



Bluebonnet Foot and Ankle Institute, LLC

REGISTRATION FORM

(Please Print)

| | | | | | | | |
|--|---------------------------------|--|---------------------------------------|---|---|---|---|
| Today's date: | | | | Primary Care Provider: | | | |
| PATIENT INFORMATION | | | | | | | |
| Patient's last name: | | First: | Middle: | <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. | <input type="checkbox"/> Miss <input type="checkbox"/> Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid | |
| Maiden Name: | Race: | Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Refused | | | Birth date: | Age: | Sex: <input type="checkbox"/> M <input type="checkbox"/> 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): | | | | <input type="checkbox"/> Dr. | | <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital | |
| <input type="checkbox"/> Family | <input type="checkbox"/> Friend | <input type="checkbox"/> Close to home/work | <input type="checkbox"/> Yellow Pages | | <input type="checkbox"/> Other | | |
| 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? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Occupation: | Employer: | Employer address: | | | | Employer phone #: () | |
| Is this patient covered by insurance? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | Insurance Carrier: | | | | |
| Insurance Address: | | Insurance Phone #: | Birth date: | Group #: | Policy #: | Co-payment: \$ | |
| Patient's relationship to subscriber: | | <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other | | | | | |
| Name of secondary insurance (if applicable): | | Subscriber's name: | | | Group #: | Policy #: | |
| Patient's relationship to subscriber: | | <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> 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 _____ Shoe Size _____

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
 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
 Lung Cancer ☐ Yes ☐ No
 Pacemaker/Defibrillator ☐ Yes ☐ No
 Prostate Cancer ☐ Yes ☐ No
 Seasonal Allergies ☐ Yes ☐ No
 Seizures ☐ Yes ☐ No
 Stroke ☐ Yes ☐ No

Are you currently experiencing any of the following

Neuropathy ☐ Yes ☐ No
 Gout ☐ Yes ☐ No
 Pregnant ☐ Yes ☐ No
 Leg Swelling ☐ Yes ☐ No
 Unplanned Weight Loss ☐ Yes ☐ No
 Dialysis ☐ Yes ☐ No
 Edema ☐ Yes ☐ No
 Foot Deformity ☐ Yes ☐ No
 Nausea/Vomiting ☐ Yes ☐ No
 Enlarged Glands ☐ Yes ☐ No
 Joint Pain ☐ Yes ☐ No
 Muscle Aches ☐ Yes ☐ No
 Lymphoma/Leukemia ☐ Yes ☐ No
 Shortness of Breath ☐ Yes ☐ No
 Problems Healing ☐ Yes ☐ No
 Others: _____

Surgical History

Family

Medications (Use back if needed)

Please list all current medications including over the counter

ALLERGIES

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

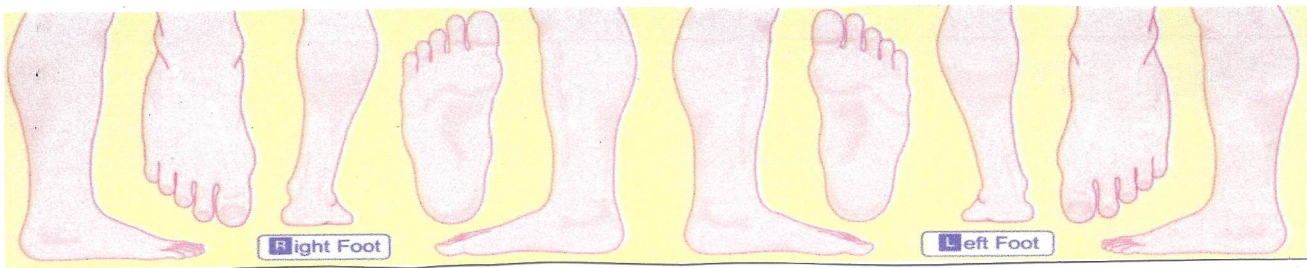


Bluebonnet Foot and Ankle Institute, LLC

Current Foot or Ankle Problem(s)

Please describe your current problem(s): _____

Mark pain or discomfort on the diagram:



Please rate your pain from 1 (lowest) to 10 (highest): 1 2 3 4 5 6 7 8 9 10

Circle the type of pain you are experiencing: No pain Sharp pain Dull pain Aching Burning Itching Radiating
Stabbing Other pain (please describe): _____

When did this problem start? _____

Did the problem develop suddenly or gradually? _____

What makes it feel worse (please circle)? Walking Standing Daily activities Resting Running Certain shoes
Other: _____

What makes it feel better? _____

How has this problem affected your lifestyle/ability to work? _____

If this was caused by an injury, please describe: _____ Work related? Y N

Statement of Medical History Accuracy "I have answered the questions on this form as accurately as possible. I understand that providing incorrect or misleading information can limit the physician's ability to accurately diagnose and treat my condition. It is my responsibility to inform the physician of any changes in my medical status."

Signature

Date

Responsible Person, if other than patient

Relationship

Date



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
3921 Steck Ave, Suite A114
Austin, Texas 78759
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-Rays

Hospital Records

Other _____

All

I understand that the information in my health records 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 the potential for unauthorized 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 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