PODIATRY ASSOCIATES OF SOUTHEAST TEXAS
PLEASE PRINT

DATE ____________

PREFERRED PHONE # ________________________**ALTERNATE PHONE #**________________________

PATIENTS NAME ____

STREET ADDRESS ____

CITY________________________STATE___________________ZIP CODE___________________________

SEX ☐ M ☐ F AGE______ DATE OF BIRTH _____-_____-_____ ☐ SINGLE ☐ MARRIED ☐ WIDOW
☐ DIVORCED ☐ SEPARATED

SOCIAL SECURITY # __________________________ **WERE YOU INJURED AT WORK**?_____________

PATIENT EMPLOYED BY ________________________OCCUPATION_____________________________

BUSINESS ADDRESS ___________________________BUSINESS PHONE____________________________

SPOUSE NAME _________________________

NAME OF PRIMARY INSURANCE _____________________IS REFERRAL REQUIRED?_________________

NAME OF SECONDARY INSURANCE ____

NAME OF INSURED ____

INSURED DATE OF BIRTH ___-____-____ EMPLOYER__________________WORK#_____________________

RELATIONSHIP TO PATIENT ______________________SOCIAL SECURITY # __________________________

EMERGENCY CONTACT _____________________________**PHONE#**________________________________

WHO IS YOUR FAMILY DOCTOR? ____

WHO REFERRED YOU HERE? ____

Due to Doctor/Patient CONFIDENTIALITY, this office is not allowed to release any information, written or by phone regarding your condition without written consent from you. Often times, family members will phone the office regarding your visit. Please sign below indicating YOUR PREFERENCE. Also, please supply us with a list of those persons to whom we can release information. **If the patient is a minor, signature should be the responsible party**.

PATIENT SIGNATURE: ____

I **DO** give permission to release my medical information to the following persons:

PERSONS NAME	**RELATIONSHIP TO PATIENT**
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

PATIENT SIGNATURE: ____

I **DO NOT** give permission to release medical information

PODIATRY ASSOCIATES OF SOUTHEAST TEXAS

I understand that honest and complete answers to each question stated below 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 an uncertain about any question on the form, I should ask the doctor or a member of the office staff for assistance.

YES	NO	
☐	☐	Is the patient currently a resident of a Skilled Nursing Facility?
☐	☐	Are you now, or have you been in the past 2 years, under the care of a physician for any reason? If so, for what illness?____________________
☐	☐	Do you have diabetes? What year were you diagnosed?____________________
☐	☐	Are you on any medications for **DIABETES?** Name and dose of medication:____________________ ____________________ ____________________ What is your blood sugar normally?____________________
☐	☐	Can you take Aspirin products?
☐	☐	Do you have any history of bleeding ulcers or hiatal hernia?
☐	☐	Have you ever experienced any side effects from anesthesia?

Have you been treated for any of the following?

YES	NO	
☐	☐	Heart Problems
☐	☐	Asthma
☐	☐	Blood Born Illness, i.e. ***HIV / Hepatitis A, B, C***

Do you have a family history of any of the following?

YES	NO		
☐	☐	Diabetes	
☐	☐	Gout	
☐	☐	Heart Trouble	
☐	☐	Varicose Veins	
☐	☐	Neuromuscular Disease	
☐	☐	Peripheral Vascular Disease	
☐	☐	Do you consume alcohol?	Amount:____________________
☐	☐	Do you use tobacco?	Amount:____________________

Please answer the following questions as completely as possible.
What is your current foot problem?____
____
Is your foot problem related to a work injury? ____________________________________
Height:________________Weight:___________________Shoe Size:__________________________
Surgeries:____

PODIATRY ASSOCIATES OF SOUTHEAST TEXAS
FINANCIAL POLICY

Your covered medical expenses are based on the contract between **YOU** and **YOUR** insurance carrier. Our office will **try** to verify your insurance coverage and collect the necessary co-pay, deductible and/or co-insurance amounts. Although we may **estimate** what your insurance company will pay, it is the insurance company that makes the **final determination** of benefits. Therefore, it is possible that you may be responsible for more than initially estimated.

Some services rendered **may** apply to your **deductible,** and not be covered under your co-pay. If the service is applied to your deductible it is your responsibility to pay. This MAY include:

Surgery, Injections, Foot Castings, and X-rays.

Secondary Insurance

We will file a claim with your secondary insurance carrier as a courtesy. The CORRECT insurance information must be provided BEFORE services are rendered. If we have not received payment from the secondary carrier within 60 days of filing the claim the balance will become your responsibility.

If your insurance company requires a referral, **YOU** are responsible for obtaining it. Failure to obtain the referral may result in lower or **NO** payment from the insurance company.

If you have a balance on your account, we will send you a monthly statement. Unless we approve other arrangements in writing, the balance on your statement is due and payable when the statement is issued. Delinquent balances will be sent to a collection agency

MEDICARE WILL NO LONGER PAY FOR TOE NAIL TRIMMING FOR PATIENTS THAT DO NOT HAVE **DIABETES.** If you **do not** have diabetes and would like to have your toenails trimmed, we will collect **$30.00** at the time of service.

Payment options: Cash, Checks, and Credit Cards.

I authorize the release of any medical information necessary to process this claim. I hereby authorize Dr. Burrell or Dr. Lusk to apply for benefits on my behalf for services rendered. I request that payment from my insurance company be made directly to Dr. Burrell or Dr. Lusk. I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original.

PATIENT SIGNATURE:____

DATE: ___________

WE DO NOT TREAT WORK RELATED INJURIES!!

Patient Medication List

Patient Name________________________________ Date of birth:________________

Drug Allergies____

Medication & Dosage	Frequency	Doctor that prescribes this for you
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

PODIATRY ASSOCIATES OF S.E. TEXAS
NEIL A. BURRELL, D.P.M.
DEBRA J. LUSK, D.P.M.

WELCOME TO OUR OFFICE!

We would like to thank you for choosing our office for your podiatric needs. As often happens in offices, patients usually have questions regarding office appointments, etc., and we would like to take this opportunity to explain them to you so there will be no misunderstanding later.

This information is for new AND established patients:

** You are considered a "new" patient if we have not seen you in at least 3 years. This means that you will receive a bill with "new patient" charges on it. This is standard procedure for all medical offices as directed by the federal government. You must see the doctor at least once a year in order for your prescriptions to be filled.

______

(Initial)

FINANCIAL INFORMATION:

Our office staff will be happy to discuss our fees with you **PRIOR** to seeing the doctor. We want our patients to understand our fees and feel confident that they are getting the best medical care available for their dollar. **PAYMENT IN *FULL* WILL BE REQUESTED FOR EACH VISIT BEFORE YOU LEAVE** if you are not on one of the insurances that we are in network with. You will be provided with a detailed itemization of charges at the time of payment for this visit. You will receive two copies: one for you to file with your insurance, and the other for you to keep for your records. We suggest you keep this record of your visit, which will also indicate that your account is paid in full. You will also be given an appointment card as a reminder of any future appointments if needed.

NO PAYMENT ARRANGEMENTS WILL BE MADE FOR NEW PATIENTS.

______

(Initial)

ACCEPTED FORMS OF PAYMENT: **CASH, CHECK OR CREDIT CARD (VISA, MASTERCARD OR DISCOVER)**

****INSUFFICIENT FUNDS CHARGE IS $25.00**

______________________ ______________________

Signature **Date**

INSURANCE:

If you are on an H.M.O. or any insurance plan that requires referral from your primary care doctor to see a specialist, it is *YOUR* responsibility to get that referral before your visit in our office. You will also be expected to pay your co-pay upon arrival or you will have to reschedule your appointment.

______

(Initial)

We want to reiterate to you that payment for services received by you or your family members is your **sole responsibility**. **Payment is due in FULL at time services are rendered** if we do not accept your insurance or if you have a deductible on your insurance that has not been met.

______

(Initial)

DIVORCE:

Please remember that divorce is a civil action between husband and wife. Your bill is still payable and due. Federal and State laws supersede divorce actions. Divorce does not cancel financial responsibility for your minor children *you* bring in for treatment.

______

(Initial)

NOT SHOWING FOR SCHEDULED APPOINTMENT:

This is extremely troublesome for us. We realize that sometimes "things" come up and you are unable to keep an appointment. **PLEASE CALL AT LEAST 24 HOURS IN ADVANCE IF AT ALL POSSIBLE TO CANCEL AN APPOINTMENT**. **We reserve the right to discharge you as a patient if you "no show" for your appointment two or more times.**

______

(Initial)

We do attempt to call to remind you of the appointment, but ultimately it is the patient's responsibility to remember.

______

(Initial)

MEDICAL RECORDS:

This office holds your medical records in the strictest confidence. They will not be released to **anyone** (including you) without your ***explicit written permission***.

The medical records processing fee is $25.00. Medical records requests will be processed within 15 days of receipt of the written request and pre-payment.

______

(Initial)

BILLING RECORDS:

Billing records are processed in the same manner as medical records, but there is usually no fee associated for providing these records to you.

______

(Initial)

DISABILITY AND INSURANCE FORMS:

There is a $25.00 processing fee for completing disability and insurance forms. Should your insurance or disability company require medical records and/or billing records, the fees for those services will also be charged.

______

(Initial)

______________________________ ______________________________

SIGNATURE **DATE**