McKinney Podiatric Associates, P.A

MEDICAL & SURGICAL CARE FOR THE FOOT & ANKLE

HELLO! WELCOME TO OUR OFFICE!

Please print the following information.

This information is important to our records and your health.

DATE: ____________________

Patient Name: ________________________________ Birthdate: ______________________Age: ____________

Address: ____ Apt #__________

City: ____________________________ State: ____________Zip: _______________ Primary Language:_____________

Home Phone: ______________________Work: ________________________ Cell: ______________________

Employer: ______________________________ Email: ____

Social Security No: ______-_______-_______ Sex: M F Marital Status: S M D W

Race: ____________________ Ethnicity: __________________ How did you hear about us: ____________________

Family Physician: ______________________________ Physician Phone: ________________________________

Emergency Contact: ________________________Relationship: _______________ Phone: _________________

Insured's Name: ____________________________ Relationship: ______________________________________

Insured's Employer: ______________________ Insured's Work #: ________________________________

Insured's SS #: _______-_______-_______ Insured's Birthdate: _____________________________________

Primary Insurance: ____________________________ Address: ______________________________________

Subscriber ID #: ____________________________ Group #: ____________________________

Secondary _________________________________ Group #: ______________________

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:** ____

PATIENT NAME: ____ **DATE:** _____________________

WHAT IS THE REASON FOR YOUR VISIT TODAY ____

____

***ANY DRUG ALLERGIES? YES, NO LIST REACTION:** ________________________________

________	Penicillin	______	Aspirin	________	Cortisone
________	Codeine	______	Tape	________	Novocain
________	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	_____ HIV	_____ 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

If diabetic what is your A1C value? _________

***PREVIOUS SURGERIES:** ____

____

***FAMILY MEDICAL HISTORY:**

Cancer: _____Mother _____Father
Diabetes: _____Mother _____Father
Heart: _____Mother _____Father
Unknown________ Adopted ___________

Hypertension: _____Mother _____Father
Kidney: _____Mother _____Father
Lungs: _____Mother _____Father
If **YES**, what type? ______________________________

***SHOE SIZE:** __________ **HEIGHT:** ____________ **WEIGHT:** _______________

***SOCIAL HISTORY:** **Smoker? YES or NO or FORMER SMOKER How** many packs/day______yrs.______

Alcohol? YES or NO If **YES,** What kind? ___________________ How often? ______________

Have you had your flu shot? ________ Have you had your Pneumonia shot? _________

Any Falls This Year? ____

ACKNOWLEDGEMENT 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**

Preferred Pharmacy: _________________________________ **Phone:** ____________________________________

Address: ____

PATIENT CONTACT PREFERENCE:

☐ PHONE:

Ok to leave phone message with: ____

☐ Mail

☐ Email___________________________________

McKinney Podiatric Associates, P.A.

MEDICAL & SURGICAL CARE FOR THE FOOT & ANKLE

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 assignment 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 determined your claims to be your responsibility for the reasons of annual deductible, co-payment, 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 Indecency 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.

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, anesthesiologist, 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 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 coverage 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. Although 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

In compliance with Section 102.006 of Texas Occupations Code in connection with my informed consent and personal choice of doctors and facility solely based on the quality and safety of care, reputation and patient satisfaction, and my knowledge in my decision-making in exercising my rights with respect to the in-network or out-of-network coverage and cost sharing, my attending doctor(s) and/or clinic (facility) have disclosed to me at the time of initial contact and at the time of referral with respect to the choice of a doctor or facility solely in the interest of my healthcare quality and safety, as a result of my informed consent and personal choice of doctor(s) and / or facility: (A) his/her affiliation, if any, with the doctor or facility for whom the patient is referred and (B) that he / she will receive, directly or indirectly, remuneration for referring upon my such request and exercising my rights of freedom of choice for the provider(s) and facility under the in-network or out-of-network coverage as provided by my health plan, in compliance with all applicable federal and state laws, Medicare, ERISA, PPACA and the Section 102.006 of Texas Occupations Code.
Specifically, Dr Scott W. McKinney D.P.M /McKinney Podiatric Associates, P.A. has a financial interest and may receive remuneration from any and all of the following entities: St Luke's Patient's Medical Center (4600 E. Sam Houston Pkwy S. Pasadena, TX 77505) Altus Baytown Hospital (1626 W Baker Rd Baytown, TX 77521), PAD Specialists,
Dr Jorge L. Cuza D.P.M: St Luke's Patient's Medical Center (4600 E Sam Houston Pkwy Pasadena, TX 77505), PAD Specialists, Dr Mark Moss D.P.M.: Doctor's United Surgery Center, Dr Hina Hassan D.P.M.: Altus Baytown Hospital, HSI Healthcare Solutions Holdings INC., Pasadena Medical Plaza Pharmacy, Doctor's United Surgery Center, PAD Specialists

Your Responsibility for Cooperation

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 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 committed to serving you with highest quality care possible at affordable cost. Every staff at our office is ready to help you at all time.

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

X ____ ______________
Signature of Patient/ Responsible Party | Patient Name (print) | Date

X ____ ______________
Signature of Co-Responsible Party | Your Name (print) | Date

McKinney Podiatric Associates, P.A.

MEDICAL & SURGICAL CARE FOR THE FOOT & ANKLE

Dear Patient,

You are receiving this letter as notification of our prescriptive practices and compliance monitoring program regarding Schedule II medications.

The Drug Enforcement Administration (DEA) published a final rule of scheduling hydrocodone combination products from Schedule III to Schedule II on August 22, 2014. This rule will go into effect *October 6, 2014*. This ruling greatly restricts the ability of providers to prescribe hydrocodone products (Lortab, Norco and Vicodin). This ruling will change our ability to prescribe hydrocodone products and provide refills. We have no control over many of the changes our practice is required to make that may unfortunately affect your postoperative care.

The DEA also strongly recommends the institution of a drug compliance program to ensure adequate protection of our patient's health and decrease drug related mortality.

The following changes will be put into effect in our practice due to the increased restrictions that accompany this schedule change:

-Schedule II medications (Norco, Vicodin, Lortab, Percocet) prescriptions must be written on an official prescription form. This means that we will no longer be able to call in prescriptions for this medication. The prescription must be physically picked up from our office.

-We cannot legally provide phone refills on hydrocodone/oxycodone prescriptions. Patients will be prescribed an adequate supply according to a schedule that will last until their next appointment. No refills will be given between appointments. If a refill is needed an appointment must be made Monday through Friday.

-**No "last minute" appointments for refills will be made on Fridays. No exceptions will be made.**

-If your prescription is lost or stolen, we will be unable to provide you with another prescription until your next scheduled appointment.

-You should expect that narcotic based medications will not be given any longer than six weeks after your last surgery. We will continue to try and treat your pain with non-narcotic modalities after six weeks. If you believe you will require hydrocodone/oxycodone beyond six weeks, it is advised that you establish care with a chronic pain or primary care physician as soon as possible and notify our clinic that another physician will be assuming care of your pain.

-You may be required to submit a toxicology screening during appointments.

Oral DNA samples may be required to evaluate patient susceptibility to medications.

-If you have a chronic pain physician, it is advised that you make an appointment as soon as possible, as you will not be able to receive the medication from multiple physicians. We will defer to your chronic pain physician for any postoperative narcotic prescription.

If you have questions or concerns, we will direct you to your local senator or representative.

Sincerely,

McKinney Podiatric Associates, P.A.

Please sign below to acknowledge receipt of information.

Patient Signature: ____ Date: _______________________

* **Dr. Scott W McKinney**
* **Dr. Jorge L. Cuza**
* **Dr. Mark Moss**
* **Dr. Edna Reyes-Guerrero**
* **Dr. Hina Hassan**
*Diplomate American Board of Podiatric Surgery
*Fellow American College of Foot & Ankle Surgeons

No Show Policy & Procedure
For Office Visits, Procedures and Outpatient Surgery

McKinney Podiatric Associates imposes the following policy with regard to patients who fail to keep their scheduled office visit appointment, procedure appointment or scheduled outpatient surgery.

Patients who fail to show for their scheduled **office** appointment or did not notify the office **within 24 hours** of their scheduled appointment time, shall be subject to a "No Show "penalty of **$25.00**. In the event of an actual emergency and prior notice could not be given, consideration will be given, and a **one time exception may be granted**.

Patients who fail to show for their scheduled **office procedure** appointment or did not notify the office **within 24 hours** of their scheduled procedure appointment time, shall be subject to a "NO SHOW" penalty of $75.00. In the event of an actual emergency and prior notice could not be given, consideration will be given, and a **onetime exception may be granted**.

Patients who fail to show for their scheduled **outpatient surgery** appointment or did not notify the office **within 72 hours** of their scheduled surgery time, shall be subject to a "NO SHOW" penalty of **$150**. If the surgery is cancelled by a physician as a medical necessity, then the patient is not subject to a "NO SHOW" fee. Insurance authorization denials also exempt the patient from such a fee.

____________________________ ____________________
Patient Printed Name Date

____
Patient or Guardian Signature

____________________________ ____________________
Witness Signature Date