by the doctors and staff of Woodly Foot and Ankle Specialists, PC.

initials _____

My insurance company may not cover my charges for the following reasons: My insurance company may not cover the service, my insurance may not be in effect, the charges may be applied to my deductible/co pay and/or coinsurance, I did not bring a referral for this care, the referral did not arrive in time for the visit or for any other reason deemed by my insurance.

initials _____

As a courtesy to me, the staff of Woodly Foot and Ankle Specialists, PC will make every effort to verify my insurance, its benefits and coverages, **however**, it is my responsibility to verify my plan's network, benefits and coverages for services provided by Woodly Foot and Ankle Specialists, PC. **The doctors and staff of Woodly Foot and Ankle Specialists, PC will file my insurance when appropriate, but I will be ultimately responsible for all charges.**

initials _____

I understand that payment is due at the time of service. I understand that my account will be turned over to collections if payment is not made after 61 days of 1st bill from Woodly Foot and Ankle Specialists, PC.

initials _____

***** I understand that if I am to start physical therapy there will be a one time fee for the pads that will be dispensed to me.*****

initials _____

****24 HOUR APPOINTMENT CANCELLATION NOTICE IS REQUIRED****

I Understand that a Fee of \$30.00 will be accessed to my account if I fail to provide a 24 hour cancellation notice resulting in a missed appointment.

initials _____

X _____

Patient/Parent/Guardian Signature

Services will not be provided without a signed financial statement



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Patient Name: _____

History & Medical Information

1) Explain your foot/ankle problem: Right Left _____

2) When did pain/discomfort begin (date): Days? _____ Weeks? _____ Months? _____

Describe your pain/discomfort: Burning Numbness Sharp Other _____

3) What makes the pain/discomfort better? _____

4) Have you had a physical trauma or an accident? No Yes _____

5) Occupation: _____ Is your problem work related? No Yes

6) Past Medical History

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gout | <input type="checkbox"/> Thyroid Disorders | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Nerve Disorders | <input type="checkbox"/> Prostate Disorders |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Neurological Disorders | <input type="checkbox"/> Lung/Respiratory Disorders |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Osteo Arthritis | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke | |
| | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Disease | |

7) List all medications/herbs/vitamins: _____

8) Allergies: (Describe reaction) None

<input type="checkbox"/> Penicillin	<input type="checkbox"/> Codeine	
<input type="checkbox"/> Anesthesia	<input type="checkbox"/> DEMEROL	
<input type="checkbox"/> Aspirin	<input type="checkbox"/> MYCINS	
<input type="checkbox"/> Sulfa	<input type="checkbox"/> TAPE	<input type="checkbox"/> Other _____

9) Surgical History: Have you had surgery? Yes No

10) Social History: (only check was is pertinent to you)

<input type="checkbox"/> Tobacco Use	<input type="checkbox"/> ALCOHOL USE	<input type="checkbox"/> Exercise Habits _____
<input type="checkbox"/> Caffeine Use	<input type="checkbox"/> DRUG USE	