ANKLE AND FOOT INSTITUTE OF TEXAS

816 Towne Ct. Ste 100
Saginaw, Texas 76179
P: 817-847-8500
F: 817-847-8522
WWW.AAFOOT.COM

PATIENT INFORMATION:

Name:_____Date:_____ Home

Phone:_____Work:_____Ext.____ Cell:,_____

Address:_____

Email Address: _____

Date of Birth:_____ Social Security Number:_____ Sex: ( )M( )F

Race: _ _ _ _ _ _ _ Ethnicity:._____ Primary Language:_____ Pharmacy

Address phone#:_____

Whom may we thank for referring you? _____

INSJJRANCE INFORMATION

Primary Insurance:_____

ID/Member#_____ Group Number: _____

Policy Holder Name (if not patient: _____DOB_____Relationship: _____

Secondary Insurance : _____

ID/Member#..... Group Number: _____

Policy Holder Name (if not patient): _____DOB____ _ Relationship: _____

EMERGENCY CONTACT INFORMATION:

Name: Relationship:,_____

Cell:_____Home Phone:._____

MEDICAL PROVIDERS:

Name of Family Physician: _____Phone:_____ Date Last Seen:_____

Name of Former Podiatrist:_____Phone:_____Date Last Seen:_____

PHARMACY INFORMATION:

Pharmacy Name: _____Phone: _____

Address:_____

(Street) (City) (State) (Zip

****

I certify that the above insurance information is current and accurate. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions and its representatives may use my health care information and may disclose such information to the above-named insurance company for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services received.

_ _ _ _ _____.X_____ _ _ _ _ _ _

PRINT Name of Indiv./Legal Guardian SIGNATURE of Indiv./Legal Guardian Date

ANKLE AND FOOT INSTITUTE OF TEXAS

Patient Name:_____ Date of Birth:_____ Today's Date: _____

HISTORY OF PRESENT ILLNESS/ WHAT BRINGS YOU IN?

What is your specific foot/ankle problem? Injury? _____

_____

_____

When did the problem begin? _____

The problem is: D Improving D Worsening D Unchanged

What aggravates the problem? _____

Is the problem painful? D Yes D No If so, rate your current pain: (none) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Describe the pain: D Sharp D Dull D Aching D Throbbing D Cramping D Itching ☐ Popping
D Burning D Tingling D Clicking D Shooting D Stabbing D Other: _____

Which foot/ankle is involved? D Right D Left D Both

First visit to a doctor for this problem? D Yes D No

Have you had a similar problem in the past? D Yes D No

How was the problem onset? D Sudden D Gradual

The problem is worst: D AM D PM D At Rest D With Activity

What improves the problem? _____

Describe previous treatments: _____

Is this from a Work Related injury? D Yes D No Is this from an Auto Accident? D Yes D No Date: _____

PAST MEDICAL HISTORY

D Diabetes Type 1 or 2 Duration __ years Last Blood Sugar____ HbAlc __

D Acid Reflux/GERD

D Accidents/injury _____date:_____

D Anemia

D Anesthesia Complications

D Arthritis (D Osteo / D Rheum)

D Artificial Joints

D Back Problems/Sciatica

D Blood Clot/DVT ____ date: _

D Cancer:

D Cellulitis/Skin Infection (D MRSA?)

D Circulation Problems

D Defibrillator

D Dementia/Alzheimer's (circle)

D Depression/ Anxiety (circle)

D Dialysis

D Ear/Nose/Throat Issues

D Excessive/Easy Bleeding

D Fibromyalgia

D Foot/Leg Ulcer (circle)

D Gout

D Healing Problems/Keloids

D Heart Disease/Heart Attack/CHF/Afib

D High Blood Pressure (D Low BP?)

D HIV or AIDS

D Immune Disorder

D Kidney Disease

D Liver Disease (D Hepatitis B or C)

☐ Leg Cramps/Leg Pain at Rest

☐ Lung Condition/COPD/Asthma/___ _

D Lupus

D Lymphadema

D Mitral Valve Prolapse/Murmur

D Multiple Sclerosis

D Neuropathy

D Osteomyelitis/Bone Infection

D Osteoporosis

D Pacemaker

D Parkinson's Disease

D Previous Addiction to:

D Pulmonary Embolism

D Raynauds Disease/Phenomena

D Seizure Disorder/Epilepsy

D Sickle Cell Disease/Trait

D Sleep Apnea

D Stomach Ulcers

D Stroke D Rt D Lt year

D Thyroid Condition (D Hi D Lo)

D Tuberculosis

D Venous Insufficiency (PAD/PVD)

D Pregnant? Breastfeeding? (circle)

LIST ALL PREVIOUS SURGERIES

☐ Amputation (s) __ Date:
☐ Hip Replacement Date:
☐ Knee Replacement Date:
☐ Cardiac Surgery Date:
☐ Foot Surgery: LEFT or RIGHT Date:
☐ Other:

_____

_____

_____

_____

FAMILY HISTORY (circle relative)

	Mother	Father	Sister	Brother	GrandParent
D Cancer		M	F	S B	GP
D Diabetes	M	F	S	B	GP
D Heart Disease	M	f	S	B	GP
D High Blood Pressure	M	F	S	B	GP
D Anesthesia Complications	M	F	S	B	GP
D Other: _____	M	F	S	B	GP

IMMUNIZATIONS

☐ Tetanus- Date last received: _____
☐ Influenza - Date last received: _____
☐ Pneumonia - Date last received: _____
☐ COVID - Date last received: _____
# of boosters: _____

Other problems not listed above.:.:_____

_____

ANKLE AND FOOT INSTITUTE OF TEXAS

Patient Name:_____ Date of Birth:_____ Today's Date: _____

MEDICATIONS (including herbs & supplements):

List of Medications:	Dose	Purpose

Are you taking your medications as prescribed? 0Yes 0No

ALLERGIES:

- ☐ Latex, Adhesive tape
- ☐ Other pain remedies
- ☐ Sulfa Drugs
- ☐ Other anesthetics
- ☐ Other Antibiotics
- ☐ Codeine
- ☐ Penicillin
- ☐ Morphine
- ☐ Shrimp, Iodine or Merthiolate
- ☐ Other anesthetics
- ☐ Aspirin, Advil, Aleve, Motrin
- ☐ Novocaine
- ☐ Empirin, Tylenol
- ☐ Other narcotics
- ☐ Other:

SOCIAL HISTORY:

Occupation: _____

☐ I Drink Alcoholic Beverages How much/often? _____

D I Use or Have Used Tobacco Products Type: _____

Packs/Day__ _ Years _____ When Stopped?

D I Use or Have Used Illegal Drugs

D Do you see Pain Management? D Yes D No Name and Phone# _____

ADDITIONAL

Age Height._____Weight..... cShoe Size ___ _

REATMENT CONSENT:

In order for Dr. Matthew Cerniglia, DPM to evaluate and treat the medical condition(s) I present, I am authorizing consent to allow for typical examinations, review of diagnostic testing, administration of medications, application of medical products, and all other pertinent care with reason of the practice of foot and ankle medicine. I agree to ask questions to clarify treatment should I not understand the treatment plan.

_____ _____ _____

PRINT Name of Indiv./Legal Guardian SIGNATURE of Indiv./Legal Guardian Date

PRIVACY STATEMENT

Ankle and Foot Institute of Texas is committed to protecting your privacy. We strive to provide you with the newest information through our web-based technology to give you a safe online experience. This Privacy Statement applies to our web site which governs any data collection and usage. By using this website, you consent to the data practices described in this statement.

Use of Cookies: This web site uses "cookies" to help us personalize your online experience. A "Cookie" is a text file that is placed on your hard disk by a web page server. Cookies are uniquely assigned to you and can only be read by a web server in the domain that issued the cookie to you. Cookies are common practice and cannot be used to run programs or deliver viruses to your computer.

Security of your Personal Information: We recommend all users keep their personal information private. The Practice secures the personal information of our users from being accessed from unauthorized individuals and entities.

Collection of your Personal Information: This Practice collects personally identifiable information, such as your e-mail address, name, home or work address or mobile telephone number to better understand our patient base and their relationship towards the practice. In addition, information about your computer hardware and software is automatically collected by this website. This information can include: your IP address, browser type, domain names, access times and referring Web site addresses. This information is used for the operation of the service, to maintain quality of the service, and to provide general statistics regarding use of this Web site. Please keep in mind that if you directly disclose personally identifiable information or personally sensitive data through public message boards, this information may be collected and used by others. This Practice is not responsible for the privacy statements or other content on any other Web sites.

Use of your Personal Information: This practice does not lease, sell, or rent its patient information to third parties. This practice does not use or disclose sensitive personal information, such as race, religion, or political affiliations, without your explicit consent. This practice will disclose your personal information, without notice, only if required to do so by law.

Third Party Partners: This practice may share data with trusted partners to help us perform statistical analysis, send you email or postal mail or provide customer suppo1t. All such third parties are prohibited from using your personal information except to provide these services and they are required to maintain the confidentiality of your information.

Changes to this Statement

This practice will occasionally update this Statement of Privacy to reflect company and patient feedback. We encourage you to periodically review this Statement to be informed of how this practice is protecting your information.

Contact Information: Please contact us by phone at 817-847-8500; address: 816 Towne Ct. Ste 100 Saginaw, Texas 76179.

ANKLE AND FOOT
INSTITUTE OF TEXAS

PLEASE READ CAREFULLY!

Protected Health information may be disclosed to insurance companies, managed care organizations or referring physicians during treatment, payment of healthcare operations. When information is disclosed to another entity, it may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule. You have the right to refuse or restrict our disclosure of your information. However, if you refuse or restrict disclosure, we will be unable to provide treatment to you. If you wish to refuse or restrict disclosure, please ask for a HIPAA Restriction form.

You have the right to determine how we may communicate with you concerning your treatment or payment for services. Please indicate below where we may leave messages for you.

I consent that Ankle and Foot Institute of Texas may contact me by:

Please check all that apply

□ Telephone at home
□ Leave message on answering machine at home
□ Telephone at work
□ Leave message with a person or on voice mail at work
□ Leave message on cellular phone or at any other number I provide
□ Email: _____@ _____.com net

I consent that Ankle and Foot Institute of Texas may discuss or disclose information regarding my clinical care and/or financial history with those listed here:

_____ _____
Name Relationship to patient

_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN **Date**

I acknowledge that I have been given an opportunity to read and understand **Ankle and Foot Institute of Texas'** Notice of Privacy Practices.

_____
Name of Patient

_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN **Date**

You may revoke this consent in writing except to the extent that the practice has already made disclosures in reliance upon your prior consent. If you do not sign this consent, Ankle and Foot Institute of Texas may decline to provide you treatment.

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Patient Consent for Use of Email, Text Communications with Ankle and Foot Institute of Texas

To better serve our patients, this office has established an email address tor some forms of communication with doctors, staff member and patients. For routine matters that do not require immediate response, you may feel free to contact us at those appropriate emails. At times, a doctor or staff member may use their personal cell phone to text with you at your request. Please remember, however, that this form of communication is not appropriate for use in an emergency. Please be aware that texting is not a secure form of communication.
The turnaround time for routine patient communications is one business day. The service provider may delay message delivery. **Should you require urgent or immediate attention, this medium is not appropriate.**
When sending email, please put the subject of your message in the subject line so we can process it more efficiently. Also, be sure to put your name and return telephone number in the body of the message. We also ask that you acknowledge receipt of emails coming from this office by using the auto reply feature.

Communications relating to diagnosis and treatment will be /tied in your medical record.

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of email and texting, third parties may have access to messages. When communicating from work, you should be aware that some companies consider email and texts corporate property, and your messages may be monitored. Even when emailing from home, you may feel that access to your email is not well controlled, so you should take that into consideration. In addition, you should be aware that, although addressed to a specific person, the other staff and/or doctors would have access to this information.

……

I **understand that this office will not be responsible for information loss or delay, or breaches in confidentiality that are due to technical factors beyond this office's control.**
I understand and agree to the above email policy.
By signing below, you are agreeing that we may send medical related correspondence to you via email or text, and that we may respond to your emails or texts to us via email or text.

PhotoNideo Consent: I hereby grant Ankle and Foot Institute of Texas permission to use my likeness in a photograph, video, or other digital media ("photo") in all of its publications, including web-based publications, without payment or other consideration.
I understand and agree that all photos will become the property of the Ankle and Foot Institute of Texas and will not be returned.

I hereby irrevocably authorize the Ankle and Foot Institute of Texas to edit, alter, copy, exhibit, publish, or distribute these photos for any lawful purpose. In addition, I waive any right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photo.

___ (initial) I HAVE READ AND UNDERSTAND THE ABOVE PHOTO RELEASE.

I AFFIRM THAT I AM AT LEAST 18 YEARS OF AGE, OR, IF I AM UNDER 18 YEARS OF AGE, I HAVE OBTAINED THE REQUIRED CONSENT OF MY PARENT/LEGAL GUARDIAN AS EVIDENCED BY THE SIGNATURE BELOW. I ACCEPT:

Patient Signature*: _____ Date_____

Parent/Legal Guardian Signature: _____ Date: _____

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FINANCIAL INFORMATION

Traditional Medicare Insurance:

Our office participates with Medicare. This means that we will send your claim to Medicare and we will adhere to Medicare's allowable fee schedule. Medicare sets an allowable fee for each service that they cover. Once you have met your annual deductible Medicare will pay us 80% of the allowable fee and you will be responsible for the remaining 20%. Ifyou have a secondary insurance this amount will then be sent on to them and you will be billed for any remaining balance after their payment.

Medicare has strict guidelines concerning their coverage of routine foot care such as trimming nails, or paring corns and calluses. The doctor will be able to determine if your routine foot care is or is NOT covered by Medicare. **Should you have a non-covered service such as this performed, you will be asked to pay for that service at the time of your appointment. We will also ask you to sign Medicare's Advanced Beneficiary Notice (ABN) indicating you were informed that Medicare will not be paying for that particular service.** The ABN will be provided at the time of visit.

If you have any other service such as a new patient office visit or a visit for a new problem performed on the same day as routine nail care or another non-covered service, Medicare will be billed for the covered service and we will collect the uncovered service fee from you that day as well.

All Other Insurances including Medicare Replacement Plans:

Ankle and Foot Institute of Texas will submit your claims to all other insurance companies providing:

At each visit we receive a copy of all current insurance identification cards.
Our Patient Information Form is current and correctly completed.
Our Financial Policy is signed.

If we have not heard from your secondary insurance within 60 days, you will be billed directly. In that event you must contact the insurance company directly to find out why your claim has not been paid. It is the patient's responsibility to give us their current insurance information. Ifwe do not have a copy of your current insurance card, or have received incorrect or old insurance information, all charges will become the patient's responsibility. **All uncollected co-pays and co-insurances from prior visits will be due at the time of your next appointment,** as specified in your insurance contract and mandated by your carrier in our participating provider agreement.

For your convenience, we accept cash, all major credit cards, debit cards, care credit and personal checks.

Payment is expected at each visit.

You will receive a billing statement for all personal balances due. If we have not received a response from you by phone or received a payment or letter regarding your unpaid balance within 90 days, your account will be sent to our collections department. ___ (initials)

No Insurance:

If you do not have health insurance, charges for the day's medical service are due at the time of service unless other arrangements have been made with the office in advance. In many cases, a cash payment discount may be given to patients without health insurance. _____ (initials)

Care Credit:

This is offered as a payment option for patients who qualify. Please speak to the office staff if you would like more information. There is a $35.00 fee assessed for returned checks. We understand that unexpected financial problems do arise. We encourage you to contact the office at (817-847-8500) immediately for assistance in managing your account. _____ (initia!i)

Referrals/ Authorizations:

It **is the patient's responsibility to obtain all referrals if your insurance requires one.** We will do all we can to assist you, but it is ultimately your responsibility. Ifa required referral is NOT in place PRIOR to your appointment, we may reschedule the appointment until it is received. ____ (initials)

FMLA/Disability Forms:

The doctor at Ankle and Foot Institute of Texas will complete your insurance disability form for al a fee of $25.00 for every disability form to be completed. The fee is payable upon presentation of the forms. The forms will NOT be completed until the $25.00 fee is received. ____ (initials)

I understand that there is a $10.00 fee for copies of medical records. Please call office to request medical records if necessary. _____(initials)

Missed/Canceled Appointment Policy:

We reserve the right to charge a patient for a missed/canceled appointment. If you cannot make your scheduled appointment, you should give us 24 hours notice. A charge for a missed appointment is NOT a charge for the service itsel[Established patient missed appointments will be assessed at a tee of$30.00 for each missed appointment. New patient no shows or late cancellations will result in a lee of$50. A $100 fee will be charged for surgery reschedule/cancellation. A $300 fee will be charged for surgery day no show/cancellation. Habitually missed/canceled appointments could lead to a patient being discharged from the practice. _____(initials)

Collections:

Ankle and Foot Institute of Texas will attempt to make payment tenns that meet your needs. If we do not hear from you by phone, mail or partial payment within 90 days of a statement being sent, you may be referred to a collection agency. In the event your account is assigned to collection, the patient agrees to be responsible for a 25% collection fee, as well as all court costs and attorney fees. _____(initials)

I understand that ifa custom DME product is ordered for me, such as orthotics, an air cast, night splint, surgical shoe, ankle brace, Powersteps, etc. that they are non-refundable and non-returnable. Ifmy insurance denies them for any reason, I understand it is ultimately my responsibility and I will pay for the product(s) I have received. _____(initials)

I understand that Ankle and Foot Institute of Texas's financial policy is in effect for the entire time I am a patient, not just for the date that I sign the policy. If Ankle and Foot Institute of Texas has any changes, our office will have you fill out a new form at that time. _____(initials)

I authorize **Ankle and Foot Institute ofTcxasn** to release information regarding my medical history and treatments to my insurance company in order for them to be paid. I also authorize payments for services to be paid directly to **Ankle and Foot Institute of Texas** from my insurance company.____ (initials)

I understand that unpaid balances must be paid prior to making a follow up appointment. I understand that I will speak with an office staff to initiate a payment plan ifmy balance is unmanageable. _____ (initials)

I acknowledge by signing my name below, as the patient or guardian of the patient, that I have read and initialed all of the above financial disclosures and understand and will comply. I have asked questions, if necessary, and I have had those questions answered and 1 understand.

Patie11t/Guardian Name(print)	*Patient /Guardian Signature*	*Date*