Travis Bodeker, DPM
9701 N. Sam Houston E., Suite 150
Humble, TX 77396
Ph: 281-973-5237 Fax: 832-412-2016

Today's Date _____
Patient's Name (Mr. / Mrs. / Ms.)_____
Parents (if minor)_____
Mailing Address_____
City /State/ Zip_____
Primary Phone_____ Work/Cell_____ Email_____
DOB_____ Sex_____ DL#_____ SS#_____-_____-_____
Marital Status_____ Religion_____ Race_____
Ethnicity (please circle): Hispanic or Latino Non-Hispanic or Latino Other Unknown Declined
Employer _____ Occupation _____
Primary Care Physician _____

How did you find our office? _____Name if referred by a friend or family_____

Emergency Contact Information: (Please provide a contact NOT living with you)

Name _____ Relationship _____ Phone_____

Responsible Party

Who is responsible for the account? (Mr. /Mrs. /Ms.) _____
Address/City/State/ Zip _____
Relationship to patient _____ SS#_____-_____-_____ DOB _____
Employer _____
Occupation_____
Primary Phone_____ Work/Cell _____ Other _____

Primary Insurance
Ins. Co._____
Policy # _____
Group # _____
Policy Holder's DOB _____
Relationship to Pt _____

Secondary Insurance
Ins. Co. _____
Policy #_____
Group # _____
Policy Holder's DOB _____
Relationship to Pt _____

Financial Policy

Any out-of-pocket expense for the patient such as co-pays, deductibles, or co-insurances, must be paid at the time of services including services that are not covered under the patient's benefit plan.

Authorization and Release (please sign below)
I authorize the release of any medical information necessary to process this bill to my insurance company, and request payments of benefits be made to Fall Creek Foot and Ankle. I acknowledge that I am financially responsible for payment of services not covered by insurance.

Signature: _____ Date: _____

Office and Financial Policies

Welcome and thank you for choosing Fall Creek Foot and Ankle for your medical care. We are committed to providing you with the highest quality medical care in an efficient and cost-effective manner. We hope that by providing you with our policies in advance we can prevent any misunderstanding or frustration at the time of your visit.

Initials:_____ **Insurance**: The patient is responsible for knowing their insurance benefits including their deductible and out- of-pocket expense. Copay, Deductibles and patient's financial portion including any balance will be collected at the time of service. You may be asked to reschedule your appointment for non-payment. We will gladly file your insurance claim on your behalf. We will not be involved in disputes between you and your insurance company regarding coverage and/or policy benefits. You are responsible for the timely payment on your account.

Initials:_____ **Cancellations:** Please call our office 24 hours in advance if you are unable to keep a scheduled appointment. If you do not cancel within 24 hours, you may be charged a No Show Fee of $50.

Initials:_____ **Referrals:** Patients with an **HMO** policy need referrals to see any specialist. You may be required to go back to your primary care physician to obtain a referral for a specialist that we want you to see. This is an HMO guideline that we have no control of.

Initials:_____ **Patient Balances:** Please be prepared to pay the current visits as well as any past balances on your account. Copay, Deductible, Out-of-pocket expense and non-covered services will required at the time of service. For your convenience we take cash, check and credit cards.

Initials:_____ **Late Arrivals:** We do our best to have less patient wait time but when a patient arrives late, it is impossible to stay on schedule. If you arrive 15 minutes late you may be asked to reschedule your appointment to keep our schedule on time.

Initials:_____ **Dishonored Checks:** A $30 Return Check Fee will be assessed on all dishonored checks. If you have 2 dishonored checks on file, check payment will no longer be a payment option for you but will gladly accept cash or credit card payments on your future visits.

Initials:_____ **Collections:** You will be receiving at least 3 statements from our office for balances owed. Please ensure to make payment arrangements, if necessary, to keep your account current. If your address changes it is your responsibility to inform our office to update our records. Otherwise, your account will be turned over to collections when it is returned as a bad address. When your account is already in collections, you **may not** be seen until the account is paid in full at the collection agency.

Initials:_____ **Prescriptions:** It is the patient's responsibility to call the pharmacy 5 days prior to running out of medication. **Refills may take 2 – 4 business days to be refilled.**

I have read, understand and agree to the above office and Financial/Office policies. I hereby attest that I have given and agree to provide current demographics and insurance information and authorize release of information necessary for insurance filing and pre-certification by signing this statement.

Patient name:_____ DOB: _____

Signature:_____ Date:_____

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Ph: 281-973-5237 Fax: 832-412-2016

Patient Questionnaire

DOB: _____/ _____/_____

PATIENT NAME: _____ **Date**: _____/ _____/ _____

MEDICATION ALLERGIES
□ None □ List: _____

MEDICATIONS (prescription and over the counter)
□ None □ List: _____
_____
Pharmacy Name: _____

HEALTH CARE PROVIDERS (Please all)
□ Primary care physician：_____
□ Specialty : _____ Name : _____
□ Specialty : _____ Name : _____
□ Specialty : _____ Name : _____
□ Specialty : _____ Name : _____

REASON FOR VISIT TODAY
_____
_____

PODIATRY HISTORY
☐ Heel pain/arch pain
☐ Bunion pain
☐ Flat feet
☐ Numbness or tingling in feet
☐ Trauma or injury
☐ Warts (top/bottom of foot)
☐ Hammertoes – curled toes
☐ Ability to sleep due to foot pain
☐ Other pain/discomfort:
_____
☐ Ankle pain
☐ Rash on foot
☐ Painful corns
☐ Itching of feet
☐ Circulation
☐ New exercise
☐ Shooting pain in feet & lower legs

SOCIAL HISTORY
- Occupation: _____
- Hobbies: _____
- Do you smoke? Yes No
  If yes, quantity per day: _____
- Do you drink alcohol? Yes No
  If yes, quantity per week: _____
- Pets: ☐ None ☐ List: _____

HOSPITALIZATIONS
☐ None ☐ List: _____
_____

MAJOR ILLNESSES/SURGERIES
☐ None ☐ List: _____
_____
_____

REVIEW OF SYSTEMS – Check all that apply

SKIN
☐ – *Normal*
☐ Abnormal scarring
☐ Poor healing
☐ Plastic surgery
☐ Radiation
☐ _____

CONSTITUTIONAL
☐ – Normal
☐ Fever
☐ Weight loss
☐ Loss of appetite
☐ _____

NEURLOGIC
☐ – *Normal*
☐ – Stroke
☐ – Seizure
☐ _____

PSYCHIATRIC
☐ - *Normal*
☐ Depression
☐ Anxiety
☐ _____

HEAD/NECK
☐ – *Normal*
☐ Vision impairment
☐ Contacts / Glasses
☐ Hearing aid
☐ Dentures
☐ _____

CARDIOVASCULAR
☐ – Normal
☐ Pacemaker
☐ Defibrillator
☐ Artificial heart valve
☐ Heart Murmur
☐ Hypertension
☐ Heart attack
☐ _____

RESPIRATORY
☐ - *Normal*
☐ Sleep apnea
☐ _____

HEME /LYMPH
☐ – *Normal*
☐ Anemia
☐ Bleeding problems
☐ _____

GASTROINTESTINAL
☐ - *Normal*
☐ Ulcers
☐ Reflux
☐ Liver Damage
☐ _____

INFECTION
☐ - Normal
☐ - Staph/MRSA/VRE
☐ – HIV
☐ – Hepatitis
☐ Immunosuppression
☐ Need to take Antibiotics before dental procedure
☐ _____

ENDOCRINE
☐ – *Normal*
☐ – Diabetes
☐ Kidney disease
☐ _____

MUSCULOSKELETAL
☐ - *Normal*
☐ Artificial joints in last 2 years
☐ _____

Are you pregnant/planning to be pregnancy/fertility treatments? Y / N _____

Are you breast feeding? Y / N _____

Health Insurance Portability and Accountability Act (HIPAA)

A. Inspection and copies of protected health information – you may inspect and / or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that a request for copies be made in writing and we ask that request for inspection of your health information also be made in writing. Please send your request to the person listed at the end of this document. We may ask that a narrative of that information be provided rather than copies. However, if you do not agree to our request, we will provide copies. We can refuse to provide some of the information you ask to inspect or ask to be copied for the following reasons: The information is psychotherapy notes; the information reveals the identity of a person who provided information under a promise of confidentiality; the information is subject to the Clinical Laboratory Improvements Amendments of 1988; the information has been compiled in anticipation of litigation. We can refuse to provide access to or copies of some information for other reasons, provided that we arrange for review of our decision to deny access. Texas law requires us to be ready to provide copies or a narrative report within 15 days of your request. We will inform you when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing. HIPAA permits us to charge a reasonable cost-based-fee.

B. Amendments of Medical Information – you may request an amendment of your medical information in the designated records set. Any such request must be made in writing to the person listed at the end of this document. We will respond within 60 days of your request. We may refuse to allow an amendment for the following reasons: The information was not created by this practice or physicians in this practice; the information is not part of the designated records set; the information is not available for inspection because of an appropriate denial; the information is accurate and complete. Even if we refuse to allow an amendment, you are permitted to include a patient statement about the information at issue in your medical records. If we refuse to allow an amendment to be made and tell others that we now have the correct information.

C. Accounting of Certain Disclosures – HIPAA privacy regulations permit you to request , and us to provide, and accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by our or your representative. Please submit any request for an accounting to the person at the end of this document. You first accounting of disclosures (within a 12-month period) will be free. For additional request within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you, and you may choose to withdraw or modify your request before any costs are incurred.

D. Appointment Reminders, Treatment Alternatives, and Other Benefits – We may contact you by (telephone, mail or both) to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

E. Complaints – If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. We will not retaliate against you for filling a complaint with us or the government.

F. Our Promise to you – We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of your privacy practices with respect to protected health information, and to abide by the terms of notice of privacy practices in effect.

G. Question and Contact Person for Request - If you have any question or want to make a request pursuant to rights described above, please contact: Maybelle Encarnado, Phone # (936) 441-1230

I acknowledge that I have been given an opportunity to review Fall Creek Foot and Ankle Notice of Privacy Policies and have been provided a copy if I desire one.

_____ _____ _____

Signature of Patient or Legal Representative | Relationship to Patient | Date

Family members we may discuss your financial or medical information with: _____

_____

Health Disclosure Consent Form

I, _____ , DOB _____, will allow Fall Creek Foot and Ankle, PLLC, to disclose information to the following person(s) about my health. I have also reviewed and acknowledged the Notice of Privacy Practices.

I will allow disclosure to the following person(s):

Name:	Relationship:
1._____	_____
2. ._____	_____
3._____	_____
4._____	_____
5._____	_____

Can we leave a message to your voicemail? _____ Yes _____ No

If Yes, what number (s)? _____ (I understand that I am the only person who can this message for HIPAA purposes)

Leave message only for the following:

_____ Appointment Reminder

_____ Normal Lab Results

_____ Response to your voicemail

_____ Referral/Testing/ Procedure Schedule

_____ _____

Signature of Patient or Personal Representative Date