WOODLY
FOOT & ANKLE SPECIALISTS, PC

Today's Date:_____

PLEASE PROVIDE YOUR INSURANCE CARD(S) AND PHOTO ID

PATIENT'S LAST NAME: FIRST NAME:

PATIENT'S GUARANTOR/GUARDIAN:

PATIENT'S ADDRESS: CITY: STATE: ZIP

HOME PHONE: CELL PHONE:

DATE OF BIRTH: Email Address:

GENDER: F M SHOE SIZE: HEIGHT: WEIGHT:

MARTIAL STATUS: SPOUSE'S or PARENT'S NAME:

MY FOOT PROBLEMS ARE:

HOW LONG HAVE YOU HAD THE PROBLEM(S): DAYS: WEEKS: YEARS:

INSURANCE INFORMATION

ARE YOU THE INSURED: Y N If NO - NAME OF INSURED:

PRIMARY INSURANCE: GROUP #

POLICY# EFFECTIVE DATE

SECONDARY INSURANCE: GROUP #

POLICY# EFFECTIVE DATE

COMPLETE THIS SECTION ONLY IF NAME OF INSURED IS DIFFERENT FROM PATIENT

LAST NAME: FIRST NAME: GENDER: F M

INSURED'S ADDRESS

CITY: STATE: ZIP:

HOME PHONE: WORK PHONE:

INSURED'S DATE OF BIRTH: SOCIAL SECURITY NUMBER:

WHAT IS THE INSURED'S RELATIONSHIP TO THE PATIENT:

PLEASE COMPLETE THIS SECTION

Pharmacy: LOCATION AND PHONE NUMBER:

PATIENT'S PRIMARY CARE PHYSICIAN:

ADDRESS:

CITY: STATE ZIP

PHONE: DATE OF LAST VISIT:

Please read carefully: For the purpose of filing insurance claims and insurance verificaton, I authorize the release of any information and I assign benefits to the doctor. I acknowledge that if the doctor and/or staff are **misquoted** my benefits, and/or my eligibility by my insurance company, the doctor and/or staff are **not responsible for the insurance company's mistake.** I will be billed based on my insurance company's explanation of benefits. By signing below, I agree to the above terms of financial responsibility.

PATIENT SIGNATURE (OR PARENT/GUARDIAN SIGNATURE IF PT IS a MINOR) DATE:

WOODY
FOOT & ANKLE SPECIALISTS, PC

PATIENT NAME _____

TODAY'S DATE _____

HISTORY & MEDICAL INFORMATION

EXPLAIN YOUR FOOT PAIN LEFT RIGHT

_____

PRIMARY CARE PROVIDER: _____ **DATE LAST SEEN:** _____

WHEN DID PAIN/DISCOMFORT BEGIN? DAYS? WEEKS? MONTHS?

DESCRIBE YOUR DISCOMFORT

BURNING *NUMBNESS* *SHARP* *OTHER* _____

WHAT MAKES THE PAIN/DISCOMFORT BETTER? _____

_____

HAVE YOU HAD PHYSICAL TRAUMA OR AN ACCIDENT? NO

YES, describe: _____

OCCUPATION _____ IS YOUR PROBLEM WORK RELATED?

PAST MEDICAL HISTORY *CIRCLE ALL THE APPLY:*

ANEMIA	HEART DISEASE	NERVE DISORDERS	RHEMATIOD ARTHRITIS
BLEEDING DISORDER	HEPATITIS	NEUROLOGICAL DISORDERS	PROSTATE DISORDER
CANCER	HIGH CHOLESTEROL	OSTEOARTHRITIS	LUNG/RESPIRATORY DISORDER
DIABETES	HIV/AIDS	STROKE	
EPILEPSY	HIGH BLOOD PRESSURE	THYROID DISORDERS	
GOUT	KIDNEY DISEASE		

LIST OF MEDICATIONS: _____

_____

_____

ALLERGIES ***CIRCLE ALL THAT APPLY*** NONE

PENICILLIN	CODEINE	ASPIRIN	MYCINS	OTHER, PLEASE LIST
ANESTHESIA	DEMEROL	SULFA	TAPE	

SURGICAL HISTORY YES NO

IF YES, PLEASE DESCRIBE: _____

_____

SOCIAL HISTORY ***CIRCLE ALL THAT APPLY***

TOBACCO USE	ALCOHOL USE	EXERCISE HABIT, PLEASE DESCRIBE:
CAFFEINE USE	DRUG USE	_____

Patient Name DOB: Acct#

Financial Responsibility

Durable Medical Equipment, orthotics, in-office surgery (including injections), and physical therapy are often not covered by even the most comprehensive medical insurances, including secondary to Medicare. Unfortunately, this can result in out-of-pocket expenses for you. As a courtesy to you, it is our policy to communicate with your insurance company to help you avoid any circumstances where you would unknowingly have out-of-pocket expenses due to non-covered benefits, deductibles, copays, and coinsurance. **However, we are not responsible if your insurance company misquotes your benefits and/or coverages.** By signing below, you assume full responsibility for all allowable charges not covered by your medical insurance.

Please contact your insurance company in advance if you have any questions about what expenses you may incur. If your insurance will not allow a service provided by our office and you prefer not to pay out-of-pocket, please let us know so we can discuss other options.

_____ DATE: _____

Signature of Patient (or Parent/Guardian) Date

****

Stride Healthcare, PLLC Signature Authorization

Information Release

I authorize the providers of Stride Healthcare, PLLC to release any information obtained in the course of my evaluation and/or treatment to my insurance company(ies), primary care physicians, and/or attorney(s). I further authorize any other medical provider of services to release full details of my condition to Stride Healthcare, PLLC for the purpose of medical treatment.

Initials: _____

Direct Payment

I authorize payment directly to Stride Healthcare, PLLC for the amount due in my pending claim for podiatry expenses payable under the terms of my insurance. I agree that I am responsible for any services or supplies that may not be covered by my insurance.

Initials: _____

Balance Payment

I agree that I am responsible for any balance not paid by my insurance based on my insurance company's explnation of benefit, (including Medicare secondary insurance). I understand that if I fail to resolve any balance determined to be my responsibility, my account may be forwarded to collections.

Initials: _____

Photographic and Radiological Release - Clinical Records

I authorize the providers of Stride Healthcare, PLLC to take necessary clinical photographs and X-rays with the understanding that such records are for confidential clinical purposes only. If my insurance company requires medical records to process my claim, I authorize the release of my records for that purpose.

Initials: _____

Change of Information

I will use best efforts to notify Stride Healthcare, PLLC PC of any change to my information (address, phone numbers, insurance company etc) in a timely manner. Should I fail to notify Stride Healthcare, PLLC of a change in my insurance carrier, I agree that I will be responsible for any charges not payable due to my failure to obtain any necessary referrals, authorizations, and/or coverage benefits. I realize that this is my responsibililty when seeking the care of a specialist.

Initials: _____

I have read and fully understand the above statements. I agree that I am bound and hereby give my consent.

_____ DATE _____

Patient Signature (Parent or Guardian) Date

Patient Name DOB: Acct#

Statement of Financial Responsibility

Please read and sign

I understand that I am responsible for any charges incurred during any visit or treatment by the doctors and staff of Stride Healthcare, PLLC.

Initials: _____

As a courtesy to me, the staff of Stride Healthcare, PLLC will make every effort to verify my insurance, its benefits and coverages, however, it is my responsibility to verify my plan's network, benefits, and coverages for services provided by Stride Healthcare, PLLC. The doctors and staff of Stride Healthcare, PLLC will file my insurance when appropriate, but I will be ultimately responsible for all charges.

Initials: _____

If my insurance company misquotes my benefits to the staff of Stride Healthcare, PLLC, we are not responsible for the mistake. I understand that I will be billed for any amounts not covered according to my insurance's explanation of benefits.

Initials: _____

My insurance company may not cover my charges for the following reasons: My insurance company may not cover the service, my insurance may not be in effect, the charges may be applied to my deductible/copay and/or coinsurance, I did not bring a referral for this care, the referral did not arrive in time for the visit or for any other reason deemed by my insurance.

Initials: _____

If my insurance requires a referral, it is my responsibility to ensure that this doctor's office has received my referral. If a referral is not on file with this doctor's office and I am seen, I will be charged the self pay rates.

Initials: _____

I understand that payment is due at the time of service. I understand that my account will be turned over to collections if payment is not made after 61 days of 1st bill from Stride Healthcare, PLLC.

Initials: _____

*****24 HOUR APPOINTMENT CANCELLATION NOTICE IS REQUIRED*****

I Understand that a Fee of $30.00 will be accessed to my account if I fail to provide a 24 hour cancellation notice resulting in a missed appointment.

Initials: _____

X_____ **DATE:**_____

Patient/Parent/Guardian Signature

Services will not be provided without a signed financial statement

WOODLY
FOOT & ANKLE SPECIALISTS, PC

TODAY'S DATE: _____

Due to Health Insurance Portability and Accountability Act (HIPPA) of 1996, the following information must be filled out by each patient annually.

I authorize Charlton G. Woodly, DPM to release my medical or insurance information as necessary to process my medical claims and coordinate or manage my healthcare.

YES **NO**

In the event a family member or caregiver attends your office visits and is the exam room at the time of your evaluation and/or treatment, I give Dr. Charlton G. Woodly, DPM of Stride Healthcare, PLLC, and its physicians or employees my permission to

YES **NO**

Does Dr. Charlton G. Woodly, DPM have permission to send a copy of your treatment note to your Primary Care Physician per his/her discretion?

YES **NO**

Please provide the numbers below where we have consent to leave a message:

May we leave a message at your home?	**YES**	**NO**	HOME PHONE: _____
May we leave a message at your work?	**YES**	**NO**	WORK PHONE: _____
May we contact you via message/text or	**YES**	**NO**	CELL PHONE: _____
May we contact you on your email?	**YES**	**NO**	EMAIL: _____

With whom may we discuss or release information about your care, treatment or diagnosis?

NAME: _____ PHONE: _____ Relationship to you? _____

NAME: _____ PHONE: _____ Relationship to you? _____

NAME: _____ PHONE: _____ Relationship to you? _____

NAME: _____ PHONE: _____ Relationship to you? _____

*****How Did You Hear About Us or Whom May We Thank For Referring You*****

LAST NAME: _____ FIRST NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

Patient/Parent/Guardian Signature _____ **DATE SIGNED:** _____

PRINT PATIENT'S NAME: _____

HIPAA NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment:

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations:

We may use or disclose, as-needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility.

We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment. We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration

requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation.

Required Uses and Disclosures:

Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights:

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically. You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerning or objections to this form, please ask to speak with our Medical Director in person or by phone at 817-284-8271.

Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided.

We welcome your comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.

Your signature below is acknowledgement that you have received this Notice of our Privacy Practice.

Printed Name: _____

Signature: _____

Date: _____