Dr. Francine Rhinehart, DPM
2100 W Colorado Blvd. Dallas Tx. 75211
Tel: (214) 865 9968 | Fax: (469) 543 3301

Please fill out completely or mark areas "n/a" if they do not apply

PATIENT INFORMATION:

Name _____ Birth Date _____ Sex: _____

Social Security Number _____ Marital Status:

Race: Ethnicity:

Address:

City/State Zip

PRIMARY Phone (___) ___-____ Email:

Are you employed? Name of Employer:

Emergency Contact _____ Relationship _____

Home Phone (___) ___-____ Cell Phone (___) ___-____ Other (___) ___-____

PRIMARY CARE DOCTOR:

_____ Phone: (___) ___-____ _____

NAME OF PCP DATE LAST SEEN

INSURANCE: *Please give **ALL** cards to the receptionist so we may copy them to your patient chart.*

Primary Insurance Company Name _____

Secondary Insurance Company Name _____

RESPONSIBLE PARTY: *The person who supplies the patient's insurance or who is responsible for payment if uninsured*

Name _____ Social Security Number _____ DOB _____

Relation to Patient _____ Phone (___) ___-____ Other (___) ___-____

PHARMACY INFORMATION:

_____ _____ Phone (___) ___-____

NAME OF PHARMACY CITY/ZIP CODE

I certify that the above insurance information is current and accurate; I authorize assignment of insurance to Francine Rhinehart DPM. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. F. Rhinehart DPM and its representatives may use my health care information and may disclose such information to the above-named insurance company for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services received. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____ _____

PATIENT NAME (PRINT) PATIENT SIGNATURE DATE

All information provided on this form will remain confidential in compliance with our HIPAA guidelines

Medical History

Have you ever been treated for (select all that applies):

- ☐ Corns/Calluses
- ☐ Warts
- ☐ Athlete's Foot
- ☐ Fungal Nails
- ☐ Ingrown Nails
- ☐ Neuroma
- ☐ Leg/Foot Ulcers
- ☐ Foot Numbness
- ☐ Bunions
- ☐ Broken Foot/Bone
- ☐ Broken Ankle
- ☐ Ankle Sprain
- ☐ Hammer/Mallet Toe
- ☐ Leg/Foot Cramp
- ☐ Flat Feet
- ☐ Arch pain
- ☐ High Arch Feet
- ☐ Knee Pain
- ☐ Lower Back Pain
- ☐ Heel Pain
- ☐ Rash
- ☐ In-Toeing
- ☐ Toe Walking
- ☐ Gait Problems
- ☐ Childhood Foot Problems

Do you get leg cramps after activity?

Does foot pain limit your desired activities?

Do you have any difficult walking?

Any pain in the calves or buttocks when walking?

Is the pain relieved by stopping & standing still?

List the sports and other actives in which you are involved:

_____

_____

_____

Patient Medical History: Have you ever been treated for:

- ☐ Stroke
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Phlebitis
- ☐ Vascular Disease
- ☐ Heart Condition
- ☐ Anemia
- ☐ Poor Circulation
- ☐ Eyes: Glaucoma
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Keloid/Thick Scar
- ☐ Gout
- ☐ Osteoporosis
- ☐ Alzheimer's
- ☐ Sciatica
- ☐ Lyme's Disease
- ☐ Rheumatic Fever
- ☐ Arthritis
- ☐ Headaches
- ☐ Hearing/Ear Disorder
- ☐ Epilepsy
- ☐ Nerve Disorder
- ☐ Psychiatric Disorder
- ☐ Asthma
- ☐ Lung Disease
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Thyroid Problem
- ☐ Dark Urine
- ☐ Chronic Light Stool
- ☐ Weight Loss
- ☐ Cancer
- ☐ Stomach Ulcer
- ☐ None of the above

Other: _____

Surgical History: Surgical procedures and complications:

_____

_____

_____

Past Family & Social History

List immediate family members who have had:

Diabetes _____ Foot Problems _____

Arthritis _____ Heart Attack _____

Stroke _____ High Blood Pressure _____

Cancer _____ Birth Defects _____

# of Childbirths ____ Are you currently pregnant?

Are you slow to heal after cuts

Any abnormal bruising, bleeding or scarring?

Do you smoke now?

Did you ever smoke?

If you quit, what year did you do so? _____

Alcohol use? ☐ None ☐ Rarely ☐ Moderately ☐ Daily ☐ Quit

Recreational Drugs?

Are you currently taking any medications?

Are you taking Insulin?

List medications, dose & purpose below:

_____

_____

_____

_____

_____

_____

Are you taking your medications as prescribed?

Allergies: Is there a history of skin reaction or other outward reaction or sickness following an injection, oral or topical administration of:

- ☐ Latex, Adhesive tape
- ☐ Penicillin
- ☐ Other antibiotics
- ☐ Empirin, Tylenol
- ☐ Aspirin, Advil, Aleve, Motrin
- ☐ Celebrex
- ☐ Other pain remedies
- ☐ Morphine
- ☐ Codeine
- ☐ Other narcotics
- ☐ Novocaine
- ☐ Other anesthetics
- ☐ Sulfa drugs
- ☐ Shrimp, Iodine or Merthiolate

Clearly list additional medication, drugs, foods, etc.

_____

_____

_____

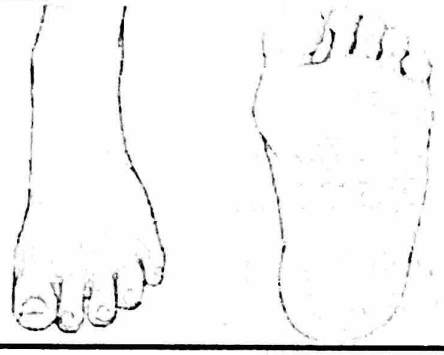
_____

Review of Systems: Are you currently experiencing any of the following:

General:	☐ Decreased Strength	☐ Weight change	☐ Decreased exercise tolerance				
Head:	☐ Headaches	☐ Vertigo	☐ Injury				
Eyes:	☐ Abnormal vision	☐ Double vision	☐ Diminished vision	☐ Increased drainage	☐ Pain		
Ears:	☐ Change in hearing	☐ Tinnitus	☐ Bleeding	☐ Vertigo			
Nose:	☐ Nose bleed	☐ Obstruction	☐ Discharge	☐ Inflammation of mucous membrane			
Mouth:	☐ Dental difficulties	☐ Gum bleeding	☐ Use of dentures				
Neck:	☐ Stiffness	☐ Pain	☐ Tenderness	☐ Noted masses			
Chest:	☐ Shortness of breath	☐ Wheezing	☐ Cough	☐ Spitting up blood			
Heart:	☐ Chest pains	☐ Palpitations	☐ Fainting	☐ Breathlessness			
Abdomen:	☐ Difficulty Swallowing	☐ Appetite change	☐ Vomiting	☐ Bowel habit changes	☐ Tarry Stool	☐ Pain	
Neurologic:	☐ Weakness	☐ Tremor	☐ Seizures	☐ Changes in mentation	☐ Lack of muscle control		
Psychiatric:	☐ Depressive symptoms	☐ Change in sleep habits		☐ Changes in thought content			

Patient's Current Chief Complaints (CC)/History of Present Illness (HOPI)

LEFT FOOT



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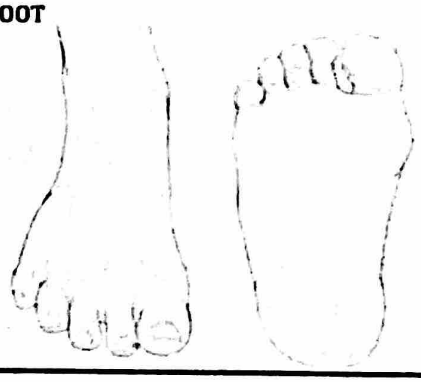

Indicate the location of your problem or pain on the diagrams above.

Does the pain radiate anywhere else on the foot/leg? ☐ Yes ☐ No

Indicate the severity of pain/discomfort

☐ None ☐ Light ☐ Moderate ☐ Strong ☐ Severe

How long ago did pain/discomfort start?

☐ Years ☐ Months ☐ Weeks ☐ Days ☐ Hours

Pain occurs while

☐ Walking ☐ Standing ☐ Running ☐ Wearing Shoes

Does pain/discomfort cause difficulty with daily activity? ☐ Yes ☐ No

Pain discomfort is

☐ Aching ☐ Burning ☐ Dull ☐ Sharp ☐ Tender ☐ Throbbing ☐ Tingling

Is this problem work related? ☐ Yes ☐ No

Date of injury: _____ Date of report to employer: _____

FOR STAFF USE ONLY

Physician's notes:

Patient's Vitals:

Patient's Height & Weight:

Patient's Shoe Size:

Misc.:

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AUTHORIZATION OF MEDICAL INFORMATION

Please read the following questions carefully and sign at the bottom of the page. You have the right to review our privacy practices at any time.

Please refer to our HIPAA notice located in our reception area.

☐ I have read and understand the HIPAA notice.

☐ I decline reading the HIPAA notice but, am fully aware that it is always available to me.

Please **CHECK** where we may leave a message if necessary:

☐ HOME ☐ ANSWERING ☐ WORK ☐ CELL PHONE

May we discuss your medical condition with members of your family or friends? YES ☐ NO ☐

If **YES**, please list the name of that person and their relationship to the patient.

NAME: _____

RELATIONSHIP TO PATIENT: _____

PHONE NUMBER: _____

Please list ANY information from your medical record you would **NOT** like Dr. Francine Rhinehart DPM to disclose:

_____

_____

_____

I give permission to Francine Rhinehart DPM *o release information, either verbal or written regarding my medical condition only, for the purpose of medical management.*

_____
Patient Name (print)

_____ _____
Signature of Patient/Legal Guardian Date

This release may be rescinded at any time in writing from the patient/legal guardian.

Please note: Dr. Francine Rhinehart DPM HIPAA policy is in effect for the entire time you are a patient of ours not just for the date that you sign the policy. If we have any changes we will have you fill out a new form at that time.

FINANCIAL INFORMATION

Traditional Medicare Insurance:
Our office participates with Medicare. This means that we will send your claim to Medicare and we will adhere to Medicare's allowable fee schedule. Medicare sets an allowable fee for each service that they cover. Once you have met your annual deductible Medicare will pay us 80% of the allowable fee and you will be responsible for the remaining 20%. If you have a secondary insurance this amount will then be sent on to them and you will be billed for any remaining balance after their payment.

Medicare has strict guidelines concerning their coverage of routine foot care such as trimming nails, or paring corns and calluses. The doctor will be able to determine if your routine foot care is or is NOT covered by Medicare. **Should you have a non-covered service such as this performed, you will be asked to pay for that service at the time of your appointment. We will also ask you to sign Medicare's Advanced Beneficiary Notice (ABN) indicating you were informed that Medicare will not be paying for that particular service.** The ABN will be provided at the time of visit.

If you have any other service such as a new patient office visit or a visit for a new problem performed on the same day as routine nail care or another non-covered service, Medicare will be billed for the covered service and we will collect the uncovered service fee from you that day as well.

All Other Insurances including Medicare Replacement Plans:
Dr. Francine Rhinehart DPM (F.R DPM) will submit your claims to all other insurance companies providing:

- At each visit we receive a copy of all current insurance identification cards.
- Our Patient Information Form is current and correctly completed.
- Our Financial Policy is signed.

If we have not heard from your secondary insurance within 60 days, you will be billed directly. In that event you must contact the insurance company directly to find out why your claim has not been paid. **It is the patient's responsibility to give us their current insurance information.** If we do not have a copy of your current insurance card, or have received incorrect or old insurance information, all charges will become the patient's responsibility. **All uncollected co-pays and co-insurances from prior visits will be due at the time of your next appointment,** as specified in your insurance contract and mandated by your carrier in our participating provider agreement.

For your convenience F.R DPM accepts cash, all major credit cards, debit cards, and personal checks. Payment is expected at each visit.

You will receive a billing statement for all personal balances due. If we have not received a response from you by phone or received a payment or letter regarding your unpaid balance within 90 days, your account will be sent to our collections department.

No Insurance:
If you do not have health insurance, charges for the day's medical service are due at the time of service unless other arrangements have been made with the office in advance. In many cases a cash payment discount may be given to patients without health insurance.

Care Credit:
This is offered as a payment option for patients who qualify. Please speak to the office staff if you would like more information.

There is a $35.00 fee assessed for returned checks. F.R. DPM understands that unexpected financial problems do arise. We encourage you to contact the office at (F.R DPM immediately for assistance in managing your account.

Referrals/Authorizations:
It is the patient's responsibility to obtain all referrals if your insurance requires one. We will do all we can to assist you, but it is ultimately your responsibility. If a required referral is NOT in place PRIOR to your appointment, we may reschedule the appointment until it is received.

FMLA/Disability Forms:
The doctor at F.R. DPM will complete your first insurance disability form for you at no charge. **You will be charged a fee of $25.00 for every disability form to be completed thereafter. The fee is payable upon presentation of the forms. The forms will NOT be completed until the $25.00 fee is received.**

I understand that there is a $10.00 fee for copies of medical records. Please call office to request medical records if necessary.

Missed Appointment Policy:
F.R. DPM reserves the right to charge a patient for a missed appointment. If you cannot make your scheduled appointment, you should give us 24 hours notice. A charge for a missed appointment is NOT a charge for the service itself. One missed appointment, or severe weather problems will NOT result in a patient being charged. **Consecutive missed appointments or repeated missed appointments will be assessed at a fee of $30.00 for each missed appointment.** Habitually missed appointments could lead to a patient being discharged from the practice.

Collections:
F.R. DPM will attempt to make payment terms that meet your needs. If we do not hear from you by phone, mail or partial payment within 90 days of a statement being sent, you may be referred to a collection agency. In the event your account is assigned to collection, the patient agrees to be responsible for a 25% collection fee, as well as all court costs and attorney fees.

I understand that if a custom DME product is ordered for me, such as orthotics or special shoes, or I receive an air cast, night splint, surgical shoe, and ankle brace, Dyna-Flex Plate or Powersteps, that they are non-refundable and non-returnable. If my insurance denies them for any reason, I understand it is ultimately my responsibility and I will pay for the product(s) I have received.

I understand that Francine Rhinehart DPM financial policy is in effect for the entire time I am a patient not just for the date that I sign the policy. If More Than Just Podiatry has any changes, our office will have you fill out a new form at that time.

I authorize Dr. Francine Rhinehart DPM to release information regarding my medical history and treatments to my insurance company in order for them to be paid. I also authorize payments for services to be paid directly to Dr. Francine Rhinehart DPM from my insurance company.

I understand that unpaid balances have to be paid prior to making a follow up appointment. I understand that I will speak with an office staff to initiate a payment plan if my balance is unmanageable.

I acknowledge by signing my name below, as the patient or guardian of the patient, that I have read and initialed all of the above financial disclosures and understand and will comply. I have asked questions, if necessary, and I have had those questions answered and I understand.

Print: _____ Date: _____

Signature: _____ Date: _____

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Authorization for Use or Disclosure of Protected Health Information

Name of Patient: _____ Date of Birth: _____

Social Security #: _____ Contact: _____

Address: _____
Street City/State Zip Code

I, _____ hereby authorize _____ to disclose my medical records as indicated below to:

_____
Name of Company, Provider, Individual

_____
Address City State Zip Code

Specific information to be released:
- ☐ Office Visits
- ☐ Lab Reports
- ☐ X-Ray Reports
- ☐ Consult Reports
- ☐ Operative Reports
- ☐ Other _____

My purpose/use of the information:
- ☐ Changing physicians
- ☐ Continuing care
- ☐ At my ( ) request
- ☐ Workers' Compensation
- ☐ Other _____
- ☐ 2nd Opinion
- ☐ Legal
- ☐ Insurance
- ☐ School

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:

YES, DISCLOSE THIS INFORMATION • _____

NO, DO NOT DISCLOSE THIS INFORMATION • _____

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient/facility receiving it, and would then no longer be protected by Federal privacy regulations.

I may revoke this authorization by notifying Dr. Francine Rhinehart DPM in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

I understand that this authorization will expire on _____ OR 6 months from date of release. A photocopy of this form will be considered as valid as the original.

By signing below, I acknowledge that I have read and understand this Authorization

• _____ _____ _____
Signature of Patient/Legal Guardian Relationship to Patient Date

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places.

Federal/state laws permit a fee to be charged for the copying of patient records. Fee of $25.00 is to be paid at the time of collection. Based on HB 351, new maximum fees for copying will be $27.13 plus $0.62 per page for the cost of labor and supplies for copies provided in paper form and $27.13 for additional costs if records are maintained off-site. Based on HB 351, the new maximum fees for copying will be $24.85 plus $0.57 per page, or $108.88 total, whichever is less, for copies provided electronically.

_____	_____
Records Received By	Date
For Office Use Only	
Date Request Filled: _____	By _____
Patient Account # _____	
Photo ID Presented: _____	Fee: $25.00