NEW BRAUNFELS PODIATRY

WELCOME TO OUR PRACTICE

PATIENT INFORMATION

All information will be confidential.

We are not a Worker's Compensation Provider.
We do not file Texas Worker's Comp cases or motorcycle/motor vehicle Accident claims.

Patient Name _____ Age: _____

Social Security # _____ - _____ - _____ Date of Birth: _____

Gender: Male ☐ Female ☐ Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Address_____ City_____ State_____ Zip_____

Home Phone #_____ Cell Phone #_____

Work Phone #_____ Email:_____

Employer_____ Position_____

Primary insured's name if other than patient_____ D.O.B._____

Pharmacy:_____ Location:_____

Who is Your Primary Care Doctor?_____

How did you hear about our practice?_____

Emergency Contact:_____ D.O.B._____

Relationship:_____ Phone:_____

To the best of my knowledge, the questions on the forms have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of Patient, Parent or Guardian D.O.B. Date

I have read a copy of the New Braunfels Podiatry Associates, LLC Notice of Privacy Practices.

Patient/Guardian Signature _____Date _____

ALL INSURED PATIENTS

I request that payment of authorized insurance benefits be made to J. Jacob Ransom, D.P.M. or New Braunfels Podiatry, for any services furnished to me by that physician. I authorize any holder of medical information about me at New Braunfels Podiatry to release said information to the insurance entity requesting it.

Patient/Guardian Signature _____Date_____

I wish the following individual(s) to have access to my medical information:

_____D.O.B _____
_____D.O.B _____

Staff Will Fill out This Section If Patient's Signature Not Obtained

Our office made a good faith effort to obtain **Acknowledgement of Receipt** of our Notices of Privacy Practices, but it could not be obtained for the following reason:

___ Patient refused to sign.

___ Emergency situations kept us from obtaining the patient's signature.

___ Language barriers kept us from obtaining the patient's signature.

___ Other _____

Name _____ DOB _____ Date _____
Last, First

What is your specific foot/ankle problem? _____

Current Prescription Medications

☐ Consent to obtain RX History from pharmacy

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Allergies

☐ No Known Drug Allergies

☐ Yes ☐ No Penicillin
☐ Yes ☐ No Aspirin
☐ Yes ☐ No Codeine
☐ Yes ☐ No Adhesive Tape
☐ Yes ☐ No Sulfa
☐ Yes ☐ No Local Anesthetic
☐ Yes ☐ No Other _____

Past Medical History

Diabetes # years _____	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	Aids or HIV	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Tendency to form large scars	☐ Yes ☐ No
Cardiologist: _____	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No
Arthritis: Type _____	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No
Thyroid Problems _____	☐ Yes ☐ No	Bleeding Problems	☐ Yes ☐ No
Gout	☐ Yes ☐ No	Alcoholism	☐ Yes ☐ No

Any other disease (please list) _____

Previous Surgeries

1. _____
2. _____
3. _____
4. _____

Social History

Occupation _____

Tobacco: ☐Non Smoker ☐Current ☐Past Quit Date_____

Alcohol: ☐Non Drinker ☐Social ☐Daily

Height _____ Weight _____

Have You Experienced Any of These Symptoms Recently?

General

General good health lately ☐ Yes ☐ No
Fever/Chills ☐ Yes ☐ No

Respiratory

Shortness of breath ☐ Yes ☐ No
Past anesthesia difficulties ☐ Yes ☐ No

Cardiovascular

Palpitations/Arrythmias ☐ Yes ☐ No
Chest Pain ☐ Yes ☐ No
Swelling of feet or ankles ☐ Yes ☐ No

Gastrointestinal

Stomach ulcers ☐ Yes ☐ No
Reflux ☐ Yes ☐ No
Intolerance to Aspirin/NSAIDS ☐ Yes ☐ No

Endocrine

Excessive thirst or urination ☐ Yes ☐ No

Musculoskeletal

Joint pain/stiffness ☐ Yes ☐ No
Muscle pain/cramps ☐ Yes ☐ No

Integumentary

Rash or itching ☐ Yes ☐ No
Varicose Veins ☐ Yes ☐ No

Neurological

Tremors ☐ Yes ☐ No
Numbness/Tingling ☐ Yes ☐ No

Hematologic/Lymphatic

Bleeding tendency ☐ Yes ☐ No
Past transfusion ☐ Yes ☐ No

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff.

- As our patient, you are responsible for all authorization/referrals needed to seek treatment in this office.
- **We are NOT a worker's compensation insurance provider. We do not file Worker's Comp cases or motorcycle/motor vehicle accident claims.**
- **Is this a work related or a vehicle accident injury?** ☐ **Yes** ☐ **No**
- Payment for services rendered will be due at the time of service. We will accept VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, CASH AND CHECKS. **Checks and Cash are our preferred payment method.**
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with insurers and other health plans to accept an assignment of benefits. We will bill the insurers/health plans that we have an agreement with, but we require you to pay the copay, deductible and coinsurance at the time of service for your treatment.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have authorization, you will be responsible for the complete charge.
- You must inform the office of all insurance changes, authorization and referral requirements. In the event the office is not informed, you will be responsible for any charges denied by your insurance.
- Surgical procedures require pre-payment. You will be informed in advance of your cost estimate. This estimate is never a guarantee of payment or coverage. Payment will be due five days prior to the surgery.
- Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due to this office.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party: _____ Date: _____

New Braunfels Podiatry Associates Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INFORAMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Understanding Your Health Record/Information

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in education health professionals;
- A source of data for medical research;
- A source of information for public health officials charged with improving the health of the nation;
- A source of data for facility planning and marketing and
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used help you to:

- Ensure its accuracy
- Better understand who, what, when, where and why others may access your health information
- Make more informed decision s when authorization disclosure to others

Your Health Information Rights:

Although your health record is the physical property of the healthcare practitioner or facility that complied it. The information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information
- Obtain a paper copy of the notice of information practices upon request
- Inspect and copy your health record
- Amend your health record
- Obtain an accounting of disclosures of your health information
- Request communications of your health information by alternative means or an alternative location
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities:

This organization is required to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practice and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice

For More Information or to report a Problem

If you have questions and would like additional information, you may contact our office at (830) 625-1642.

If you believe your privacy rights have been violated, you can file a complaint with our office or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment, and Health Operations

We will use your health information for treatment. For example: Information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his/her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way the physician will know how you are responding to treatment.

We will use your health information for payment. For example: A bill may be sent to your or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations. For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used; in an effort, to continually improve the quality and effectiveness of the healthcare and service we provide.

Other Uses or Disclosures

Business Associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the Emergency Department and Radiology, certain laboratory tests, and a copy service we use when making copes of your health record. When these services are contracted, we may disclose your heath information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. So that your health inflation is protected, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with Family: Health professionals, using their best judgement, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof, health information necessary for your health, and the health and safety or other individuals.

Law Enforcement: We may disclose your health information for law enforcement purposes as required by law, or in response to a valid subpoena.

Federal law makes provision for your health information to be release to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.