PATHWAY
FOOT & ANKLE CENTER

PATHWAY FOOT & ANKLE CENTER, PLLC
3100 SAM RAYBURN HWY. MELISSA,TX 75454
469-215-2366 (P) | 469-215-2377 (F) | www.pathwayfac.com

Patient Name: _____ Date of Birth: _____
Last First MI

SSN #: _____Age: _____ Gender: _____ Race: _____ Ethnicity: _____

Address: _____
Street City/State ZIP

How did you hear about us? _____

Leave a Message?

Home Phone: _____ Yes / No
Cell Phone: _____ Yes / No
Work Phone: _____ Yes / No

Permission to request your medication record from the pharmacy database?
Yes / No

Email: _____ Primary Language: _____

Do you have a legal Guardian or Healthcare Power of Attorney (HPOA/DPOA)? Yes / No
If yes, Name: _____ Relationship:_____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Care Doctor: _____ Phone: _____

Pharmacy: _____ Phone: _____
Name Location

Is there a family member or other person you would like for us to share your Medical Information with?
____ NO If Yes, Name(s): _____

HEALTH INSURANCE (If you have Tricare, subscriber information **MUST** be provided)

Insurance Carrier:_____ Phone:_____
Member ID:_____ Group #:_____
Subscriber:_____ DOB: _____

Secondary Insurance:_____ Phone:_____
Member ID:_____ Group #:_____
Subscriber:_____ DOB: _____

WORKER'S COMP / INJURY / AUTO ACCIDENT

Is this a work-related injury? Yes / No Insured/Payor: _____
Who is your employer: _____ Phone: _____
Claim#: _____ Date of injury:_____ Body Part Injured:_____
How did the injury happen? _____
_____
_____

Patient Name:_____ Date of Birth:_____

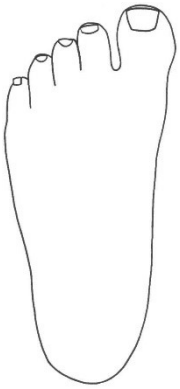
CURRENT PROBLEM

WHAT IS YOUR MAIN PODIATRIC CONCERN? _____

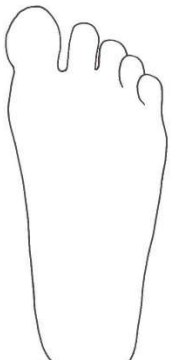
WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

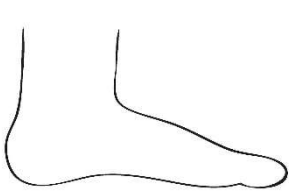
LEFT FOOT

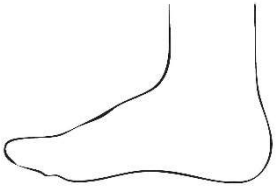
TOP



BOTTOM



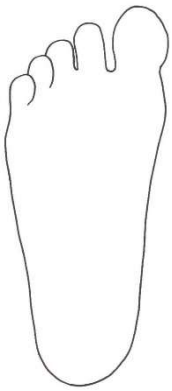




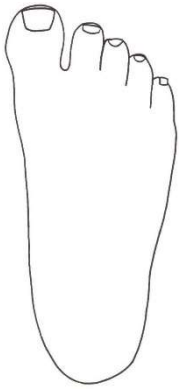
INSIDE OF FOOT **OUTSIDE OF FOOT**

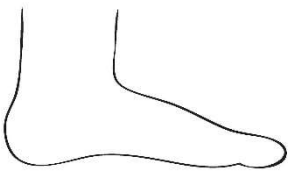
RIGHT FOOT

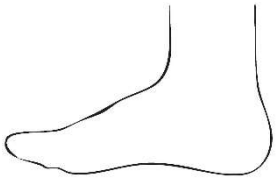
BOTTOM



TOP







INSIDE OF FOOT **OUTSIDE OF FOOT**

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING
☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES
☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE
☐ RUNNING ☐ OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

Patient Name:_____ Date of Birth:_____

Social History

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Use of Alcohol: ☐ Never ☐ No longer use ☐ History of alcohol abuse
☐ Current USE - Type _____ ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

Use of Tobacco: ☐ Never ☐ Quit – how long ago? _____ ☐ Smoke _____ packs/day for _____ years

Use of Recreational Drugs: ☐ Never ☐ Quit – How long ago? _____ Type _____

☐ Current USE - Type _____ ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

Employer: _____ Occupation: _____

How much are you on your feet at work? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

Do others depend upon you for their care? ☐ Children–age(s) _____ ☐ Pet(s)–what kind? _____
☐ Elderly or disabled family member ☐ Other _____
Exercise: ☐ Never ☐ Rare ☐ Occasional ☐ weekly ☐ Several times a week ☐ Daily

Types of exercise:_____

Family History

Do you have a family history of: ☐ Diabetes: Type 1 or Type 2 ☐ Cancer ☐ Heart Disease
☐ High Blood Pressure ☐ Stroke ☐ Coronary Artery Disease ☐ Thyroid Disease
☐ Rheumatoid Arthritis
☐ Other

_____

Your Medical History

Have you ever had any of the following?

Acid Reflux	Y	N		Fibromyalgia	Y	N		Neuropathy	Y	N
Anemia	Y	N		Gout	Y	N		Open Sores	Y	N
Arthritis	Y	N		Heart Attack	Y	N		Pneumonia	Y	N
Asthma	Y	N		Heart Disease/Failure	Y	N		Polio	Y	N
Back Trouble	Y	N		Hepatitis	Y	N		Rheumatic Fever	Y	N
Bladder Infections	Y	N		HIV+/AIDS	Y	N		Sickle Cell Disease	Y	N
Abnormal Bleeding	Y	N		High Blood Pressure	Y	N		Skin Disorder	Y	N
Blood Clots	Y	N		Kidney Disease	Y	N		Sleep Apnea	Y	N
Blood Transfusion	Y	N		Liver Disease	Y	N		Stomach Ulcers	Y	N
Bronchitis/Emphysema	Y	N		Low Blood Pressure	Y	N		Stroke	Y	N
Cancer	Y	N		Migraine Headaches	Y	N		Thyroid Disease	Y	N
Diabetes: Type 1 or Type 2 (circle)	Y	N		Mitral Valve Prolapse	Y	N		Tuberculosis	Y	N
Other Conditions:											

Patient Name:_____ Date of Birth:_____

DO YOU HAVE ANY ALLERGIES? YES / NKDA – No Know Drug Allergies

If Yes, list them here):

_____

_____

Please list all medications you are currently taking (Include prescriptions, over-the-counter meds & herbal supplements):

Name	Dose	How Often Do You Take?

Please list all prior surgeries:

Date	Type of Surgery	Location

Please list all prior hospitalizations (other than for surgery):

Reason for hospitalization	Date

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

FOR MOBILE CARE ONLY:

1. I acknowledge and understand that I can discontinue service at any time and will not be charged for cancellations or appointments should a resident refuse treatment.
2. I affirm that I am authorized to coordinate the care for the resident identified in Section A. Furthermore, I affirm that I am responsible for payment on podiatric services rendered. Residents that qualify for Medicaid or Medicare will only be charged for services authorized by Medicaid or Medicare unless otherwise discussed with and consented by resident and/or POA. The guarantor identified in Section B is not financially liable for services that Medicaid or Medicare fails to cover.
3. I authorize Pathway Foot & Ankle Center, PLLC to obtain medical records form the resident's care facility for the purpose of providing podiatric care. Pathway Foot & authorized to request, record, and archive the resident's diagnoses, current medications, historical medications, and history of healthcare providers.
4. I authorize Pathway Foot & Ankle Center, PLLC to obtain authorization for podiatric services from the resident's physician of record or from the facility's medical staff.
5. I authorize Pathway Foot & Ankle Center PLLC to contact me about the resident's foot and ankle care, the guarantor's billing preferences, and any issues surrounding coverage. INITIALS: _____

_____ _____

PRINT NAME OF PATIENT, PARENT OR GUARDIAN SIGNATURE OF DOCTOR

_____ _____

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

_____ _____

SIGNATURE DATE

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PATIENT FINANCIAL AGREEMENT & ACKNOWLEDGEMENT OF OFFICE POLICIES

Pathway Foot & Ankle Center, PLLC believes that part of good health care practice is to establish and communicate an office and financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to have a full understanding of our policies.

1. **PAYMENT** is expected at the time of your visit. We accept cash, check, VISA, MASTERCARD, DISCOVERY, and money order. Payment will include any unmet deductible, co-insurance, co-payment amount, and charges not covered by your insurance company. If you do not carry insurance, or if your coverage is under a pre-existing condition clause, payment in full is expected at the time of your visit unless otherwise discussed as a self-pay option. All non-filed services are expected to be paid at the time of service.

2. **INSURANCE:** We are participating insurance providers for most insurance plans. We will file all the claims for these plans. **Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. As a courtesy to our patients, we will verify your insurance coverage, however, our verification is not a guarantee of benefits payable by your insurance. If you have a managed care plan that requires a referral to see a specialist, you must obtain that referral in order for your visit to be covered under your medical insurance.** If you do not have the valid referral and still wish to be seen, you will be asked to pay for the visit prior to your services. **In order to bill your insurance and to meet filing guidelines, we do ask for a copy of the front and back of your most recent insurance card(s) along with a copy of your photo ID.** If there is another guarantor of the insurance for the patient being scheduled, we ask for a copy of the guarantor's ID as well.

   If our providers are not listed in your plan's network, you may be responsible for partial or full payment. In this case, we offer a self-pay option based off our published self-pay fee schedule.

3. **POLICY ON NON-COVERED SERVICES:** This practice offers access to many innovative services and procedures, some of them are deemed as "not covered" by insurance. In some cases, you will be given an ABN (Advanced Beneficiary Notice) for these types of services/procedures before they are provided/performed. You will be responsible for payment in full at the time of service.

4. **RETURNED CHECKS** will incur a $45.00 service charge.

5. **RESPONSIBILITY FOR PAYMENT:** I understand that I, personally am financially responsible to Pathway Foot & Ankle Center, PLLC for charges non covered by the assignment of insurance benefits and all non-covered charges.

6. **AUTHORIZATION & ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize Pathway Foot & Ankle Center, PLLC to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to Pathway Foot & Ankle Center, PLLC all payments otherwise payable to me for Pathway Foot & Ankle Center, PLLC services.

7. **CONSENT AND DISCLOSURES:** I voluntarily consent to medical treatment for myself and/or my dependents.

8. **RELEASE OF INFORMATION:** I hereby authorize and direct Pathway Foot & Ankle Center, PLLC to release (verbally and/or in writing) confidential medical information to any person, entity, government agencies, insurance carriers, or others who are financially liable to Pathway Foot & Ankle Center, PLLC for charges for medical treatment, and for quality management, utilization review, transfer of medical care, and follow up purposes. I understand that a copy of this document may be used with the same effectiveness as an original.

9. **SELF-PAY OPTION:** Pathway Foot & Ankle Center, PLLC will attempt to collect from all billable insurances. If services are found to be ineligible and/or denied, then the self-pay option will be available for services to be rendered.

10. **BILLING AND COLLECTION:** Pathway Foot & Ankle Center, PLLC will submit a claim for payment to your insurance company. In the event your insurance carrier/company denies the services provided, you will be responsible for the payment in full. We appreciate prompt payment in full for any outstanding balance.

11. **APPOINTMENT NO-SHOWS:** Pathway Foot & Ankle Center, PLLC dedicates one-on-one time with each patient to properly access and treat. In order to provide the same level of attention for each patient, **we do require a 24-hour notice for cancellations of appointments in the Pathway Foot & Ankle Center, PLLC Clinic location.** If you have 2 consecutive no-shows in the clinic, you will be discharged from Pathway Foot & Ankle Center, PLLC. You will be provided the discharge notice in writing and also asked to sign the document acknowledging your discharge. We will provide you with a list of podiatrists in the area if requested.

I have read and understand the practice's office and financial policies and I agree to be bound by its terms.

I also understand and agree that such terms may be amended by the practice at any time.

Signature of Patient/Guarantor, if applicable **Date**

Disclaimer: Pathway Foot & Ankle Center, PLLC does not consider an individual seeking treatment to be a patient until a preliminary assessment is completed and the individual has been notified that he/she/they has been accepted as a patient; simply making an appointment does not automatically initiate doctor-patient relationship.

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HIPAA ACKNOWLEDGEMENT/CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name _____

Signature _____

Signature Date _____

Relationship to Patient (if patient unable to sign) _____