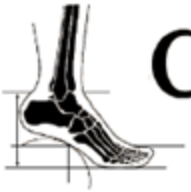

CENTER FOR FOOT AND ANKLE RESTORATION

Charles E. Cook, M.D.
John M. Noack, M.D.

www.footankledallas.com
Phone: 214-265-7175
Fax: 214-691-5940

Patient Profile

Name:_____ Date of Birth:_____

Address:_____
(Street) (City) (State) (Zip)

Home#: (_____)_____-_____ Work#: (_____)_____-_____

Email:_____ Preferred Contact Method: email/cell/work/home

Marital Status: _____ Sex: Male/Female SS#: _____

How did you hear about us? Another Patient / Physician Referral / Google / Other: _____

Referring Physician: _____ Phone #: (_____)_____-_____

Primary Care Physician: _____ Phone #: (_____)_____-_____

Language: _____ Race: _____ Ethnicity: Latino/Not Latino/Decline

Next of Kin/Emergency Contact & Phone #: _____

Occupation: _____ Employer: _____

Preferred Pharmacy: _____ Pharmacy Phone #: (_____)_____-_____

INSURANCE INFORMATION: (If you have **Medicare and a secondary plan**, please inform the receptionist)

Insurance Carrier: _____ Member ID#: _____

Name of Insured: _____ Relationship to Insured: Self/Spouse/ Child/Other

Insured's Date of Birth: _____ Insured's SS# _____

I authorize Orthopedic Specialists to release medical information that may be necessary to request reimbursement by my insurance company to whom I have submitted claims. I understand I am responsible for all medical fees during my treatment with Orthopedic Specialists. If surgery is required, I assign all medical and or surgical benefits to include major medical benefits to which I am entitled to Orthopedic Specialists. This assignment will remain in effect until revoked by me in writing. A photocopy of assignment is to be considered as valid as an original. I understand that this office does not accept returns or issue refunds for any durable medical equipment. I understand that all refunds for my account must be requested by myself or my guarantor, and may take up to 90 days to process. I have reviewed this office's Notice of Privacy Practices, which explains how medical information will be used and disclosed. This includes the knowledge that all communications via email are not secure, and any information I send/receive is also not secure.

In the event I should need surgery, I understand Dr. Cook and Dr. Noack are in partnership with a group of surgeons and Texas Health Resources in the ownership of Texas Institute for Surgery.

By signing below, I acknowledge that I have read the above information.

Signature:_____ Date:_____

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Financial Policy I

Thank you for choosing our office as your health care providers. We are committed to providing excellent health care services. As part of our professional relationship, it is necessary that you have an understanding of our financial policy.

By signing below, you understand and accept that it is your responsibility to:

CURRENT INSURANCE: Provide us with your CURRENT ACTIVE INSURANCE CARD upon check-in at every visit, as well as if your insurance changes at any time. Failure to do this will prevent this office from filing your claims to meet insurance timely filing deadlines, and you will be financially responsible for any services denied.

SECONDARY INSURANCE: We do not file to secondary insurance unless it is traditional Medicare. If you have Medicare B and a supplemental insurance plan, it is your responsibility to update your Coordination of Benefits with Medicare and your supplement every year so that Medicare forwards your claim directly to your supplemental insurance. If your supplement does not pay your claim because your COB is not updated accurately, you will receive a statement in the mail from our office and are responsible for payment.

UNDERSTAND YOUR INSURANCE BENEFITS: It is your responsibility to know and understand your contractual insurance benefits including if we are participating providers for your insurance plan. Copays, deductibles, and coinsurances are due at the time of services rendered. **All fees collected at the time of service are estimates** based on your plan benefits verified through your insurance, and you may receive additional charges or a credit after insurance has processed all claims. Should your insurance refuse payment for any services including durable medical equipment, you will be financially responsible for those services at our self-pay prices. You will receive a statement (to the billing address you provide) notifying you of any balance due on your account. If you have any questions, it is your responsibility to contact our billing department within 30 days of receipt of your statement.

REFUNDS: Refunds can only be issued after your insurance has processed all outstanding claims, and may take up to 90 days to process.

BOUNCED CHECKS/CHARGEBACKS: You will be charged a **$35 Returned Check Fee** for any checks that the bank returns unpaid for any reason as well as any credit card chargebacks.

NO SHOW FEES: You may be charged a **NO SHOW Fee of $35** if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date.

COLLECTIONS: Failure to keep your account balance current may require us to cancel your appointment and all further treatment until your balance is paid in full.

ALL ESTIMATED FEES ARE COLLECTED AT THE TIME SERVICES ARE RENDERED, BUT THESE ARE ESTIMATES ONLY BASED ON YOUR VERIFIED INSURANCE BENEFITS

WE ACCEPT CASH, MASTERCARD, VISA, AND DISCOVER.

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Financial Policy II

Our healthcare providers take great pride in offering the best medical treatments available to our patients, regardless of Insurance and government/FDA recommendations and approvals. Every insurance plan is unique, and insurances choose what medical diagnoses and treatments they consider medically necessary for their members, including traditional Medicare.

It is your responsibility to communicate with your insurance to determine coverage based on your plan and it's policies. Below we have provided you with a list of potentially non-covered medical treatments that we offer our patients. This list does not include every possible diagnosis and treatment, but ones we have found to be commonly non-covered.

If a diagnosis or treatment is deemed non-medically necessary by your insurance based on its own policies, it will be non-covered and the cost will fall on you, the patient.

You may be asked to pay for a service or treatment that is considered non-medically necessary prior to treatment being rendered. If your insurance covers the treatment and you have paid for it out of pocket, you will be provided with a refund per our policy. You may call your insurance to determine if any of the below are covered by your individual plan.

POTENTIALLY NON-COVERED MEDICAL DIAGNOSES AND TREATMENTS:

Calluses
Flat feet
Cavus foot pattern
Other congenital foot deformities

Durable Medical Equipment (orthotics, ankle braces, walking boot, etc.)
Skin and Ulcer Debridement
Plantar Wart Destruction
Shockwave Therapy
Platelet Plasma Injections
Stem Cell Injections
Total Ankle Replacement Surgery

By signing this form, you acknowledge you have read, understand, and accept our Financial Policies.

Patient/Guarantor Signature: _____ Date: _____

Orthopedic Specialists
8440 Walnut Hill Ln., Ste 110
Dallas, TX 75231

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HIPAA Authorization Form

I, _____ give permission to all my health care providers and payers to release and release my protected health information described below to:

Name(s):	Relationship:
_____	_____
_____	_____
_____	_____

This medical information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims purposes or related reasons.

Health information to be released (check one):

[] My complete medical records (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing) OR

[] My complete medical records, as noted above, apart from the following information:

(please specify) _____

This authorization will be effective until (check one):

[] All past, present and future periods OR [] Date or event: _____

unless I revoke it. (NOTE: You can revoke this authorization in writing at any time by notifying your healthcare providers.)

Name of the patient: _____ Date: _____

Signature of the person granting this authorization: _____

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Social Needs Screening

HOUSING

1. Are you worried or concerned that in the next two months you may not have stable housing that you own, rent, or stay in as a part of a household?
   - ☐ Yes
   - ☐ No
2. Think about the place you live. Do you have problems with any of the following? (check all that apply)
   - ☐ Bug infestation
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Inadequate heat
   - ☐ Oven or stove not working
   - ☐ No or not working smoke detectors
   - ☐ Water leaks
   - ☐ None of the above

FOOD

3. Within the past 12 months, you have worried that your food would run out before you got money to buy more.
   - ☐ Often true
   - ☐ Sometimes True
   - ☐ Never true
4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.
   - ☐ Often true
   - ☐ Sometimes True
   - ☐ Never true

TRANSPORTATION

5. Do you put off or neglect going to the doctor because of distance or transportation?
   - ☐ Yes
   - ☐ No

CHILD CARE

6. Do problems getting child care make it difficult for you to work or study?
   - ☐ Yes
   - ☐ No

EDUCATION

7. Do you have a high school degree?
   - ☐ Yes
   - ☐ No

UTILITIES

8. In the past 12 months, has the electric gas, oil, or water company threatened to shut iff services in your home.
   - ☐ Yes
   - ☐ No
   - ☐ Already shut off

EMPLOYMENT

9. Do you have a job?
   - ☐ Yes
   - ☐ No

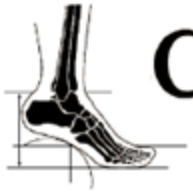
FINANCES

10. How often does this describe you? I don't have enough money to pay my bills.
    - ☐ Never
    - ☐ Rarely
    - ☐ Sometimes
    - ☐ Often
    - ☐ Always

PERSONAL SAFETY

11. How often does anyone, including family, physically hurt you?
    - ☐ Never (1)
    - ☐ Rarely (2)
    - ☐ Sometimes (3)
    - ☐ Fairly often (4)
    - ☐ Frequently (5)

12. How often does anyone, including family, insult or talk down to you?
    - ☐ Never (1)
    - ☐ Rarely (2)
    - ☐ Sometimes (3)
    - ☐ Fairly often (4)
    - ☐ Frequently (5)



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Patient Questionnaire I

PATIENT NAME:_____ **DATE:** _____

Please describe the problem you are here for today: [] Left [] Right [] Ankle [] Foot [] Other (Please explain below)

_____

How long have you had the problem? _____ Date of injury (if applicable): _____

If it is an injury, how did the injury happen and where did it occur: _____

Is this a work-related injury? ___Yes ___No

Please check mark the type of symptoms you have: (check all that apply)

[] Sharp [] Aching [] Stabbing [] Dull [] Cramping [] Throbbing [] Pins & Needles [] Numbness [] Constant [] Intermittent

On a scale of 1-10, how severe is the pain? No Pain 1 2 3 4 5 6 7 8 9 10 Severe Pain

What makes it worse : Standing / Walking / Running / Shoe wear / Exercise : _____

What makes it better : Rest / Elevation / Ice / Anti-inflammatories / Activity modification : _____

Do you walk with an assisted device? [] Cane [] Crutches [] Walker Did you bring: []X-rays [] MRI []CT [] Bone Scan

What physician(s) have you seen for this problem? _____

MEDICAL HISTORY: Please check any health issues that apply to you:

[] No known medical problems			
[] AIDS/HIV	[] Cancer, breast	[] Gout	[] Childhood diseases
[] Alcoholism	[] Cancer, colon	[] Heart attack	[] Liver problems
[] Alzheimer's	[] Cancer, lung	[] High blood pressure	[] Bleeding problems
[] Anemia	[] Cancer, prostate	[] Hepatitis	[] History of infections
[] Rheumatoid Arthritis	[] COPD	[] Kidney problems	[] Neuromuscular disorder (Parkinson's, etc)
[] Asthma	[] Depression	[] Arthritis	[] Other heart problems
[] Blood clot, leg	[] Diabetes, I or II	[] Seizures	[] PACEMAKER
[] Blood clot, lung	[] Drug abuse	[] Bleeding ulcers	
[] Stroke	[] Sleep apnea	[] Use of blood thinners	

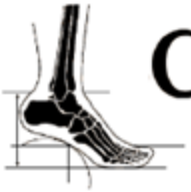
Please describe any other health problems you have not checked in the above list:_____

_____

_____

_____

_____



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Patient Questionnaire II

SURGICAL HISTORY: Please list any surgeries you have had in the past: **[] No surgical history**

_____

_____

_____

Have you ever had general anesthesia? [] Yes [] No If yes, any problems? [] Yes [] No _____

FAMILY MEDICAL HISTORY: Please check any of the following family medical problems and circle the familial affiliation

[] **No Known Family Medical Problems** **F = Father M = Mother S = Sibling C = Child**

[] AIDS/HIV	F M S C	[] Diabetes	F M S C	[] Kidney	F M S C
[] Anemia	F M S C	[] Gout	F M S C	[] Liver Disease	F M S C
[] Blood Clots	F M S C	[] Heart Attack	F M S C	[] Muscle Disease	F M S C
[] Cancer	F M S C	[] Hemophilia	F M S C	[] Osteoporosis	F M S C
[]Coronary	F M S C	[] Hypertension	F M S C	[] Osteoarthritis	F M S C
[] Rheumatoid Arthritis	F M S C	[] Other: _____			

SOCIAL HISTORY: [] Employed [] Student [] Disabled [] Retired

Do you smoke: [] Yes [] No If yes, how many per day? _____ If no, have you smoked in the past? [] Yes [] No

Height: _____ ft. in. Weight: _____ lbs. Shoe size: _____ Could you be pregnant? [] Yes [] No

CURRENT MEDICATIONS: Please list prescription and over the counter medications WITH dose amounts

Name of medication:	Dosage:	How often do you take it:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES (DRUGS ONLY): [] **No Known Drug Allergies**

Name of medication:	Reaction if taken:
_____	_____
_____	_____
_____	_____

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Patient Questionnaire III

REVIEW OF SYSTEMS: **Please check all that apply. If all are negative, check this box []**

Constitutional
[] Weight Loss or gain
[] Weakness
[] Fatigue
[] Fever

Cardiovascular
[] HIGH BLOOD PRESSURE
[] Chest Pain
[] Rheumatic Fever
[] Palpitations
[] PACEMAKER

Musculoskeletal
[] Joint Pain
[] Arthritis
[] Muscular Weakness
[] Stiffness
[] Muscular Pain

Eyes
[] Glasses or Contacts
[] Blurred Vision
[] Glaucoma
[] Cataracts
[] Excessive Tearing

Respiratory
[] Shortness of Breath
[] Cough
[] Wheezing
[] Asthma
[] Bronchitis

Skin
[] Rashes
[] Sores
[] Lumps
[] Dryness
[] Itching

Endocrine
[] Thyroid Trouble
[] Excessive Sweating
[] Excessive Thirst

ENMT
[] Ears Ringing
[] Ear aches
[] Hearing Aid
[] Frequent Colds
[] Hay Fever
[] Nosebleeds
[] Dentures
[] Bleeding Gums
[] Frequent Sore Throats

Gastrointestinal
[] Heartburn
[] Rectal Bleeding
[] Abdominal pain
[] Gallbladder trouble
[] Hepatitis

Genitourinary
[] Blood in Urine
[] Urinary Infections
[] Kidney Stones
[] Burning on Urination
[] Sexual Transmitted Disease

Neurologic
[] Headache
[] Dizziness
[] Seizures
[] Loss of Sensation
[] Vertigo

Psychiatric
[] Nervousness
[] Depression
[] Mood Change

Hemolymphatic
[] ANEMIA
[] Easy Bruising
[] Easy Bleeding
[] Swollen Glands

Immunologic
[] Reactions to Drugs
[] Skin Rashes
[] Reactions to Foods

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Fall Risk Assessment

Complete ONLY if you are 65 years of age or older

PATIENT NAME:_____ **DATE:** _____

Please circle **YES** or **NO** for each statement below:

YES (3) NO I have fallen more than once in the past year.

YES (3) NO I have fallen at least once in the past year and sustained an injury from this fall.

YES (2) NO I have fallen once in the past year.

YES (2) NO I use or have been advised to use a can or walker to get around safely.

YES (1) NO I sometimes feel unsteady or lose my balance when walking.

YES (1) NO I sometimes steady myself by holding onto furniture or walls.

YES (1) NO I need to push myself up from out of a chair with my hands.

YES (1) NO I sometimes have trouble stepping up onto a curb.

YES (1) NO I frequently have to rush to the toilet.

YES (1) NO I have lost some feeling in both of my feet.

YES (1) NO The medication I take sometimes makes me feel light headed or sleepy.

YES (1) NO I take medicine to help me sleep or improve my mood.

YES (1) NO I often feel sad or depressed.

_____ **Total** Add up the number of points from your circled answers.

If you scored 4 or more points, you may be at risk for falling. Please discuss ways that may help prevent future falls with your physician.