PATIENT REGISTRATION FORM

Patient information *(please use full legal name, no nicknames, circle all that apply*

Last name ______________________ First Name ______________________ MI ______

Address ______________________________

City ______________ State _____ Zip __________ Home Phone: ______________

Work Phone ______________ Cell Phone ______________ Social Security _____ - _____ - _____

Gender M F Marital Status S M D W Birth date ________ E-mail: ______________

Emergency contact ______________________ Emergency phone ______________

Referring Physician ______________________ Phone ______________

Primary Physician (if different from referring) ______________________ Phone ______________

Employer name and address: ______________________________

Pharmacy: Albertsons CVS Kroger Savon TomThumb Walgreens Wal-mart Other: __________

Pharmacy (general location and phone): ______________________________

Guarantor information *(Person responsible for paying this bill)*

Relationship to Patient: Self Spouse Parent Other: __________

Last name ______________________ First Name ______________________ MI ______

Address ______________________ City ______________ State _____ Zip __________

Phone: ______________ Social Security _____ - _____ - _____ Birth date ______________

Insurance information *(please allow receptionist to photocopy your insurance ID card)*

Primary insurance: ______________ HMO PPO POS

Claims address and phone: ______________________________

Policy ID number: ______________ Group number ______________

Secondary insurance: ______________ HMO PPO POS

Claims address and phone: ______________________________

Policy ID number: ______________ Group number ______________

Rev:7/31/2008

the CLUB FOOT CLUB!

Clubfoot Clinic

New patient form

When was your child diagnosed with clubfoot? ____________________________________

Does anyone else related to your baby have a history of clubfoot or congenital defects?____________________________________

Does your child have any other known congenital defects?____________________________________

____

Has the clubfoot(feet) been treated anywhere else?_(if no, skip to # 10)________________

1. How soon after birth did the casting start?____________________
2. How many casts were applied____________________
3. How were the casts removed?____________________
4. Were the casts removed by you at home?____________________
5. Were the casts plaster or fiberglass?____________________
6. How often were they changed?____________________
7. Did these casts go from the toes to the groin?____________________
8. Was the "Ponseti Method" used?____________________
9. Did your child have any sores from the casts?____________________
10. Who is your pediatrician and which state does he/she practice?________________
    Who is your perinatologist?____________________
11. Would you like me to contact either of them?

MEDICAL HISTORY FORM

Name__________________________ Date of Birth__/__/____ Sex M ☐ F ☐ DATE ____________________

Whom may we thank for referring you? ______________________________

YOUR CHILD'S PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS

General

☐ Fever
☐ Chills
☐ Night Sweats
☐ Unexplained Weight Loss
☐ Serious Infection
☐ Diabetes Mellitus
Avg. blood sugar ________
☐ HIV Infection
☐ Cancer (type)___________
☐ Anemia

Cardiovascular

☐ Chest Pain
☐ Heart Attack when?__________
☐ High Blood Pressure
☐ Congestive Heart Failure
☐ Heart Murmur
☐ Heart Valve Disease
☐ High Cholesterol
☐ Atrial Fibrillation
☐ Blood Clots In Veins
☐ Vascular Grafts

Respiratory

☐ Shortness of Breath
☐ Wheezing
☐ Asthma
☐ Bronchitis
☐ Emphysema
☐ Tuberculosis
☐ Pneumonia
☐ Coughing Blood

HEENT

☐ Double Vision
☐ Eye Pain
☐ Glaucoma

Musculoskeletal

- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Degenerative Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Broken Bones
  Where?_______________
- ☐ Osteoporosis
- ☐ Psoriatic Arthritis
- ☐ Lupus
- ☐ Fibromyalgia
- ☐ Chronic Back Pain
- ☐ Chronic Neck Pain
- ☐ Muscle Weakness
- ☐ Previous Foot/Ankle Surgery

Endocrine

- ☐ Gestational Diabetes
- ☐ Under Active Thyroid

Gastrointestinal

- ☐ Nausea/Vomiting
- ☐ Diarrhea
- ☐ Stomach Ulcer
- ☐ Gallstones
- ☐ Hepatitis
- ☐ Hernia
- ☐ Liver Disease
- ☐ Hemorrhoids
- ☐ Rectal Bleeding
- ☐ Colon Polyps
- ☐ Irritable Bowel Syndrome

Genitourinary

- ☐ Incontinence
- ☐ Kidney Stones
- ☐ Kidney Disease
- ☐ Frequent Urinary Infections

Skin

- ☐ Rash
- ☐ Ulceration
  Where? _______________
- ☐ Skin Cancer
- ☐ Eczema
- ☐ Change in Skin Color

Neurologic/Psychiatric

- ☐ Neuropathy
- ☐ Numbness Tingling
- ☐ Sciatica
- ☐ Seizures
- ☐ Stroke
- ☐ Migraine Headaches
- ☐ Memory Loss
- ☐ Depression
- ☐ Anxiety
- ☐ Multiple Sclerosis

Other:

____

____

____

____

____

____

____

Surgery Performed on your Child:(List complications if any)

____

____

____

____

DISCLOSURE AND CONSENT FORM

Patient Last Name ______________________________ First Name ______________________________ DOB: ________

Authorization for Medical Treatment:

I authorize the physicians in charge of the care of this patient to administer any treatment as may be necessary or advisable in the diagnosis and treatment of this patient. This authorization includes but is not limited to routine diagnostic procedures, laboratory tests, rehabilitation therapy and x-rays. I acknowledge that no guarantees have been made to be as to results of my treatments, tests or procedures. I also authorize copies of the medical records to be released to other physicians and health care facilities as deemed necessary by any physician whose care the patient is under.

Assignment of Benefits

I assign all benefits to and authorize direct payment of benefits to Metroplex Foot and Ankle Center, PLLC, all insurance benefits and or Medicare/Medicaid benefits to which I may be entitled. This assignment specifically included, but is not limited to, major medical and disability insurance proceeds and benefits. It also specifically includes proceeds and benefits accruing under any settlement, structured or otherwise or awarded in judgment for personal injuries caused by a third party. A photocopy of this assignment shall be as valid as the original.

Statement of Responsibility

I understand that I am financially responsible to Metroplex Foot and Ankle Center, PLLC as the patient, guardian, conservator, or insured for all charges not covered by the above assignment, which charges may include any medical insurance deductibles and co-insurance. I understand that to sign as a guarantor means that if the patient does not pay for all charges, I, as guarantor will be responsible for such payment.

Non-covered Medicare/Medicaid Services:

Medicare/Medicaid have certain outpatient procedures that are excluded from coverage, including but not limited to those of routing diagnostic workups or routine physical examinations. If the patient's medical chart indicates that the patient's treatment is one for which no Medicare/Medicaid benefits are allowable, I understand that all charges incurred during treatment will be the patient's own financial responsibility. There are other limitations and charges for which the patient may be responsible; the patient will be provided additional information with regard to these charges and limitations on a separate written form.

Authorization to Release information to Insurance Company/Third Party Payer:

I authorize Metroplex Foot and Ankle Center, PLLC and any physician, therapist, practitioner, pharmacist or other person, any hospital including Veterans Administration or government hospital, any medical service organization, any insurance company, or any other institution or organization to release any medical information about the patient necessary to determine any benefits which may be payable for this treatment.

Personal Valuables:

Metroplex Foot and Ankle Center, PLLC, shall not be liable for the loss of or damage to any personal property.

The undersigned certified that he or she has read the foregoing or is the guarantor/guardian and is duly authorized by or on behalf of the patient to execute the above and accept its terms.

Patient or Guarantor Signature ______________________________ Date: ______________________

Guarantor name (if different from above): ____

FINANCIAL RESPONSIBILITY FORM

It is your responsibility to provide us with your most current insurance information. If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered. We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company. We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company.

You are financially responsible for services not covered by your insurance company. Before receiving services, you must verify that we are participating providers for your insurance company. In the event we are not participating providers, we will file the initial claim as a courtesy. Payment, however, is due in full at the time of service. We charge the usual and customary fees for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Copayments, coinsurance and/or deductibles are due at the time of service. We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim regardless of our estimation.

It is your responsibility to provide us with your most current billing information. ª You must provide your most current billing address, all available telephone numbers and any other important contact information. If your address or contact information changes, it is your responsibility to contact us with the updated information. We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30 days after receipt of the initial statement. You can call **(817)595-1310.**

Payment in full is due upon receipt of the statement. Patient balances not paid in full within 30 days of the statement issue date are deemed past due. **Past due accounts may be subject to a $5.00 monthly late fee and/or a 1.5% monthly interest fee and may be referred to a professional collection agency and/or attorney for further collection activity.** You will be responsible to pay all collection costs incurred, including attorney's fees and court costs if applicable.

If you are not able to pay the balance due in full, you must arrange a payment schedule. Any late fees already incurred on past due balances will be included in any mutually agreed upon arrangements. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney. You will be responsible for all collection costs incurred, including attorney's fees and court costs if applicable.

In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add $25.00 to your original balance. In addition, we may seek all additional legal remedies provided to us under Texas law. We may charge you a "No Show" fee of $35.00 if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date.

Failure to keep your account balance current may require us to cancel or reschedule your appointment.

Patient or Guarantor Signature ______________________ Date: ________________

Guarantor name (if different from above): ____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that Metroplex Foot and Ankle Center, PLLC, reserves the right to change their Notice of Privacy Practices and prior to implementation will post a copy in the physician office. I may request a copy of the updated Notice of Privacy Practices by calling the physician's office or requesting a copy in person at my appointment.

Patient or Guardian Signature ______________________ Date: __________________

Guardian name (if different from above): ____

The following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for Metroplex Foot and Ankle Center, PLLC. to share my protected health information with:

Name ______________________ Relationship: __________________

Name ______________________ Relationship: __________________

Name ______________________ Relationship: __________________