# TEXAS FOOT & ANKLE SPECIALISTS
**A DIVISION OF STRIDE HEALTHCARE**

**Dr. William Arrington · Dr. Justin Wade· Dr. Michael Birau ·Dr.Will Stephens**

Patient Name: _____ Date of Birth: _____ Sex: ____M ____F

Adress: _____
Street Apt. No City State Zip

Home#: _____ Work#: _____ Cell#: _____

Email: _____ ** Circle preferred method for reminder calls.

Emergency Contact: _____ Emergency Phone: _____ Relationship: _____

Primary Language: _____ Race: _____ Ethnicity: _____ Social: _____

**Marital Status (circle):** Married Single Divorced Widowed Partner **Employed: __Y__N Employer:** _____

**Employer Address:** _____ **Phone:** _____ **Fax:** _____

**Preferred Pharmacy:** _____ **Pharmacy Phone:** _____

**Pharmacy Location and/or Address:** _____

**PRIMARY CARE PHYSICIAN** **Must be a doctor of Family Medicine, Primary care, Internal Medicine, Endocrinology

Name: _____

Primacy Physician Phone: _____ Date Last Seen: _____

***PLEASE NOTE: Medicare related Insurances require that a Primary Care Physician be listed for certain services to be paid***

**HOW DID YOU HEAR ABOUT US? (circle)**

Physician Internet Insurance Friend Family· Other _____

## INSURANCE INFORMATION

**PRIMARY INSURANCE NAME:** _____ Employer: _____

Policy Holders Name: _____ Social Security #: _____

Policy Holders Date of Birth: _____ Patient Relationship to Policy Holder: _____

**SECONDARY INSURANCE NAME:** _____ Employer: _____

Policy Holders Name: _____ Social Security #: _____

Policy Holders Date of Birth: _____ Patient Relationship to Policy Holder: _____

Patient's Signature: _____ Date: _____

# TEXAS FOOT & ANKLE SPECIALISTS
A DIVISION OF STRIDE HEALTHCARE

**Dr. William Arrington · Dr. Justin Wade · Dr. Michael Birau · Dr. Will Stephens**

**Patients Name:** _____ **Shoe Size:** _____

**Reason for your visit:** _____ **Pain Level:** _____

**Alcohol Intake (circle):** None Daily Occasionally Rarely **Caffeine Intake (circle):** None Daily Occasionally Rarely

**Smoker:** _____ pack(s)/day X _____ years **Previous smoker:** YES NO **How much/long:** _____

**Height:** _____ ft _____ in **Weight:** _____ lbs

**Date of Last Flu Vaccine:** _____ **Pneumonia Vaccine:** _____ **COVID Vaccine:** _____

**Medications: List current medications:**

_____ _____

_____ _____

**Past Medical History: If you have or have had any of the following conditions, please Check ALL that apply.**

- ☐ Athlete's Foot
- ☐ Atrial Fibrillation
- ☐ Bipolar Disorder
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Cancer
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Currently Pregnant
- ☐ Deep Vein Thrombosis (DVT)
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes I
- ☐ Diabetes II
- ☐ Dialysis
- ☐ Eczema
- ☐ Endocrine Disorder
- ☐ Epilepsy
- ☐ Fibroid Tumors
- ☐ GERD
- ☐ Glaucoma
- ☐ Gout
- ☐ HIV/AIDS
- ☐ Heart Attack
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Immune Disease
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Lymphedema
- ☐ Nail Disease
- ☐ Neuropathy
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Peripheral Arterial Disease (PAD)
- ☐ Peripheral Vascular Disease (PVD)
- ☐ Psoriasis
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Disease
- OTHER:

**Allergies (circle): Penicillin, Sulfa Drugs, Aspirin, Codeine, Iodine, Tape, Cortisone, Local Anesthesia, General Anesthesia, Tramadol,**
**Other:** _____

**Family History: Please circle any medical conditions that run in your family and write which member(s) affected.**

**Diabetes** _____ **Gout** _____ **Heart Disease** _____ **Circulation Problems** _____ **High Blood Pressure** _____

**High Cholesterol** _____ **Other** _____

**Surgeries: List all surgeries you have had. Begin with the most recent. Please give month, date and year if possible: MM/DD/YYYY**

_____

_____

**If diabetic, who treats your diabetes?** _____ **Phone #:** _____

**Last A1C?** _____ **Date Performed:** _____ **Performed by:** _____

# TEXAS FOOT & ANKLE SPECIALISTS
A DIVISION OF STRIDE HEALTHCARE

**CHIEF COMPLAINT / HISTORY OF PRESENT CONDITION** _____.

Current foot problem(s): _____

_____

_____

Please circle all that apply →

**COURSE**

Intermittent / Constant

Progressive / Varied

**LOCATION**

left / right / foot / ankle / 1st toe

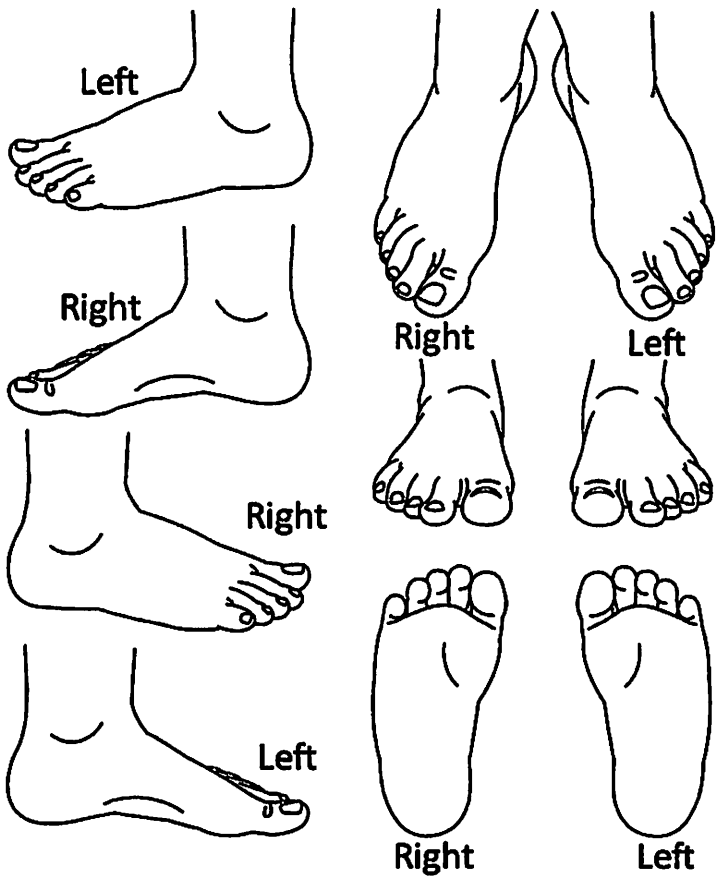
2nd toe / 3rd toe / 4th toe / 5th toe

**NATURE**

sharp / dull / achy / burning

stabbing / tingling / numbness

Please circle your problem areas on the diagram below:




---

**Duration**(how long have you had the problem):

_____

_____

_____

**Onset**(how did it start/any injury or trauma):

_____

_____

_____

**Aggravating Factors**(what makes it worse):

_____

_____

_____

**Treatment**(have any treatments been done):

_____

_____

_____

StrideCare

**Your doctor is a member of StrideCare, a multi-specialty network of providers focused on delivering comprehensive lower extremity care. Below you will find important questions that will help us determine whether you are at risk for vascular disease and might benefit from early detection and treatment options.**

**Please take a moment to answer the questions below:**

| | | |
|---|---|---|
| Have you ever had any testing done to your legs for poor circulation? | ☐ YES | ☐NO |
| **RISK FACTORS** | | |
| Have you ever been told you have diabetes? | ☐ YES | ☐NO |
| Do you have high blood pressure or are you on blood pressure medication? | ☐ YES | ☐NO |
| Do you have high cholesterol or are you on a medication to lower your cholesterol? | ☐ YES | ☐NO |
| Do you smoke or have you ever smoked? | ☐ YES | ☐NO |
| Have you ever been told that you have had a heart attack or stroke? | ☐ YES | ☐NO |
| Has anyone ever told you that you have poor circulation in your legs, intermittent Claudication (pain with activity that improves with rest) or peripheral arterial disease? | ☐ YES | ☐NO |
| Have you ever had an angioplasty or stent placed in the heart or leg? | ☐ YES | ☐NO |
| **SYMPTOMS OF Arterial Conditions** | | |
| Do you have any infections or sores that are not healing on your legs, feet or toes? | ☐ YES | ☐NO |
| Has your walking pace slowed enough to significantly alter your daily activities? | ☐ YES | ☐NO |
| Do your legs ever feel tired or heavy causing you to stop and rest? Do they get better with rest? | ☐ YES | ☐NO |
| When you walk, do you ever have to stop because you have pain or cramping in your calves, thighs, or buttocks? Does the pain go away with rest? | ☐ YES | ☐NO |
| Do you ever experience cramping, tightness, "Charlie horses" or pain in the legs or feet when lying down that improves when you stand up? | ☐ YES | ☐NO |
| Have you given up things you once enjoyed doing over the last year due to leg fatigue, weakness, or discomfort? | ☐ YES | ☐NO |
| Have you ever had trauma to either of your legs? | ☐ YES | ☐NO |
| Do you have any infections or sores that are not healing on your legs, feet or toes? | ☐ YES | ☐NO |
| **SYMPTOMS OF Venous Conditions** | | |
| Do you have aching/pain in your legs? | ☐ YES | ☐NO |
| Do you get cramps in your legs? | ☐ YES | ☐NO |
| Do your legs feel heavy? | ☐ YES | ☐NO |
| Do you get itching or burning in your legs? | ☐ YES | ☐NO |
| Do you have restless legs? | ☐ YES | ☐NO |
| Discoloration/darkening of the skin below your knee? | ☐ YES | ☐NO |
| Episodes of redness or inflammation below the knee? | ☐ YES | ☐NO |
| Do you have swelling in your legs, ankles, or feet? | ☐ YES | ☐NO |
| Throbbing in your legs? | ☐ YES | ☐NO |
| Do your legs feel tired/fatigued? | ☐ YES | ☐NO |
| Do you have varicose veins or spider veins? | ☐ YES | ☐NO |
| Sores, ulcers, wounds that are difficult to heal? | ☐ YES | ☐NO |
| **At StrideCare we deeply value our patients and want to provide you excellent service. Would you give us permission to contact you to discuss your vascular health and options for lower extremity care?** | ☐ YES | ☐NO |

# TEXAS FOOT & ANKLE SPECIALISTS
A DIVISION OF STRIDE HEALTHCARE

**Dr. William Arrington · Dr. Justin Wade · Dr. Michael Birau · Dr. Will Stephens**

**Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.**

- **As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.**
- **Unless other arrangements have been in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.**
- **Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctors. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within 60 days, you will receive a bill.**
- **All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.**
- **You must inform the office of all insurance changes and authorization/ referral requirements. In the event the office is not informed, you will be responsible for any charges denied.**
- **There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery or at the time of your Pre-op appointment.**
- **Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due to the office.**
- **Patients who are 90 days past due on their balance will be sent to collections unless a payment plan has been put into place.**
- **There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.**
- **In fairness to all our patients, we understand that emergencies occur, but repeated no shows or cancellations with less than 24 hours' notice will result in a fee of $25.00. You might be asked to pay before you are seen by the doctor.**
- **Patients who come to office fifteen minutes later than scheduled appointment might be asked to reschedule.**

**Signature of Patient/ Responsible Party:** _____ **Date:** _____

# TEXAS FOOT & ANKLE SPECIALISTS
A DIVISION OF STRIDE HEALTHCARE

Dr. William Arrington · Dr. Justin Wade · Dr. Michael Birau · Dr. Will Stephens

## HIPAA COMPLIANCE PATIENT CONSENT FORM

**The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. The terms of this notice may change. If so, you will be notified at your next visit to update your signature and date.**

**By signing this form, you consent to our use and disclosure of your protected healthcare information according to the indications below.**

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- This privacy policy may be changed by the practice, when necessary, as required or allowed by law.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- This privacy policy will stay in effect until the time that it is revoked by the patient or changed as required by law.

**PLEASE INDICATE YOUR PREFERENCES REGARDING YOUR PERSONAL HEALTHCARE INFORMATION:**

| | | | |
|---|---|---|---|
| **Health notifications:** | **____ E-mail** | **____ Phone** | **____ Text message** |
| **Auto Appointment Reminders:** | **____ E-mail** | **____ Phone** | **____ Text message** |
| **Practice Announcements:** | **____ E-mail** | **____ Phone** | **____ Text message** |
| **Billing information:** | **____ E-mail** | **____ Phone** | **____ Text message** |

**Please indicate the phone number and/or e-mail you would like to use below:**

_____

**May we discuss your medical condition with a family member? ____ Yes ____ No**
**If YES, please list the name of the members allowed:**

_____ **Relationship to patient** _____

_____ **Relationship to patient** _____

**I consent to have my medical records shared with other Texas Foot & Ankle/ Stride Healthcare providers.**
**____ Yes ____ No - Only upon my request**

**I consent to have my medical records shared with my care providers outside the Stride Healthcare network.**
**____ Yes ____ No - Only upon my request**

**This consent was signed by:** _____
**(PRINTED NAME PLEASE)**

**Patient or Guardian Signature:** _____ **DATE:** _____

TEXAS FOOT & ANKLE SPECIALISTS
A DIVISION OF STRIDE HEALTHCARE

# NOTICE OF PRIVACY POLICY

Effective date: December 2014

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully; you will be asked to sign a document indicating that you have received and reviewed this document.

## *About This Notice*

State and federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this notice. We must follow the privacy practices as described below. This Notice will take effect on your first date of service with us following December 1, 2014 and will remain in effect until it is amended or replaced by us. It is our right to change our privacy practices provided state and federal laws allow the changes. Before we make a significant change, this notice will be amended to reflect the changes and we will make the Notice available upon request. You may request a copy of our privacy notice at any time by contacting our front desk agent at the phone number, fax, or address indicated above.

## *Typical Uses and Disclosures*

Your information including any health information that is collected from you or created or received by our office that relates to past, present, or future physical or mental health or to a health condition that could potentially identify you will be treated as confidential and "need to know" by our office. The following purposes are examples of regular and allowable usage of your information, though this list is not all-inclusive.

**Treatment:** We may use your health information to provide you with our professional, medical services. We have established a "minimum necessary" standard that limits employee access to your information to allow only access to that information necessary to fulfill their primary job functions. Everyone on our staff is required to sign a compliance statement indicating their commitment to keep your information confidential and protected.

**Disclosure:** We may disclose or share your healthcare information with other health care professionals, including your other physicians, your insurance companies, etc. who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy similar to this one. Your information may also be accessed by our business trading partners who assist in electronic claims submission and supporting our medical records software. These companies have signed legal agreements to protect your information in the same manner we do. Health information about you may also be disclosed to your family, friends or other persons as designated by you on your HIPAA form signed at your initial patient encounter. This authorization form is in effect from the date completed by you forward without expiration, but you

may request to update or alter your designated information recipients at any time. Using the HIPAA form, you may also restrict the types of information your designated individuals can receive.

**Payment:** We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the mailing of statements or collecting unpaid balances.

**Emergencies:** We may use or disclose your information to notify, assist in the notification of a family member or anyone responsible for your care in case of any emergency involving your care, location, general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our best professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays, or other similar forms of health information and/or supplies unless you have advised us otherwise.

**Healthcare and Business Operations:** We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities. We may also disclose medical information for management or financial audits or evaluations.

**Required by Law:** We may use or disclose your health information when we are required to do so by law, for example: court or administrative orders, subpoena, discovery request or other lawful process. We will use and disclose your information when requested by national security, intelligence and other local, state and federal law officials and/or if you are an inmate or otherwise under the custody of law enforcement. The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials. If you are an inmate, we may release your information to the correctional facility for continued care. We may also provide information to coroners or medical examiners attempting to identify remains or to organizations handling procurement of organs and tissues for transplantation.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or to the health or safety of others.

**Public Health Responsibilities:** We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury, and/or disability.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders, including but not limited to, voicemail messages, e-mails, postcards, or letters.

**Research:** Under some circumstances, we may use and disclose medical information about you for research purposes, for example comparing outcomes of patients who receive a certain treatment. All research projects do require that you be noticed and approve the use of your identifiable information (name or

address, for example) if such is required for the research report. Wherever possible this type of information will be restricted.

**Change of Practice:** In the event that partners or associates are added to the practice, they will have full access to the records created under the existing physicians. If the Practice owners decide to sell the practice, all patient information may be disclosed to another health care facility or group of physicians in a sale, transfer, merger, or consolidation of the practice.

**Marketing Health-Related Services:** We will NOT communicate your health information for marketing purposes or any other purpose where our Practice would receive payment without prior written authorization to do so. Our office does not participate in the sale of patient information. If, in the future, the Practice engages in any fundraising via communication to you, you will be given the option to opt out of receiving such items.

## *YOUR RIGHTS*

You have the **right to obtain a copy of this notice** at any time. You also have the **right to inspect and get copies of your health information** (and that of an individual for whom you are legal guardian) with the proper request form and 72 hours processing time. Once your request is approved, an appointment can be made for you to review your protected information. Copies in excess of 5 pages, if requested, may be subject to a fee which must be paid at the time the copies are received. Our front-desk agent can provide the proper form when requested. If copies are mailed, postage charge will also be included and payment must be received prior to mailing. If you prefer a summary or explanation, we can provide that instead. Under limited circumstances, we may deny your request but will allow a review by a third party healthcare professional of our choice. We will abide by the review determination.

You have the **right to amend your information** if you feel it is inaccurate or incomplete. Your request must be in writing and include an explanation of why the information should be amended. Under certain circumstances, your request may be denied with an explanation of the denial. You also have the **right to restrict** which individuals can receive information about you using your HIPAA form completed when you began seeing our physicians. While we do not typically offer information to your health/insurance plan regarding items you pay for out of pocket, you do have the right to restrict this information so that it will not be disclosed even if specifically requested. A new HIPAA form can be completed upon request at any time and will replace any previous forms you had submitted effective upon the date of your signature and completion. Though we can deny the restrictions, we will try to comply wherever possible. You have the **right to an accounting of our information disclosures.** If a disclosure is made for a non-typical use as defined above, our employees are required to document the disclosure; routine disclosures are not recorded. At any time, you may request an accounting of these disclosures. To request this accounting, please provide a written request and allow us 72 hours for processing of your request. This accounting will include dates of disclosures, to whom the information was disclosed, and what information was disclosed. Our office will abide by this policy, and subsequent changes, to protect your health records until 50 years after your demise at which point privacy laws no longer apply.

You also have the **right to request a particular correspondence method.** To request that the Practice communicate in a certain manner, please make your request in writing and specify exactly which method of contact you prefer; you do not need to state a reason for your request. We will make every effort to accommodate all reasonable requests. Our office does use a patient portal in connection with email correspondence. While the patient portal is a secure site used for transmitting confidential information,

email itself is not considered a secure means of communication. If you request to receive documentation, including personal health information, via email, we will provide it to you in that format at your own risk.

## *CHANGES TO THIS NOTICE*

We reserve the right to change our policies and make new provisions effective for all personal h ealth information that we maintain. Should our information practices change, we will post the amended Notice of Privacy Practices in our office and on our website. You may request that a copy be provided to you.

## *BREACHES OF INFORMATION*

In the event that unsecured (unencrypted) confidential information about you is 'breached' and the use of the information poses a significant risk of financial, reputable, or other harm to you, we will notify you of the situation and any steps you should take to protect yourself against harm due to the breach. We will also inform any other parties required under our legal obligations determinant upon the extent of the breach.

## *QUESTIONS AND COMPLAINTS*

If you have any questions or would like further explanation or clarification of this policy, please ask any of our employees and they will direct you to the proper individual to have the issues addressed or explained. If you feel we may have violated your privacy rights, or if you disagree with a decision we made reg arding your access to your health information, you may file the complaint in the form of a written letter to:

Privacy Compliance Officer
Texoma Foot and Ankle Specialists
101 N. US Highway 75
Denison, TX 75020

We support your right to the privacy of your information and will not retaliate if you choose to file a complaint with us or with the U.S. Department of Health and Human Services (HHS). All complaints must be filed within 180 days of when you knew or should have known that the act occurred.