McKinney Podiatric Associates, P.A.

MEDICAL & SURGICAL CARE FOR THE FOOT & ANKLE

DATE: _____

PATIENT INFORMATION

Patient Name: _____ Birthdate: _____ Age: _____
Address: _____ Primary Language: _____
City: _____ State:_____ Zip: _____
Home Phone:_____ Cell Phone: _____
Work Phone:_____ Employer: _____
Email: _____
Social Security No:_____-_____-_____ Sex: ○M ○F Marital Status: ○S ○M ○D ○W
Race: _____ Ethnicity: _____
Emergency Contact: _____ Relationship:_____ Phone: _____

REFFERED INFORMATION

Family Physician: _____ Physician Phone: _____
Referred to our office by: _____

INSURANCE INFORMATION

Insured's Name: _____ Relationship: _____
Insured's Employer: _____ Insured's Work #: _____
Insured's SS #: _____-_____-_____ Insured's Birthdate: _____
Primary Insurance: _____ Address: _____
Subscriber ID #: _____ Group #: _____
Secondary Insurance: _____ Address: _____
Subscriber ID #: _____ Group #: _____

ACKNOWLEDGMENT

PATIENT OR AUTHORIZED PERSON'S SIGNATURE

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to myself or to the party who accepts assignment.

_____
Signature

I HEREBY GIVE MY PERMISSION TO THIS OFFICE TO EXAMINE AND TREAT AS INDICATED

DATE: _____ SIGNATURE: _____

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PATIENT NAME: _____ **DATE:** _____

CHIEF COMPLAINT:

_____

_____

***ANY DRUG ALLERGIES?** NONE: ____☐____

☐ Penicillin	☐ Aspirin	☐ Cortisone
☐ Codeine	☐ Tape	☐ Novocaine
☐ Sulfa Drugs	☐ Any Antibiotic	☐ Other (please list)

_____

***CURRENT MEDICATIONS:** NONE: ____☐____

If YES, please list: _____

_____

*** PAST MEDICAL HISTORY:**

☐ Acid Reflux	☐ Epilepsy	☐ Rheumatic Fever
☐ Anemia	☐ Gout	☐ Shortness of Breath
☐ Blood Clots or Phlebitis	☐ Growths	☐ Stomach Ulcers
☐ Cancer	☐ Heart Problems	☐ Strokes
☐ High Cholesterol	☐ High Blood Pressure	☐ Thyroid
☐ Diabetes	☐ Kidney Problems	☐ Tuberculosis
☐ Difficulty Healing	☐ Liver Problems	☐ Varicose Veins
	☐ Lung Problems	☐ NONE

***PREVIOUS SURGERIES:** _____

_____

***FAMILY MEDICAL HISTORY:**

Cancer:	☐ Mother	☐ Father	Hypertension:	☐ Mother	☐ Father
Diabetes:	☐ Mother	☐ Father	Kidney:	☐ Mother	☐ Father
Heart:	☐ Mother	☐ Father	Lungs:	☐ Mother	☐ Father

Unknown ☐ Adopted ☐ If YES, what type? _____

***SHOE SIZE:** _____ **HEIGHT:** _____ **WEIGHT:** _____

***SOCIAL HISTORY:**

Smoker? ○YES ○NO ○FORMER SMOKER How many packs/day? _____ YRS ____

Alcohol? ○YES ○NO If YES, What kind? _____ How often? _____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Signature of Patient/Guardian **Date**

PHARMACY INFORMATION

****MUST NOT BE LEFT BLANK!!****

Preferred Pharmacy: _____ **Phone:** _____

Address: _____

PATIENT CONTACT PREFERENCE

☐ PHONE
Ok to leave phone message with: _____

☐ MAIL

☐ EMAIL

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PATIENT FINANCIAL POLICY

Thank you for choosing us as your surgical care facility. Our goal is to provide you with highest quality surgical care at affordable cost. To make our services available to as many patients as possible on an affordable basis, we have adopted the financial collection policy outlined below. We ask you to read the policy carefully and sign prior to any treatment.

- WE MAY ACCEPT ANY ASSIGNABLE INSURANCE WITH APPLICABLE COVERAGE.
- FULL PAYMENT IS DUE AT TIME OF SERVICE UNLESS ARRANGED OTHERWISE.
- WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD, AND AMERICAN EXPRESS CARD.
- WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.
- WE ACCEPT ALL HEALTH SAVINGS ACCOUNT (HSA) PAYMENT.
- PATIENT REQUESTS FOR COPIES OF RECORDS MAY TAKE 2-4 WEEKS OR LONGER TO RECEIVE AND REQUIRES A CURRENT SIGNED PATIENT MEDICAL RELEASE FORM ON THE DATE OF REQUEST. CHARGES OF $25 OR MORE MAY APPLY TO ALL RECORD REQUESTS. IN ORDER TO PROTECT YOUR SECURITY, FAXED REQUESTS FOR RECORDS ARE NOT ACCEPTABLE.
- PLEASE ALLOW A MINIMUM OF 48 HOURS FOR COMPLETION OF ANY FMLA/DISABILITY FORMS AND THERE WILL BE A $25 CHARGE DUE AT THE TIME WE RECEIVE THE FORMS.
- THERE WILL BE A $25 CHARGE ON ALL RETURNED CHECKS.

Regarding Insurance

We may accept assignment of insurance benefits at our discretion if acceptable insurance identification is provided. Acceptable insurance identification is defined as a valid insurance card, policy/plan with applicable coverage, or telephone verification. As a courtesy to our patients, verifiable and assignable insurance will be billed by this surgeon's office. However, you will be personally responsible for your account balance regardless whether or not if your insurance will pay for your total balance of your claims, unless you're eligible for discounts under our indigency policy pre-determined before the services are rendered. Your insurance policy/employee benefits plan is a contract between you and your insurance company/employee benefits plan. We are not a party to that contract. In the event we do not accept assignments of benefits we require that you be pre-approved on our extended payment plan by providing a credit card or personal checking account with authorization to charge that amount for the balance due, if your insurance company/employee benefits plan has not paid your account in full within 45 days or has detemined your claims to be your responsibility for the reasons of annual deductible, co-payments, non-covered services and not medically necessary.

We encourage our patients to contact their plans for clarification of benefits prior to services rendered.
As our patient, you are responsible for all authorizations/referrals needed to seek treatment.
If a patient chooses or is required to bill his/her own insurance, this office will provide an itemized statement and a HCFA-1500 Form to the patient, but will treat the account as self-pay.

Patients must inform the office of all insurance changes. In the event the office is not informed in a timely manner, you will be responsible for any charges denied.

Regarding Discount

Due to the Affordable Care Act (ACA), we may offer discounts, reduction or waiver of deductibles, co-insurance and co-pay to any eligible patient under our Corporate Indigency Policy in accordance with applicable federal and state laws. These discounts are based on medical needs and ability to pay on a case-by-case basis and patients may apply for financial indigency discount assistance by asking our staff to determine if you're eligible.

Regarding Surgeon and Facility Charges

We will disclose to every patient our surgeon charges as clearly as practically possible before your medical or surgical procedures if it is known to us. Please feel free to ask our staff if you have any questions about charges and your payment responsibilities.

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As you may be aware, your insurance company requires your doctors and surgeons to charge and bill the services separately from surgical facilities or hospitals. You shall not be surprised that you will receive separate surgeon, anethesiologist, diagnostic labs, radiologists, pathologists, and others in addition to the surgical facility bills for your surgery. If you have any questions about your surgical facility bills, please direct your questions to that surgical center.

While we don't anticipate any unforeseeable circumstances, we have no control over any such event(s) that may arise. Should you require additional medical or surgical care in any event of the post surgical complications and reactions, you may incur additional expenses at this facility or outside this facility, such as a hospital.

The charges only include the stated date of services at this facility and do not include any other date of services from us or other providers and facilities. **Surgical procedures will require pre-payment. You will be informed in advance of your financial portion.**

Regarding PPO and HMO Network Participation

As you may know, you may have a choice to choose a surgeon or surgical facilities with or without PPO or HMO participation under different insurance coverage and benefits levels. We are dedicated to providing highest quality care to every patient, however we have no power to change your insurance coverae or network limitations. Most health care plan or insurance policies may provide surgical coverage to non-PPO providers and facilities, but at lower percentage of insurance reimbursement. Althought it is your responsibility to verify your insurance coverage for non-PPO/HMO providers, we will always disclose to you as to our participation status to your insurance plan. We also provide every patient with financial assistance or discount with high deductibles and coinsurance for our Corporate Indigency Policy in accordance with applicable federal and state laws.

Please understand that we will verify your insurance coverage and obtain pre-certification if applicable for all services as a courtesy to you before your surgery. Please note that all insurance verification is not a guarantee of insurance payment.

Compliance & Disclosure under Texas Occupations Code - Section 102.006

If we accept your insurance assignment as a payment from your insurance reimbursement, you agree to timely cooperate with your insurance company or health plan in the course of insurance claim processing, such as insurance inquiries, requests for additional information, claims status verification or any inquiries for the purpose of your claim processing. You also agree to notify us immediately of any insurance inquiry or request for additional information and provide us with a copy of any documentation received from the insurance company or submitted to insurance company from you.

In an event that you do not receive insurance payment checks for your surgeries rendered by this doctor, you agree to submit such insurance reimburse check to our office within five (5) business days after your receipt of insurance checks. In a failure or refusal to forward or send us the insurance reimbursement checks for the medical services from this provider, all of your discount arrangement will be voided, and the total balance is due immediately, as there is no justification for you to keep the insurance payment for our services as you promised to pay for our services. You further agree to compensate us for any legal fees if we have to retain any legal services to collect past dues.

We are commited to serving you with highest quality care possible at affordable cost. Every staff at our office is ready to help you at all times.

I have read the Financial Policy. I understand and agree to this Financial Policy.

_____	_____	_____
Signature of Patient/Responsible Party	Patient Name (print)	Date
_____	_____	_____
Signature of Co-Responsible Party	Your Name (print)	Date