Bluebonnet Foot and Ankle Institute, LLC

REGISTRATION FORM

(Please Print)

Today's date:	Primary Care Provider:

PATIENT INFORMATION

Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Maiden Name:	Race:	Ethnicity ❑ Hispanic/Latino ❑Not Hispanic/Latino ❑ Refused	Birth date: / /	Age:	Sex: ❑ M ❑ F
Social Security #	Address:				Home # : ( ) Cell #: ( )
P.O. Box:	City:	State:	ZIP Code:		
Occupation:	Employer:		Employer phone #: ( )		
Preferred Pharmacy(w/address):					
Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital		
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other	
Other family members seen here:					
Email address for portal registration:					

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Subscriber Name:	Birth date: / /	Address (if different):		Home phone #: ( )	
Is this person a patient here? ❑ Yes ❑ No					
Occupation:	Employer:	Employer address:		Employer phone #: ( )	
Is this patient covered by insurance? ❑ Yes ❑ No	Insurance Carrier:				
Insurance Address:	Insurance Phone #: ( )	Birth date: / /	Group #:	Policy #:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:		Group #:	Policy #:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #: ( )	Work phone #: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Bluebonnet Foot & Ankle Institute, LLC or insurance company to release any information required to process my claims.

Patient/Guardian signature **Date**

Bluebonnet Foot and Ankle Institute, LLC

HEALTH HISTORY FORM

Name:_____ **Sex** ☐Male ☐Female

Date of Birth_____ **Number of Children** _____
Best Phone # to reach you to discuss results _____
Local Pharmacy_____
Mail order Pharmacy_____
Occupation_____
Do you drink alcohol? ☐Yes ☐No **Exercise Level** None Occasional Moderate Heavy
Do you smoke? ☐Yes ☐No **Diet** Regular Gluten Free Diabetic
Do you use illegal drugs? ☐Yes ☐No

PAST MEDICAL HISTORY

Have you ever had any of the following conditions?

Anxiety	□Yes	□No
Arthritis	□Yes	□No
Asthma	□Yes	□No
Atrial Fibrillation	□Yes	□No
(BPH)Enlarged Prostate	□Yes	□No
Bone Marrow Transplant	□Yes	□No
Breast Cancer	□Yes	□No
Colon Cancer	□Yes	□No
COPD	□Yes	□No
Depression	□Yes	□No
Diabetes	□Yes	□No
Hearing Loss	□Yes	□No
Hepatitis	□Yes	□No
High Blood Pressure	□Yes	□No
HIV/AIDS	□Yes	□No
High Cholesterol	□Yes	□No
Hyperthyroidism	□Yes	□No
Hypothyroidism	□Yes	□No
Leukemia	□Yes	□No
Lung Cancer	□Yes	□No
Lymphoma/Leukemia	□Yes	□No
Pacemaker/Defibrillator	□Yes	□No
Prostate Cancer	□Yes	□No
Seasonal Allergies	□Yes	□No
Seizures	□Yes	□No
Stroke	□Yes	□No

Other _____
_____

REVIEW OF SYMPTOMS

Are you currently experiencing any of the following?

Seasonal Allergies	□Yes	□No
Runny Nose/Itchy Eyes	□Yes	□No
Palpitations/Chest Pain	□Yes	□No
Leg Swelling	□Yes	□No
Fever/Chills	□Yes	□No
Unplanned Weight Loss	□Yes	□No
Cold/Heat Intolerance	□Yes	□No
Excessive Thirst/Hunger	□Yes	□No
Swallowing Problems	□Yes	□No
Nausea/Vomiting	□Yes	□No
Diarrhea/Constipation	□Yes	□No
Burning w/Urination	□Yes	□No
Blood in Urine	□Yes	□No
Enlarged Glands	□Yes	□No
Joint Pain	□Yes	□No
Muscle Aches	□Yes	□No
Headaches	□Yes	□No
Memory Loss	□Yes	□No
Depression	□Yes	□No
Anxiety	□Yes	□No
Wheezing/Asthma	□Yes	□No
Shortness of Breath	□Yes	□No
Problems Healing	□Yes	□No

Other_____
_____

Surgical History

_____
_____
_____
_____
_____
_____

Family History

_____
_____
_____
_____
_____
_____

ALLERGIES

Please list all allergies & reactions to Medications, food, etc.

_____
_____
_____
_____

Medications (Use back if needed)

Please list all current medications including over the counter

_____
_____
_____
_____
_____

Bluebonnet Foot and Ankle Institute, LLC

PATIENT RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

Bluebonnet Foot and Ankle Institute, LLC has provided information regarding the Notice of Privacy Practices. This notice describes the practice's commitment to privacy, my rights to privacy, and how **Bluebonnet Foot and Ankle Institute** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

By signing this form, I am acknowledging that I have reviewed the Notice of Privacy Practices which explains how my medical and personal information will be used and disclosed. I understand that I am entitled to receive a copy of this document, upon request.

Patient Name (Printed)

Signature of Patient/Personal Representative **Date**

Relationship to Patient

Bluebonnet Foot and Ankle Institute, LLC

Office Policies

- An answering service is available to take your call after hours, weekends and holidays. If you are having a medical emergency please dial 911. _____**(initials)**

- Any phone calls made during regular business hours will be addressed as soon as possible. If you feel that you have an urgent medical concern, please call for an appointment. _____**(initials)**

- For all refills, please contact your pharmacy to fax our office a refill request within three business days before you run out of medication. We are not able approve refill requests after routine business hours. _____**(initials)**

- For a printed copy of your medical /billing records, there is a fee of **$30**. Any records that consist of 25pgs or more, there is a fee of **25c** per page. _____**(initials)**

- There is a **$25.00** charge for all forms and letters to be completed by our office. Please allow 5-7 Business days for completed paperwork. _____**(initials)**

- We respect the strict confidentiality of the physician-patient relationship. We ask the same of you. By signing below, you agree that you will not make any recording of any person in this facility without their express written permission. _____**(initials)**

We encourage you to be an informed consumer by understanding your coverage, how to access information from your carrier, and which ancillary providers, e.g. lab and X-ray facilities, participate with your plan. Please inform us of changes to your demographics or insurance coverage. _____**(initials)**

I have read and understand the Office Policy of Bluebonnet Foot & Ankle Institute, LLC as stated above. I authorize medical care by designated APCP staff members. I authorize the release of any Patient Health Information necessary to process claims. I authorize payment of medical or government health benefits to the treating providers.

_____ _____ _____

(Signature of patient/Legal Guardian) **(Printed Name)** **(Date)**

Bluebonnet Foot and Ankle Institute, LLC

Bluebonnet Foot and Ankle Institute & 2017 Patient's financial responsibility Policies

Any applicable deductibles, co-insurance or co-payments are due at the time of service rendered as part of your insurance contract.

Uninsured Patients-Bluebonnet Foot & Ankle Institute, LLC offers a prompt pay discount to uninsured patients. **Payments must be made at the time of services are rendered for discount to apply**.

Patients Responsibility- Bluebonnet Foot and Ankle Institute can submit the claim of your visit on your behalf but it is your responsibility as a patient to keep your file with us updated. Any claims that are denied or unprocessed due to lack of update information will be patients' responsibility. **If a patient has an insurance that requires a referral, it's the patient's responsibility to make sure the office has the referral on the day of their appointment.**

- Insurance card (scan every year) and bring with you on every visit.
- Address
- Phone number

Office Policies-

We must be able to verify eligibility before services are rendered. If patient's insurance is not able to be verified due to ineligibility or a failing insurance system the patient can do the following:

- Keep appointment and sign a waiver of responsibility
- Reschedule until insurance is verifiable or eligible
- If patient holds an HMO plan-Our provider must be selected as the primary care physician before we can actually render services.

Prompt Payment-

In order for Bluebonnet Foot and Ankle Institute to keep negotiating and accepting the majority of insurance available to our patients and consumers in general; we are responsible for collecting deductibles and coinsurances from patients as part of the services render at time of services.

- There is a **$10 fee charge if Copays** are not paid at the time of the visit
- There is a **$30 fee for returned checks**, which must be settled promptly with a credit card or cash only. If there are two or more instances of returned checks, all future payments must be paid via cash or credit card.
- A **$25.00 late cancellation/reschedule fee** will be assessed for failure to provide any notice of cancellations for any provider appointment, ultrasound testing or procedure done in our office within 24 hours. A **$50.00 No Show fee will be assessed for failure to show up to a scheduled appointment.** _____**(initials)**

Bluebonnet Foot and Ankle Institute offers payment plans and assistances in some cases. Please let us how we can help you!

Please go to our website for latest updates on our financial policies at……

I have read and understand the Office Policy of Bluebonnet Foot & Ankle Institute LLC as stated above and I understand I am responsible for any financial responsibility after insurance has been processed or if I fail to provide the office with updated information at time of service.

_____ _____ _____

(Signature of patient/Legal Guardian) **(Printed Name)** **(Date)**

Bluebonnet Foot and Ankle Institute, LLC

Authorization to Release Medical Information to Individuals/Family Members

In accordance with federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your physician or staff of the Practice to discuss your condition or finances with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____ I **Do Not** authorize the Practice to release any or all information concerning my medical care or finances to any individual.

_____ I **Do** authorize the Practice to verbally release any or all information concerning my medical care or finances to the following individuals:

X_____	_____
Name	**Relationship to Patient**
X_____	_____
Name	**Relationship to Patient**
X_____	_____
Name	**Relationship to Patient**
X_____	_____
Name	**Relationship to Patient**

_____	_____	_____
(Signature of patient/Legal Guardian)	**(Printed Name)**	**(Date)**

Bluebonnet Foot and Ankle Institute, LLC

Authorization for Release of Medical Records

Patient Name: _____ **Date of Birth:** _____

Release Records To:

Bluebonnet Foot and Ankle Institute

6633 E HWY 290
STE 310
Austin, TX 78723
Phone: 512-394-5108
Fax: 512-394-5109

Release Records From:

Facility/Doctor Name:_____

Fax Number: _____

I request a copy or summary of the following Medical Records:
Complete Medical Records
Diagnostic Lab/X-Ray
Hospital Records
Other_____
All

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndromes (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

_____ Yes, I consent to the release of this information.

_____ No, I do not consent to the release of this information.

Any other use of this information without the written consent of the patient is prohibited. However, I understand that any disclosure of information carries with it he potential for un-authorized re-disclosure and the information may not be protected by Federal confidentiality rules. I understand that I may revoke this authorization at any time by notifying my physician in writing. I understand that the revocation will not apply to apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under the policy.

This authorization will remain valid as long as I am under the care of Bluebonnet Foot and Ankle Institute, LLC..

_____ _____
Signature of Patient / Legal Representative Date

_____ _____
Relationship to patient (if legal Representative) Date