



Patient Name: _____ Sex: Male Female
Address: _____ City: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell: _____
Email: _____ Shoe Size: _____
Occupation: _____ Employer: _____
Patient's DOB: _____ SS#: _____
TX Driver's License #: _____ Marital Status: _____
Name of Spouse or Parent: _____ Contact #: _____

Primary Insurance

Insurance Company: _____ Member ID: _____
Name of Insured: _____ DOB: _____ Relationship: _____

Secondary Insurance

Insurance Company: _____ Member ID: _____
Name of Insured: _____ DOB: _____ Relationship: _____

Medical History

Reason for visit: _____

Duration of problem: _____ Have you been treated for this problem before? _____

Family Physician: _____ Phone #: _____ last visit: _____

Are you presently under the care of a physician? Yes No

Have you had any surgery in the past two years? Yes No

Are you answered "yes" to any of the above questions, please state reason: _____

Are you allergic to any medication? Yes No

If "yes" please list: _____

Are you currently taking any medication? Yes No

If "yes" please list: _____

Have you ever been treated for the following:

Diabetes	Yes No	Arthritis	Yes No
Stomach Ulcer	Yes No	Difficulty Healing	Yes No
Phlebitis	Yes No	Epilepsy	Yes No
High Blood Pressure	Yes No	Tuberculosis	Yes No
Kidney Problems	Yes No	Anemia	Yes No
Gout	Yes No	Asthma	Yes No
Stroke	Yes No	Fractured bones	Yes No

Surgical History

Please list below surgeries which have been performed on you:

Year	Procedure	Reason

Family History

Have any blood relative had any of the following:

Arthritis, Gout Yes No Relationship: _____

Asthma, Hay fever Yes No Relationship: _____

Cancer Yes No Relationship: _____

Chemical Dependency Yes No Relationship: _____

Diabetes Yes No Relationship: _____

Heart Disease, Stroke Yes No Relationship: _____

High blood pressure Yes No Relationship: _____

Kidney Disease Yes No Relationship: _____

Tuberculosis Yes No Relationship: _____

Other (Please Specify): _____

Health Habits

Do you use...	If yes, how much?
Caffeine	
Tobacco	
Drugs	
Other	

I understand that honest and complete answers to each question stated above are important to the provision of my medical care and I have answered them to the best of my ability. I have been informed that if I am uncertain about any questions on the form I should ask that doctor or member of the office staff for assistance.

PATIENT SIGNATURE

DATE

Assignment and release

I, the undersigned, certify that I (or my depend) have insurance coverage with _____ (Name of Insurance Company) and assign directly to Dr. Marco A Vargas all Insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Vargas to release all necessary information to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

RESPONSIBLE PARTY'S SIGNATURE

RELATIONSHIP

DATE

REVIEWER'S SIGNATURE

DATE



Payment Policy

Thank you for choosing Foot & Ankle Associates as your foot care provider. We are committed to providing you with quality and affordable health care. Please read the following office payment policy and feel free to ask us any questions that you may have. Once you accept this policy, kindly sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some - and perhaps all - of the services you receive may be uncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. If required, obtaining the proper referral from your Primary Care Physician is your responsibility. Patients presenting to our office without a valid referral will be asked to pay in full. This payment will be held for 48 hours and will become non refundable if the proper referral is not obtained by then.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

7. Forms and Documents. It is our policy to charge \$25.00 for completion of all forms, such as disability applications, FMLA forms, etc.

8. Fees. Our fees are representative of the usual and customary charges for our area.

9. Health Reimbursement Account- If you have an HRA account, it is your responsibility to inform the office upon your first visit. A letter from your HRA must be on file in order for us to honor not collecting at the time of service.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of patient or responsible party

Date

Foot & Ankle Associates reserves the right to amend or change its practices, policies, or procedures with regard to PHI at any time, and to make such changes effective for all PHI in our possession, including any PHI that may have been created or received proper to such changes. In the event of such a change the Foot & Ankle Associates will post a new revision of this Notice in our facility and make a copy of it available to you upon request.

Foot & Ankle Associates is required to make sure that at all times our office operates in a manner that is consistent with the provision of the most current revision of this notice. If at any time you believe that Foot & Ankle Associates has acted in manner inconsistent with our current Notice of Privacy Practices, or you feel your rights to privacy have been violated in any way, you are entitled to file a complaint with this office or with the Secretary of the Department of Health and Human Services. To file a complaint with this office, or for further information with regard to this notice or the Foot & Ankle Associates privacy practices, please contact the Office Manager at (281)342-8700. The Foot and Ankle Associates will not retaliate in any way against any individual who files a complaint either with this office or with the Secretary of the Department of Health and Human Services.

Use or Disclosure of PHI for Treatment, Payment, and Operations

The Foot & Ankle Associates may use or disclose your PHI without your authorization for your treatment, to receive payment for any services rendered, and for the normal operations of this office. For example:

Treatment- We may use or disclose your PHI in coordination treatment among our staff or with other providers, such as a primary care physician or specialist.

Payment- We may use or disclose your PHI for your Insurance company as required to obtain payment for any services that have been rendered.

Operations- We may use or disclose you PHI for quality assurance purposes, as part of employee performance evaluations, or to help train new employees.

Other Uses or Disclosures of PHI Permitted or Required Without Your Authorization

Foot & Ankle Associates may also use or disclose you PHI without your written authorization in the following situations:

1. To You: Foot & Ankle Associates may disclose your PHI to you;
2. Incidental to an Otherwise Permitted Use or Disclosure: Accidental disclosures of your PHI that occur in the course of making an otherwise permitted use or disclosure are permitted as long as Foot & Ankle Associates has taken appropriate safeguards to try to protect the confidentiality of your PHI, and has satisfied the Requirements to use the minimum amount of PHI necessary for any permitted use disclosure of PHI;
3. Appointment reminders: Foot & Ankle Associates may use or disclose you PHI to contact you to provide appointment reminders, information about treatment alternatives that may apply to you, and other health related services or benefits that may be of interest to you;
4. Disclosure to Others Involved in Your Care: PHI may be used or disclosed to family members or others designated by you as bring involves in your care. This may include notifying such individuals who are waiting for you while you are being treated in our facility, or leaving telephone messages concerning your condition, your treatment, or your account on answering machines or with family members. Such disclosures will be limited to minimum information necessary or to the extent of the person's involvement in your care. You have the right to object to such disclosure. Please notify the Front Desk if you wish to object;
5. Disaster Relief/Response: Foot & Ankle Associates may disclose your PHI to a public or private entity that is authorized by law or by its charter to assist with disaster relief efforts (for example, the Red Cross);

6. Required by the Secretary of Health and Human Services: PHI may be used or disclosed to demonstrate our compliance with the Health Insurance Portability Act, if so directed by the Secretary;
7. Required by Law: PHI may be used or disclosed to the extent required by law such as for the purposes of report abuse or neglect, in response to a judicial or administrative proceeding, or as may be required for law enforcement purposes. Such disclosures will be limited to the minimum information required by the law;
8. For Public Health Activities: PHI may be used or disclosed for public health activities such as; preventing or controlling disease, injury, or disability; reporting child abuse or neglect; reporting necessary for the Food and
9. Drug Administration (FDA); to notify someone who may have been exposed to a communicable disease; or reports to employers about work related injuries or work place surveillance;
10. To Report Victims of Abuse, Neglect, or Domestic Violence: PHI may be used or disclosed to agencies disclosures of your PHI that were made, with certain exceptions, within the six (6) years prior to the date of request. If you would like to receive an accounting of disclosures, please see the Front Desk for the proper form.
11. Right to Receive Copies of This Notice of Privacy Practices: You have the right to receive a paper copy of our most current Notice of Privacy Practices at any time. If you would like to receive a new copy, please ask the Front Desk.

Acknowledgment of Receipt of the Notice of Privacy Practices

I hereby acknowledge that I have received a copy of the Foot & Ankle Associates Notice of Privacy Practices.

Print patient name

Signature of patient

Date

For Office Use Only

Patient was given a copy of the Foot & Ankle Associates Notice of Privacy Practices but their written acknowledgment could not be obtained.

Print Employee's name

Signature of Employee

Date

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

Foot & Ankle Associates is required by law to maintain the privacy of Protected Health Information and to provide individuals with notice of our legal duties and privacy practices with respect to Protected Health Information. This document is being provided to you in fulfillment of these obligations.

Protected Health Information, or PHI as it may be referred to in this document, is information about our identity (e.g. your name, address, social security number, etc.), your past, present or future medical or mental condition (e.g. Procedures performed, lab tests ordered, etc.) , and past, present, or future payment for medical services (e.g. Insurance carrier, deductibles, payments made etc.)