Charles D. Rhodus, DPM | Foot Specialists of Tyler | Matthew Kindle, DPM

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PATIENT INFORMATION

First Name _____ **Last Name** _____

Name of Guardian (if patient is under 18 years of age): _____

Relation: ☐ Parent ☐ Grandparent ☐ Sibling ☐ Legal Guardian ☐ Other: _____

Date of Birth: _____ **Age**: _____ **Social Security Number**: _____ **Gender**: ☐ Male ☐ Female

Marital Status: _____ **Primary Language Spoke**: _____

Race: (Please select one)

☐ White
☐ Hispanic
☐ Asian
☐ Other
☐ American Indian or Alaskan Native
☐ Black or African American
☐ Native Hawaiian or Pacific Islander
☐ Decline

Ethnicity: (Please select one)

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Decline

Mailing Address: _____

City: _____ **State**: _____ **Zip Code**: _____

Home Phone: _____ **Work Phone**: _____ **Cell Phone**: _____

E-mail (for us to send your visit notes to): _____

Emergency contact: _____ **Relation**: _____ **Phone**: _____

PHARMACY/PRIMARY CARE PHYSICIAN INFORMATION

Pharmacy: _____ **Location**: _____ **#**: _____
City / Zip

Primary Care Physician: _____ **Phone #**: _____

How did you hear about us? _____

INSURANCE INFORMATION

Primary Insurance Company: _____ **Policy ID**: _____

Group #: _____ **Policy Holder Name**: _____ **DOB**: _____

Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Secondary Insurance Company: _____ **Policy ID**: _____

Group #: _____ **Policy Holder Name**: _____ **DOB**: _____

Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Patient/Guarantor Signature: _____ **Date:** _____

PATIENT MEDICAL HISTORY

Reason for your visit today: _____

When did this problem begin: _____

Have you had any previous treatments? ☐ No ☐ Yes, Treated by: _____

Check all treatments received for this condition:

☐ Pain Medication	☐ Physical Therapy	☐ Bone Scan	☐ CT Scan
☐ Injection	☐ Antibiotics	☐ Ice/Stretching	☐ Hospitalization
☐ X-Rays	☐ Surgery	☐ MRI	☐ Other: _____

Height: _____ **Weight**: _____ **Shoe Size**: _____

Have you been diagnosed with any of the following? (Mark all that apply) ☐ NONE

☐ Anemia	☐ Emphysema	☐ HIV+/Aids	☐ Liver Disease
☐ Arthritis	☐ Fibromyalgia	☐ Heart Disease	☐ Stomach Ulcer/Reflux
☐ Back Problems	☐ Glaucoma	☐ High Cholesterol	☐ Stroke
☐ Blood Clots	☐ Gout	☐ Irregular Heart Beat	☐ Thyroid Disorder
☐ Depression	☐ Heart Attack	☐ Kidney Stones	☐ Tuberculosis
☐ Diabetes	☐ High Blood Pressure	☐ Kidney Disease	☐ Other: _____

Do you smoke or chew tobacco? ☐ No ☐ Yes, how often/how many? _____

Do you drink alcohol? ☐ No ☐ Yes, how often? _____

Current Medications: _____

_____

_____

Allergies/Reactions: _____

_____

_____

Previous Surgeries (please list any complications if applicable): _____

_____

_____

Patient/Guarantor Signature: _____ Date: _____

FINANCIAL POLICY AND AGREEMENT

PAYMENTS FOR SERVICES ARE DUE AT THE TIME SERVICES ARE RENDERED: We accept cash, personal checks, MasterCard, Visa, American Express, and Discover. Returned checks are subject to a service charge of $35.00, and you will lose the privilege to write checks in our office.

MEDICARE: We will bill your insurance(s) for you. After the insurance processes your claim, you (the patient or guarantor) agree to pay the deductible and/or 20% of the allowable charges, if applicable.

COMMERCIAL INSURANCE: Copays are due at the time of service. We will bill your insurance(s) for you. After the insurance processes your claim, you agree to pay your patient responsibility.

HMO INSURANCE: It is your responsibility to obtain a referral from your primary care physician prior to your appointment, and also check with your insurance to obtain your insurance benefits.

FINANCIAL AGREEMENT: We are happy to discuss your proposed treatment and do our best to answer any questions relating to your insurance. In order to do so, please be aware of the following:

- **Your insurance is a contract between you, your employer, and the insurance company. We are not party to that contract.** To enable our office to file your insurance, you must provide accurate information at each visit.
- **Not all services are a covered benefit. Some insurance companies arbitrarily select certain services they will not cover (i.e., x-rays, labs, durable medical equipment {DME}, elective procedures, and pre-existing conditions).**
- **Due to timely filing limits for insurance companies, you must present your current insurance card at the time of check-in. If you do not have your insurance card, you may: call our office the same day as your visit, reschedule your appointment, or pay out of pocket for your visit.**

I hereby assign Foot Specialists of Tyler all payments for medical services rendered to myself or dependent. I understand that I am responsible for any amount not covered by my insurance. I hereby understand that if I do not have active insurance coverage, that I am being accepted by Foot Specialists of Tyler as a self-pay patient and am held financially responsible for all services rendered.

By signing below, I recognize that I have read and understand the office financial policy.

PRESCRIPTION AGREEMENT

NOTICE TO PATIENTS REGARDING MEDICATION PRESCRIPTIONS

Patients are given prescriptions for pain following surgery and dismissal from the hospital. These prescriptions are usually all that will be needed for pain. Tylenol can be used to relieve any residual pain. If additional medication is required, the patient should call our office during office hours and speak to a medical assistant who will answer most questions after consulting the physician when required.

Your medication can only be managed by ONE physician. If another physician is prescribing pain medication for you, we will NOT prescribe additional medication. _____ ***(initials)***

POLICIES REGARDING CALLS FOR MEDICATION

Telephone calls related to medications and/or refills must be called into your pharmacy before 4:00 PM Monday through Thursday and before 12:00 PM on Friday. Your pharmacy will then contact our office. Otherwise, the telephone call will not be handled until the next business day _____ ***(initials)***

Pain Medication will NOT be refilled or prescribed over the telephone after hours, on weekends, or holidays. _____ ***(initials)***

Patient/Guarantor Signature: _____ Date: _____

AUTHORIZATION TO TREAT/HIPAA PRIVACY NOTICE

AUTHORIZATION TO TREAT:

I hereby consent to the following treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgement of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I hereby authorize Foot Specialists of Tyler to furnish information to insurance carriers concerning my illness and treatment.

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY NOTICE:

In accordance with HIPAA, I have had the opportunity to read and receive a copy of the Privacy Practices located in the front office of Foot Specialists of Tyler. I understand that my information will be used for the purpose of treatment, payment, and healthcare operations.

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

☐ Spouse:_____

☐ Child(ren):_____

☐ Other:_____

☐ Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call: ☐ my home ☐ my work ☐ my cell Number:_____

If unable to reach me:

☐ You may leave a detailed message
☐ You may leave a message only asking me to return your call
☐ _____

The best time to reach me is (*day*)_____ between (*time*)_____.

I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.

Patient/Guarantor Signature: _____ Date: _____