Bluebonnet Foot and Ankle Institute, LLC

REGISTRATION FORM

(Please Print)

Today's date: | Primary Care Provider:

PATIENT INFORMATION

Patient's last name: | First: | Middle: | ❑ Mr. ❑ Mrs. | ❑ Miss ❑ Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid

Maiden Name: | Race: | Ethnicity ❑ Hispanic/Latino ❑Not Hispanic/Latino ❑ Refused | Birth date: / / | Age: | Sex: ❑ M ❑ F

Social Security # | Address: | Home # : ( ) Cell #: ( )

P.O. Box: | City: | State: | ZIP Code:

Occupation: | Employer: | Employer phone #: ( )

Preferred Pharmacy(w/address):

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Email address for portal registration:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Subscriber Name: | Birth date: / / | Address (if different): | Home phone #: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation: | Employer: | Employer address: | Employer phone #: ( )

Is this patient covered by insurance? ❑ Yes ❑ No Insurance Carrier:

Insurance Address: | Insurance Phone #: ( ) | Birth date: / / | Group #: | Policy #: | Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable): | Subscriber's name: | Group #: | Policy #:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone #: ( ) | Work phone #: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Bluebonnet Foot & Ankle Institute, LLC or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Bluebonnet Foot and Ankle Institute, LLC

HEALTH HISTORY FORM

Name:_____ **Sex** □Male □Female

Date of Birth_____ **Number of Children** _____ **Shoe Size** _____

Local Pharmacy_____

Mail order Pharmacy_____

Occupation_____

Do you drink alcohol? □Yes □No **Exercise Level** None Occasional Moderate Heavy

Do you smoke? □Yes □No **Diet** Regular Gluten Free Diabetic

Do you use illegal drugs? □Yes □No

PAST MEDICAL HISTORY

Have you ever had any of the following conditions?

Anxiety	□Yes	□No
Arthritis	□Yes	□No
Asthma	□Yes	□No
Atrial Fibrillation	□Yes	□No
Bone Marrow Transplant	□Yes	□No
Breast Cancer	□Yes	□No
Colon Cancer	□Yes	□No
COPD	□Yes	□No
Depression	□Yes	□No
Diabetes	□Yes	□No
Hearing Loss	□Yes	□No
Hepatitis	□Yes	□No
High Blood Pressure	□Yes	□No
HIV/AIDS	□Yes	□No
High Cholesterol	□Yes	□No
Hyperthyroidism	□Yes	□No
Hypothyroidism	□Yes	□No
Lung Cancer	□Yes	□No
Pacemaker/Defibrillator	□Yes	□No
Prostate Cancer	□Yes	□No
Seasonal Allergies	□Yes	□No
Seizures	□Yes	□No
Stroke	□Yes	□No

Are you currently experiencing any of the following

Neuropathy	□Yes	□No
Gout	□Yes	□No
Pregnant	□Yes	□No
Leg Swelling	□Yes	□No
Unplanned Weight Loss	□Yes	□No
Dialysis	□Yes	□No
Edma	□Yes	□No
Foot Deformity	□Yes	□No
Nausea/Vomiting	□Yes	□No
Enlarged Glands	□Yes	□No
Joint Pain	□Yes	□No
Muscle Aches	□Yes	□No
Lymphoma/Leukemia	□Yes	□No
Shortness of Breath	□Yes	□No
Problems Healing	□Yes	□No

Others:

_____

_____

Surgical History

_____

_____

_____

_____

Family

_____

_____

_____

_____

ALLERGIES

Please list all allergies & reactions to Medications, food, etc.

_____

_____

_____

_____

Medications (Use back if needed)

Please list all current medications including over the counter

_____

_____

_____

_____

_____

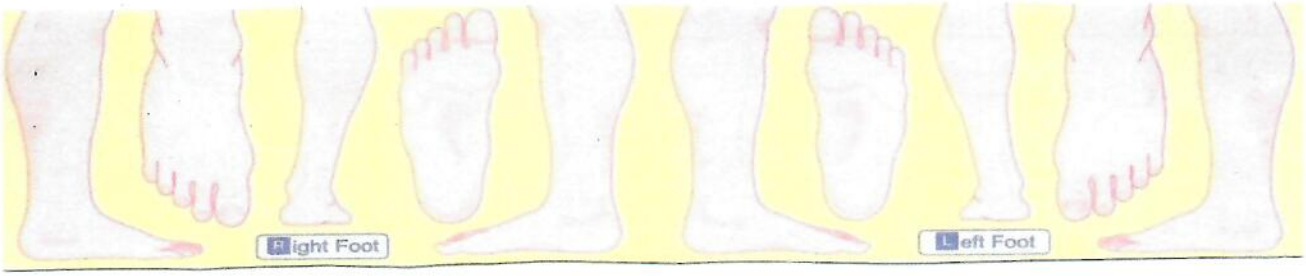
Bluebonnet Foot and Ankle Institute, LLC

Current Foot or Ankle Problem(s)

Please describe your current problem(s): _____

_____

Mark pain or discomfort on the diagram:



Please rate your pain from 1 (lowest) to 10 (highest): 1 2 3 4 5 6 7 8 9 10

Circle the type of pain you are experiencing: No pain Sharp pain Dull pain Aching Burning Itching Radiating Stabbing Other pain (please describe): _____

When did this problem start? _____

Did the problem develop suddenly or gradually? _____

What makes it feel worse (please circle)? Walking Standing Daily activities Resting Running Certain shoes Other: _____

What makes it feel better? _____

How has this problem affected your lifestyle/ability to work? _____

If this was caused by an injury, please describe: _____ Work related? Y N

Statement of Medical History Accuracy "I have answered the questions on this form as accurately as possible. I understand that providing incorrect or misleading information can limit the physician's ability to accurately diagnose and treat my condition. It is my responsibility to inform the physician of any changes in my medical status."

_____ _____
Signature Date

_____ _____ _____
Responsible Person, if other than patient Relationship Date

Bluebonnet Foot and Ankle Institute, LLC

PATIENT RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

Bluebonnet Foot and Ankle Institute, LLC has provided information regarding the Notice of Privacy Practices. This notice describes the practice's commitment to privacy, my rights to privacy, and how **Bluebonnet Foot and Ankle Institute** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

By signing this form, I am acknowledging that I have reviewed the Notice of Privacy Practices which explains how my medical and personal information will be used and disclosed. I understand that I am entitled to receive a copy of this document, upon request.

Patient Name (Printed)

Signature of Patient/Personal Representative **Date**

Relationship to Patient

Bluebonnet Foot & Ankle Institute, LLC

Bluebonnet Foot & Ankle Institute Patient Financial Responsibility Policies

Any applicable deductibles, coinsurance or co-payments are due at the time of service rendered as part of your insurance contract.

Uninsured Patients Bluebonnet Foot & Ankle Institute, LLC offers a same pay discount to uninsured patients. All monies owed must be made the day of visit for the discount to apply.

Bluebonnet Foot & Ankle Institute, will submit the claim on your behalf for the date of service. Any claims that are denied or unprocessed due to lack of update information will be patients' responsibility. ***If a patient has insurance that requires a referral, it's the patient's responsibility to ensure the Bluebonnet Foot & Ankle has the referral on the day of their appointment.***

Bluebonnet tries to verify eligibility before services are rendered, but it's ultimately the patient's responsibility to have knowledge of their insurance coverage. If a patient's insurance is not able to be verified due to ineligibility, the patient can do the following, keep the appointment, reschedule until insurance is verifiable. Some HMOs require not only a doctor to doctor referral **BUT** also an authorization approval number from their insurance prior to the appointment.

In order for Bluebonnet Foot & Ankle Institute, LLC, to keep negotiating and accepting the majority of insurance available to our patients and consumers in general; we are responsible for collecting deductibles and coinsurances from patients as part of the services rendered at time of services. To ensure that claims are processed properly, it's important that the patients updates Bluebonnet with the correct/current Insurance information, patient phone numbers and current address

There is a $30.00 fee for returned checks, which must be settled promptly with a credit card or cash only. If Bluebonnet receives 2 returned checks, we will no longer be able to accept personal checks, all future payments must be made paid with either cash or credit card.

A $25.00 late cancellation/rescheduling fee will be assessed for failure to provide any notice of cancellations for any provider appointment, within 24 hours of scheduled appointment time.

I have read and understand the Office policy of Bluebonnet Foot & Ankle, LLC, as stated above and I understand that I am responsible for any outstanding monies that my insurance didn't cover or if I fail to provide the office with any updated billing information that might delay the processing of my claim.

_____	_____	_____
Signature of Patient/Legal Guardian	Printed Name	Date

Bluebonnet Foot & Ankle Institute, LLC

Office Policies

An answering service is available to take your call after business hours, weekends and holidays, leave a message and your call will be returned the following business day. If you are having a medical emergency, go to your nearest emergency room or dial 911. _____ (initials)

Any phone calls made during regular business hours will be addressed as soon as possible, if you call before 4:00pm. If you feel that you have an urgent medical concern, please call to schedule an appointment. _____ (initials)

For refills on medications, contact your pharmacy, so they can fax the request to our office, (3), three days prior to running out of your medication. We are not able to approve refill requests after routine business hours. _____ (initials)

There is a $10.00 per page fee for all forms that are completed by the physician and letters to be typed or completed by our physicians. Forms will be completed 5-7 after being dropped off and paid for. _____ (initials)

For a printed copy of your medical /billing records, there is a fee of $35.00. _____ (initials)

We respect the strict confidentiality of the physician-patient relationship. We ask the same of you. By signing below, you agree that you will not make any recording of any person in this facility without their express written permission. _____ (initials)

We encourage you to be an informed consumer by understanding your coverage, how to access information from your carrier, and which ancillary providers, e.g., lab and x-ray facilities, participate with your plan. Please inform us of changes to your demographics or insurance coverage. _____ (initials)

I have read the office policy of Bluebonnet Foot & Ankle Institute, LLC as stated above. I authorize medical care by designated staff members at Bluebonnet Foot & Ankle Institute, LLC. I authorize the release of any Patient Health Information necessary to process claims. I authorize payment of medical or government health benefits to the treating providers.

_____ _____ _____

Signature of Patient/Legal Guardian Printed Name Date

Bluebonnet Foot & Ankle Institute, LLC

Authorization to Release Medical Information to Individuals/Family Members

In accordance with federal government privacy rules implemented through the Healthcare Portability Act of 1996(HIPAA), in order for your physician or staff of Bluebonnet to discuss your condition or fiances with members of your family or other individuals that you designate, we must obtain your written authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____ **I DO NOT** authorize Bluebonnet Foot & Ankle Institute, LLC, to release any or all information concerning my medical care or finances to any individual.

_____ **I DO** authorize Bluebonnet Foot & Ankle Institute, LLC, to verbally release/communicate any or all information concerning my medical care or finances to the following individuals listed below:

Name	Phone Number/Relationship

_____ _____ _____

Signature of Patient/Legal Guardian Printed Name Date

Authorization for Release of Medical Records

Release Records to:

Bluebonnet Foot & Ankle Institute, LLC
4131 Spicewood Springs Rd, #K-1
Austin, Texas 78759
(512) 394-5108, Fax (512) 394-5109

Release Records from:

Facility/Doctor Name: _____

Fax Number: _____

I request a copy or summary of the following Medical Records:

- Diagnostic reports
- Labs, clinical notes
- Hospital records
- Other: _____

I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndromes(AIDS), or human immunodeficiency virus(HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

_____ Yes, I consent to the release of this information.

_____ No, I Do Not consent to the release of this information.

Any other use of this information without the written consent of the patients is prohibited. Powever, I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules. I understand that I may revoke this authorization at any time by notifying Bluebonnet Foot & Ankle Institute in writing. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under the policy.

This authorization will remain valid as long as I am under the care of Bluebonnet Foot & Ankle, Institute, LLC.

_____ _____ _____

Signature of Patient/Legal Guardian Printed Name Date