SAN MARCOS FOOT & ANKLE CLINIC

Diane M. Phalen, DPM, FACFAS

Patient Name: _____ Today's Date: _____

Social Security Number: _____ Age: _____ DOB: _____

Marital Status: M S W D Sex: Male Female

Home Address: _____ Apt: _____

City: _____ State _____ Zip _____

Employer: _____ Work Phone: _____

Home Telephone: _____ Cell Phone: _____

Emergency Contact Number: _____ Name: _____

Is this a Workman's Compensation Injury? No Yes
If yes, please answer the following. If you were not injured on the job, please skip over this.
Date of Injury: _____
Please describe your injury: _____
_____
Your employer address: _____ **City:** _____ **State**____ **Zip** _____
Your Supervisor: _____ **Their telephone:** _____

Are you the employer/policy holder for your insurance policy? Yes No
If not, how are you related to the policy holder? Spouse Child

Employee's Name: _____ DOB _____
Social Security Number _____ Employer _____
Work Number: _____

Who is your regular Physician? _____

How were you referred to our office?

Dr. _____/Office referred me.
The Internet Telephone Directory
The Yellow Pages Newspaper Advertisement
My Insurance Company Other: _____

My Email Address: _____

My Pharmacy of Choice: _____

Attention Check Writers:

Our office gladly accepts our patient's personal checks.
However, please be aware that if your personal check is returned as having non-sufficient funds there will be an NSF charge of $25.00 per check. All checks that are not paid within 10 business days after notification will be handed over to the Hays County Justice Center for prosecution.

Attention Medicare Patients:

1. **Drs. Phalen and Myer do accept Medicare assignment.**
   The office does wish to bring it to your attention that there is a yearly deductible of $150.00. Your supplemental insurance may or may not cover this depending on your policy. Please be aware that once Medicare pays their share our office gladly sends the claim to the supplemental ins. if this has not already been sent by Medicare. However, if your supplemental insurance company fails to pay the amount that is owed you as the patient will become responsible for the remaining debt.

All patients:

2. Please be aware that all copayments and deductible amounts are due on the day you receive treatment. ***No payment plans will be set up on the day of your treatment.***

3. ***Please be aware that although our office will contact your insurance company the information provided to us is <u>never</u> a guarantee of payment.*** You will be responsible for all amounts that are deemed your debt by your insurance company. Once an amount becomes your debt you will receive 3 monthly statements: the initial statement, a second statement, and the final statement. There will be no statements sent after the final statement. If no payment or arrangements for payment have been received 30 days after we send the final statement the account will be handed over to Merchants and Professional Credit Bureau for collection of a debt.

Please read and sign below.

I have read and do understand all of the statements above. I understand that the office will always wait to hear from my insurance company before sending me a statement, and that we are aware that not all patients will be responsible for any given amount for their treatment.

There are times when the Physicians take pictures of our patient's foot conditions for diagnostic and treatment reasons.

I give my permission for SMFAC to take digital and film images of my foot and/or ankle. I understand that these images are the property of SMFAC and are a part of my medical record. Therefore, if I wish to have a copy of these images made I understand that I will be asked to follow the same protocol as receiving a copy of my medical record.

Signature of
Patient:_____

Date:_____

SMFAC Medical History Form

Patient Name:_____ Date:_____

Regular Physician: Dr._____ Referred? □ Yes □ No
My foot problem involves my: □ Left Foot □ Right Foot □ Both Feet
□ Left Ankle □ Right Ankle □ Both Ankles

I have had this problem for: _____ weeks _____ months _____years

Please describe your primary foot and/or ankle problem:

_____
_____
_____

Please describe any previous treatment for this problem that has been performed by you and/or another Physician:

_____
_____

Age:_____ Present Weight:_____ Height:_____ Shoe Size:_____

What kind of work do you do? _____
How many hours per day are you regularly on your feet? _____

Please list all medications that you are currently taking to include prescription meds, vitamins and herbs:_____
_____
_____

Past Medical History (Please √ all that apply)

□ High Blood Pressure
□ Diabetes X _____ months/years
□ Shortness of Breath
□ Heart Disease
□Chest Pain/Angina
□Calf Pain
□ Stroke
□ Convulsions/Epilepsy
□ Arthritis
□ Asthma
□ High Cholesterol
□ Hepatitis Type □A □B □C
□ HIV/AIDS
□ Back Injury/Pain
□ Neurological Disease
□Other:_____

Do you smoke? □ Yes □ No If yes, how much? ___ packs/day X ___ yrs
Past smoker? □Yes □No If yes, how long? _____ PPD_____

List all allergies to medications:_____
_____
Please list all past surgeries:_____
_____
Family Medical History:_____

San Marcos Foot & Ankle Clinic
Diane M. Phalen, DPM

HIPAA Privacy Practice Acknowledgement

The law requires that patients be given the opportunity to read and review their privacy rights regarding personal information. As the patient, you are not required to read the information. However, you are required to acknowledge the fact that the office has given you the opportunity to ready your privacy rights under the law.

Please be aware that in order for our office to be allowed to release any personal information to anyone other than yourself (this includes your spouse and adult children), you have to write their name(s) down on the spaces provided below. By signing your name, you are instructing our office not to release any information to anyone other than yourself. **This does not apply to minor children.** Parents of minor children (this does not apply to children who are over the age of 18 years) are granted 100% access to their minor child's personal information according to HIPAA guidelines.

I acknowledge that I have been given the opportunity to read and review my privacy rights (black binder on glass table) under the law. I am aware that if I request a copy of this, I have the right to be given one.

I give my permission for San Marcos Foot & Ankle Clinic to release my personal information to the following individuals other than myself:

1. _____

2. _____

_____ _____
Signature of Patient Date

I do NOT wish for SMFAC to release any personal information of mine to anyone other than myself. I am aware that this includes my spouse and/or adult children.

_____ _____
Signature of Patient Date

Workman's Compensation Patients Only:
I give my permission to release my personal information to my employer. I understand that only information pertaining to my on-the-job injury will be released.
Name of Supervisor: _____

_____ _____
Signature of Patient Date