DIAGNOSTIC

FOOT SPECIALISTS

www.diagnosticfootspecialists.com

Robert D. Leisten, DPM
Board Certified In Foot And Ankle Surgery

Amy L. Haase, DPM
Board Certified In Foot And Ankle Surgery

Arnold N. Farbstein, DPM
Board Certified In Foot And Ankle Surgery

Patient Name: _____ Date: _____

Have you or anyone in your household had any of the following symptoms in the last 21 days: sore throat, cough, chills, body aches for unknown reasons, shortness of breath for unknown reasons, loss of smell, loss of taste, fever at or greater than 100 degrees Fahrenheit?

Yes: _____ No: _____

Have you or anyone in your household been tested for Covid-19? **(If tested positive)** Date of positive test.

Yes: _____ No: _____ Date (mm/dd/yyyy):_____

Have you or anyone in your household visited or received treatment in a hospital, nursing home, long term care or other health care facility in the past 30 days?

Yes: _____ No: _____

Have you or anyone in your household traveled in the US in the past 21 days?

Yes: _____ No: _____

Have you or anyone in your household cared for an individual who is in quarantine or who has tested positive for Covid-19?

Yes: _____ No: _____

Do you have any reason to believe you or anyone in your household has been exposed to or acquired Covid-19?

Yes: _____ No: _____

To the best of your knowledge have you been in close proximity to any individual who tested positive for Covid-19?

Yes: _____ No: _____

Are you or anyone in your household a health care provider or emergency responder?

Yes: _____ No: _____

Signed: _____

Heights/Northwest
1740 W. 27th St., #110
Houston, Texas 77008
713-862-3338 • 713-862-8800

Galleria Area
4100 Westheimer, #148
Houston, Texas 77027
713-850-0125

Memorial City
902 Frostwood, #250
Houston, Texas 77024
713-850-0125

Bryan/College Station
3201 University Dr. E, #100
Bryan, Texas 77802
979-774-3668

PATIENT INFORMATION FORM

First Name: _____ **MI:** _____ **Last Name:** _____

Date of Birth (DOB): _____ **Age:** _____ **Gender (M,F, Other):** _____
(mm/dd/yyyy)

Social Security No.: _____ **Driver License (DL) #:** _____ **DL State:** _____

Mailing Addr: _____

_____

City: _____ **State:** _____ **ZIP:** _____

Phone (Home): _____ **Cell:** _____ **Work:** _____

Email: _____ **Marital Status:** _____
(Single, Married, Divorced, Widowed)

Ethnicity: Are you Hispanic or Latino (**Yes or No**)? _____

American Indian or Alaskan Native ☐
Asian ☐
Black or African American ☐
Native Hawaiian/Other Pacific Islander ☐
White ☐
Other ☐

Employment Status: _____ **Employer:** _____
(FT, PT, Not Employed)

Emergency Contact: _____ **Phone:** _____
Relationship to Patient: _____

How Were You Referred to Us? _____
(Website, Existing Patient, Friend or Relative, Dr. Referral, Insurance Referral, Other -Please Describe)

Legal Representative/Responsible Party: **Name:** _____
(Who is responsible for the bill, if other than the patient?) **DOB:** _____
Address: _____
City: _____ **State:** _____ **ZIP:** _____
Phone: _____
Relationship to Patient: _____

PRIMARY Insurance: **Insurance Name:** _____
Cardholder Name: _____
ID #: _____ **Group #:** _____
Insured Date of Birth: _____ **SS#:** _____
(If different from patient) (If different from patient)

SECONDARY Insurance: **Insurance Name:** _____
Cardholder Name: _____
ID #: _____ **Group #:** _____
Insured Date of Birth: _____ **SS#:** _____
(If different from patient) (If different from patient)

PATIENT HISTORY FORM

Patient Name: _____ **Date:** _____

Primary Care Dr.: _____ **City/State:** _____

Office Phone: _____ **Last Office Visit Date:** _____
(mm/dd/yyyy)

Diabetic Care

Are You a Diabetic? (Answer Yes or No): _____ **(If Yes) Is your HbA1c Level (Check 1):**

Greater than 9 ☐ Less than 7 ☐ Between 7 and 9 ☐ Level Check Not Performed ☐

Diabetic Care Dr.: _____ **City/State:** _____

Office Phone No.: _____ **Last Office Visit Date:** _____
(mm/dd/yyyy)

Preferred Pharmacy & Address: _____ **Height:** _____ **Weight:** _____

Shoe Size & Width: _____

Current Medications and Vitamins: _____

List Any Allergies to Medications: _____

Past Medical History:
(Check All That Apply)
Diabetics, complete **Diabetic Care** section (above)

- ☐ Arthritis
- ☐ Autoimmune Condition
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Circulatory Problems
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV / AIDS
- ☐ Kidney Disease
- ☐ Neurological Disorder
- ☐ Neuropathy
- ☐ Stroke
- ☐ Other _____

PATIENT HISTORY FORM

Surgical History: _____

_____

_____

_____

_____

_____

Social History:
(Check All That Apply)

☐ Tobacco Use
(If Yes, Indicate Light/Heavy Use, Current or Former User)
_____

☐ Alcohol Use
(If Yes, Indicate Light/Heavy Use, Current or Former User)
_____

☐ Caffeine Use
(If Yes, Indicate Light/Heavy Use, Current or Former User)
_____

☐ Drug Use
(If Yes, Indicate Light/Heavy Use, Current or Former User)
_____

Family History:
(Mother/Father Only, Check All That Apply)

☐ No Known Family Medical History
☐ Bleeding Disorder
☐ Cancer
☐ Diabetes
☐ Heart Disease
☐ High Blood Pressure
☐ Kidney Disease
☐ Stroke
☐ Other Issues _____

Patients Aged 65 and Older

Please answer **Y** (Yes) or **N** (N) for all questions in this section.

☐ Fallen in the past **six (6) months**?
(**If Y**) How many? _____

☐ Experienced any changes, issues with **vision**?

☐ Experienced any issues with **heart rate or heart rhythm**?

☐ Experienced any issues with incontinence?

REVIEW OF SYSTEMS

Reason for Today's Visit?

Patient Name: _____ **Date:** _____ **Doctor:** _____

Please check the conditions that you are currently experiencing, as well as previously-experienced conditions.

Constitutional	☐ Chills ☐ Weight Loss	☐ Fever	☐ Sweats	☐ *None Apply*
Eyes	☐ Cataracts ☐ Eye Glasses ☐ Retinopathy	☐ Contacts ☐ Glaucoma ☐ *None Apply*	☐ Double Vision ☐ Macular Degeneration	
Ear/Nose/Throat/Mouth	☐ Dentures ☐ Hearing Loss ☐ Ringing in Ears	☐ Difficulty Swallowing ☐ Neck Pain ☐ Sore Throat	☐ Dizziness ☐ Nose Bleeds	☐ *None Apply*
Cardiovascular	☐ Cardiovascular Surgery ☐ Congestive Heart Failure ☐ Hypertension ☐ Palpitations	☐ Chest Pain ☐ Heart Attack ☐ Leg Pain (w/ Exercise) ☐ Swelling (Legs & Ankles)	☐ Circulatory Disease ☐ Heart Murmur ☐ Pace Maker	☐ *None Apply*
Hematologic	☐ Amenia ☐ Lump (Groin or Armpit)	☐ Bleeding Abnormalities ☐ Lymphoma	☐ Blood Clots (Previous) ☐ Swollen Glands	☐ *None Apply*
Respiratory	☐ Asthma ☐ Difficulty Breathing ☐ Pulmonary Disease ☐ Wheezing	☐ Bronchitis ☐ Emphysema ☐ Shortness of Breath	☐ Coughing ☐ Pneumonia ☐ Tuberculosis	☐ *None Apply*
Gastrointestinal	☐ Acid Reflux ☐ Decrease in Appetite ☐ Stomach Ulcers	☐ Blood in Stool ☐ Diarrhea ☐ Vomiting	☐ Constipation ☐ Hepatitis	☐ *None Apply*
Endocrine	☐ Diabetes Mellitus ☐ Often Thirsty ☐ Thyroid Disorder	☐ Kidney Disease ☐ Pancreatitis ☐ *None Apply*	☐ Often Urinating ☐ Prostate Problems	
Musculoskeletal	☐ Arthralgia ☐ Feeling Weak ☐ Weakness in Limbs	☐ Broken Bones ☐ Joint Pain	☐ Bursitis ☐ Tendonitis	☐ *None Apply*
Neurologic	☐ Aphasia (Loss of Speech) ☐ Fainting ☐ Seizures	☐ Ataxia (Loss of Balance) ☐ Migraines ☐ Speech Difficulties	☐ Confusion ☐ Neuropathy (Sensation Loss) ☐ Stroke	☐ *None Apply*
Integumentary	☐ Change in Skin Color ☐ Growth on Skin ☐ Lesions ☐ Sensitivity to Sun	☐ Cracking of Skin ☐ Hair Loss ☐ Rash ☐ Skin Ulcers	☐ Eczema ☐ Keloid ☐ Recurrent Infections	☐ *None Apply*
Psychological	☐ Anxiety ☐ Tension	☐ Depression	☐ Nervousness	☐ *None Apply*

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health.

Patient/Guardian Signature: _____ Date: _____

CONSENT FOR TREATMENT

I hereby give permission to Diagnostic Foot Specialists (DFS or Practice) to examine and/or perform diagnostic tests, and treat my condition medically, surgically or orthopedically. The undersigned consents to and authorizes the administration and performance of medical care that may be in the judgment of the physician considered advisable and necessary, why may include the performance of certain blood tests for communicable diseases such as Hepatitis and HIV. DFS is authorized to furnish information, necessary to process claims, to an insurer, compensation carrier or welfare agency that may be providing financial acceptance for hospital care. I understand that although I have medical insurance, **I am solely responsible for payment of medical bills. I agree to pay all fees billed to me immediately upon completion of all services unless other arrangements have been made in advance. I also understand that payment is not dependent upon my insurance.**

SIGNATURE: _____ DATE: _____

Signature of Patient or Legal Guardian

PATIENT HIPAA ACKNOWLEDGMENT AND DESIGNATION DISCLOSURE FORM

I. **Acknowledgement of Practice's Notice of Privacy Practices**

I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP). I have read and/or was given the opportunity to read if I so chose and understood the Notice and agree to its terms. ***Notice of Privacy Practice is available at the front window upon request***

_____ _____

Name of Patient (Please Print) Date of Birth

_____ _____

Signature of Patient/Parent/Guardian Date

II. **Designation of Certain Relatives, Close Friends & Other Caregivers as my Personal Representative**

I agree that the practice may disclose certain health information to a personal representative of my choosing, since such person is involved with my healthcare and/or payment relating to my healthcare. In that case, the practice will disclose only information that is directly relevant for the person's involvement with my healthcare and/or payment relating to my healthcare.

Print Name: _____ Last 4 digits of his/her SSN (required) _____

Print Name: _____ Last 4 digits of his/her SSN (required) _____

Print Name: _____ Last 4 digits of his/her SSN (required) _____

III. **Request to Receive Confidential Communications by Alternate Means**

I authorize the practice to communicate with me in confidence about my protected health information by the alternative means that I have listed below, upon request.

Home Telephone Number: _____ **Cell Phone Number**:_____

____ OK to leave message with detailed information ____ OK to leave message with detailed information

____ Leave message with call back numbers only ____ Leave message with call back numbers only

Written Communication Address: _____

____ OK to mail to address listed above

____ OK to email me at: _____

Text Communication: _____

____ OK to send a secure, HIPAA-compliant text message to the cell phone number listed above

Other: _____

_____ _____

Name of Patient (Please Print) Date of Birth

_____ _____

Signature of Patient/Parent/Guardian Date

FINANCIAL POLICY FOR Diagnostic Foot Specialists, PC

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify you coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. All insurance information must be provided to our office at the time of service.

MEDICARE: We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However, that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any copayments, which are usually 20% for the allowed amount for an item or service

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if applicable) after payment and/or explanation of benefits (EOB) is received from your primary insurance company. If payment is not received from your secondary insurance within 45 days the balance becomes your responsibility.

COINSURANCES/COPAYMENTS AND DEDUCTIBLES: All coinsurances, copayments and deductibles must be paid at the time of services. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments or deductibles from patients can be considered fraud. Please help us in upholding the law by paying your copayment at each visit.

SELF PAY: Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES: Please be aware that some of the services that you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment of these services.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of this visit. If you do not have a referral from your primary care physician at the time of a visit, you will be financially responsible for all services received due in full upon completion of the visit. Full credit will be given if a referral is presented to our office within 48 hours of this visit. You will also be given the option to reschedule your appointment

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

PATIENT BILLING: You will be sent up to three (3) notices/statements of your financial responsibility (copay/coinsurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account may be forwarded to collections. Please let the office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. **We accept the following payment methods: Cash, Credit, or FSA/HSA cards. Personal checks are not accepted.** An additional $25.00 will be added to your statement if the check is returned for insufficient funds. In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it you our office to be applied to your balance.

I have read the above policy regarding my financial responsibility to Diagnostic Foot Specialists, PC for medical services provided. I agree to pay Diagnostic Foot Specialists, PC any balance unpaid by my insurance carrier for myself or the below named person.

PRIVACY STATEMENT: Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

Assignment of Benefits

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Diagnostic Foot Specialists, PC all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, coinsurances and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested by physicians to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance.

PRINT Patient Name: _____ Signature: _____

FINANCIALLY RESPONSIBLE PARTY (If not the patient)

PRINT Name: _____ Signature: _____

Relationship to Patient: _____ Date: _____