HIGHLANDS FOOT & ANKLE

Patient Information **Today's Date**: _____

Full Name: _____ Sex: ☐ Male ☐ Female
FIRST MIDDLE LAST

Date of Birth: _____ Social Security Number: _____
NEEDED FOR INSURANCE VERIFICATION

Race: ☐ White
☐ Hispanic or Latino
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian
☐ Hawaiian/PacificIslander

Ethnicity: ☐ Hispanic or Latino
☐ Not Hispanic or Latino

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Address: _____ Zip Code: _____

Mobile Number: _____ Home Number: _____

Email Address: _____

Emergency Contact:

Name:_____Phone:_____Relationship:_____

Work Status:

☐ Full-time ☐ Part-time ☐ Student Occupation:_____

☐ Retired ☐ Unemployed ☐ Disabled Employer Name: _____

Current Physicians

Primary Care Physician: _____ **Date Last Seen**: _____

Office Name: _____ Phone: _____ City/State: _____

Do you see a Cardiologist? ☐Yes ☐No Physician Name: _____

Do you see a Vascular Doctor? ☐Yes ☐No Physician Name: _____

Do you see a Neurologist? ☐Yes ☐No Physician Name: _____

Do you see Pain Management? ☐Yes ☐No Physician Name: _____

Pharmacy Name: _____ Zip Code:_____ Phone: _____

How did you hear ☐ Provider ☐ Friend ☐ Google ☐ Facebook ☐ Instagram

about us? 😜 ☐ Other:_____

HIGHLANDS
FOOT & ANKLE

Guarantor Information: *Only complete if patient is not responsible party*

Full Name: _____ Sex: ☐ Male ☐ Female

Date of Birth: _____ Social Security Number: _____

Home Address: _____ Zip Code: _____

Mobile Number: _____ Home Number: _____

Insurance Information:
*It is very important you provide us with accurate information so that we can bill insurance.

Primary: _____ Effective Date: _____ ID#: _____

Secondary: _____ Effective Date: _____ ID#: _____

Tertiary: _____ Effective Date: _____ ID#: _____

I certify that the above insurance information is accurate and truthful. If the information I have provided is incorrect or incomplete, I understand that Highlands Foot & Ankle, LLC may transfer any charges to self-pay, and I will be responsible for full payment. I agree to provide my insurance cards to Highlands Foot & Ankle, LLC for verification. I agree to pay the specialist copay set by my insurance company upon check-in. I agree to pay the deductible amount, or any amount that my insurance company has left me responsible. If my insurance policy has expired, Highlands Foot & Ankle, LLC will release all charges to self-pay, and I understand that I will be responsible for payment. I understand it is my responsibility to obtain all referrals and/or authorizations granted by my insurance company before being seen; otherwise, I can become responsible for all charges.

Due to the Affordable Care Act, you may be responsible for a portion of your deductible if it has not already been met.

I understand and agree to the terms and conditions stated above.

_____	_____	_____
Print Name	Signature	Date

HIGHLANDS FOOT & ANKLE

Medical History

Weight: _____ Height: _____ Shoe Size: _____ ☐ Regular ☐ Wide

Allergies ☐ No known allergies

☐ Penicillin ☐ Tetracyclines ☐ Sulfa ☐ Benadryl ☐ Local Anesthesia

☐ IV Contrast ☐ Iodine topically ☐ Latex ☐ Adhesive tape

☐ Other: _____

Describe reaction: _____

Medical Conditions

☐ Diabetes Type 1 ☐ Diabetes Type 2 ☐ Neuropathy ☐ Lymphedema

☐ High Cholesterol ☐ High B/P ☐ Low B/P ☐ Sleep Apnea

☐ Pacemaker ☐ Heart Failure ☐ Stroke ☐ COPD

☐ Sickle Cell Anemia ☐ Hepatitis: _____ ☐ HIV/AIDs ☐ Anemia

☐ Osteoporosis ☐ Arthritis ☐ Rheumatoid ☐ Lupus

☐ Liver Disease ☐ Kidney Disease ☐ Dialysis ☐ Blood Clots

☐ Birth defects: _____ ☐ Back Injury ☐ Fibromyalgia

☐ Cancer: _____ ☐ Skin disorder: _____

Are you currently pregnant? ☐ Yes ☐ No Breastfeeding? ☐ Yes ☐ No

Please list all other medical conditions not stated above:_____

_____

Please list all surgeries and year:

_____

_____

Podiatry Medical History

Reason for today's visit?

_____

Is this a recent traumatic injury? ☐ Yes ☐ No Date of Injury? _____

If so, is it work-related? ☐ Yes ☐ No Sports related? ☐ Yes ☐ No What sport? _____

Motor vehicle accident? ☐ Yes ☐ No

Have you ever been treated for foot/ankle issues in the past? ☐ Yes ☐ No

If so, please explain:

_____

_____

Do you have calf pain? ☐ Yes ☐ No If so, when does it occur? ☐ Walking ☐ At rest

HIGHLANDS FOOT & ANKLE

Family Medical History

Member	Age		Medical Conditions
Mother		☐ Living ☐ Deceased	☐ Diabetes ☐ Stroke ☐ High B/P ☐ Arthritis ☐ Auto-immune disorder: _____ ☐ Cancer: _____ Please list any not stated: _____ _____ _____
Father		☐ Living ☐ Deceased	☐ Diabetes ☐ Stroke ☐ High B/P ☐ Arthritis ☐ Auto-immune disorder: _____ ☐ Cancer: _____ Please list any not stated: _____ _____ _____

Social History

Tobacco Use: ☐ Never ☐ Former, year quit: _____ ☐ Current, years used: _____

Type: ☐ Cigarettes ☐ Vape ☐ Cigar ☐ Chew ☐ Smokeless ☐ Pipe

Frequency: _____ Exposure to secondhand smoke? ☐ Yes ☐ No

Do you drink **caffeine**? ☐ Coffee ☐ Tea ☐ Energy drinks Frequency? _____

Do you drink **alcohol**? ☐ Yes ☐ No If so, what & how often? _____

Do you use **recreational drugs**? ☐ Yes ☐ No Frequency? _____

☐ Marijuana ☐ Cocaine ☐ Meth ☐ Heroin ☐ Prescription drugs not prescribed to you

☐ Other: _____

Diet Type: ☐ Balanced ☐ Diabetic ☐ Vegetarian ☐ Vegan ☐ Other: _____

Do you **exercise**? ☐ Yes ☐ No If yes, how often & what type? _____

☐ I feel safe at home ☐ I feel safe with the person who I am here with today

☐ I understand I can talk to any staff member here, at any time, if I do not feel safe (NHTH) 1-888-373-7888

HIGHLANDS FOOT & ANKLE

Medication Record

List all medications you are currently taking, including all over-the-counter & supplements.

☐ I have provided a printed list of medications

Medication	Dosage	Reason for Medication

HIGHLANDS FOOT & ANKLE

HIPAA Privacy Authorization Form

Effective Date: _____

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. **Authorization**. I authorize Highlands Foot & Ankle, LLC (health care provider) to use and disclose the protected health information described below to an individual with the requesting party being related to the Patient by blood (to the best of our knowledge) as their (individual seeking the information).

2. **Effective Period**. This authorization for release of information covers all past, present, and future periods of health care.

3. **Extent of Authorization**. I authorize the release of my financial & complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

4. **Use**. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. **Termination**. This authorization shall be in force and effect until the death of the Patient, at which time this authorization form expires except for final balance payment as insurance can take several months.

6. **Revocation Rights**. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. **Benefits**. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. **Disclosure**. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

9. **Email**: I authorize Highlands Foot & Ankle, LLC to send my information to the family member below via email. HIPAA-compliant email and attachments

10. **Texting and Email Communication Terms**: Consent and Opt-In: By providing your phone number or email address to our practice through this website or direct communications with our office, you consent to receive text messages and emails from our firm. You can opt-out at any time by replying "STOP" to text messages or clicking/responding "UNSUBSCRIBE" in emails. Frequency: We will only send relevant messages related to our products, services or updates. We respect your privacy and will not spam you. Refer to our privacy policy posted on this website in the "About Us" Section. Message Charges: Standard message and data rates may apply for text messages. Email communication is free. Content: Our messages will include important updates, inquiries, questions or other relevant information. If you have questions, reply to our texts or emails. Disclaimer: Our general messages are for informational purposes only.

Patient's Signature (or Power of attorney-must provide notarized proof):

Patient Name: _____Patients Signature: _____ Date: _____

Name & Signature of Family member we are releasing information to: _____

Receivers Name: Signature:_____ Date: _____

Email: _____

INSURANCE & SELF PAY SECTION

All co-pays, deductibles, co-insurances and self-pays are due at the time services are rendered. I understand that it is my responsibility to provide Highlands Foot & Ankle, LLC with the correct and accurate insurance information. If I have an HMO insurance, I will be responsible for payment in full if I did not get a referral for each visit and it is my responsibility to get that from my PCP, it is NOT the responsibility of Highlands Foot & Ankle, LLC. If for any reason I am seen by any of the doctors at Highlands Foot & Ankle, LLC, I take full responsibility for not reading this disclaimer nor understanding that they are not liable for this error. I agree to provide my driver's license, insurance cards, referrals, social security number at all visits for proof of my identity. I allow Highlands Foot & Ankle, LLC to place a picture of me on their EMR system for identification purposes whether or not I have insurance. I understand that I am responsible for payment in full at time services are rendered, whether or not I have insurance. If I leave without making a payment, Highlands Foot & Ankle, LLC will send me a statement, after 3 statements & non-payment, Highlands Foot & Ankle, LLC can send me to collections/file judgment without notice. If'I am approved for a payment plan, I understand that I must fulfill this obligation. This must be signed to see the doctor.

AUTHORIZATION AND PAYMENT POLICY

1. the undersigned, certify that I (or my dependent, under the age of 18), have insurance with the above name(d) company(s), and assign directly to Highlands Foot & Ankle, LLC, Dr. David Sappington, Dr. Meredith Sappington, or any other doctor associated with this company- all insurance benefits and agree to reimburse if insurance pays me. the insured, for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctors to release all information necessary to secure the payments of benefits. I understand that I am responsible for any and all deductibles, co-pays, and out of pocket expenses. If 1 do not pay- I am subject to being placed in collections, I understand that further action, such as a judgment, can be placed on me and will pay all fees associated with collection and judgment status if payment is not received. I authorize the use of this signature on all insurance submissions.

RETURN POLICY

If products are purchased and they have a return policy I will receive and sign the policy, and a copy will be placed in my file, otherwise there is nothing that can be returned. MEDICARE/MEDICAID AUTHORIZATION (If applicable): I request that payment of benefits be made on my behalf to the above-named doctors/company for any services by that physician. I authorize any holder of medical information needed to determine these benefits or the benefits payable for related services. I understand my signature request that payment be made and authorized release of medical information to pay the claim. If "other health insurance" is indicated in item 9 on the HCFA-1500 form or elsewhere on other approval claims forms, such as electronically submitted, my signature authorizes release of the information to the insure or agency. In Medicare/Medicaid assigned cases, the physician or supplier agrees to accept the charges/payments/allowed amounts determined by the contract with the insurance company, and the patient is responsible for the amount the insurance company leaves them responsible for, including deductibles, co-pays, co-ins, non-covered services/items, or what the EOB states as patient responsibility. ALL.

INSURANCE PAYMENT POLICY

All co-pays, deductibles, and co-insurances are due at the time services are rendered. IfI leave without making a payment, Highlands Foot & Ankle, LLC will send meastatement, after 3 statements & non-payment, Highlands Foot & Ankle, LLC can send me to collections/file Judgement without notice. If I belong to an HMO, I understand that my insurance company requires a referral from my PCP and if not received by my appointment time, I will be fully responsible for payment in full at time services are rendered or I may have to reschedule to another date and time. If for some reason, Highlands Foot & Ankle, LLC does not realize or notice there is no referral on file, & I am seen as a patient for any appointment or any reason, it is still my responsibility for payment in full to the company. If I belong to a PPO, I understand that I have a co-pay, deductible, and co-insurance. I know that it is my responsibility as the patient to get authorization/referral if one is required and if it is not obtained, I am responsible. It is my responsibility

to inform a staff member of any new insurance, changes in address, phone numbers, or health and medication changes, whether or not they ask for this information

POLICY

I understand that I am responsible for payment in full at time services are rendered. If I leave without making a payment, Highlands Foot & Ankle. LLC will send me a statement, after 3 statements & non-payment, Highlands Foot & Ankle, LL.C can send me to collections, or file a judgment against me without notice. If I am approved for a payment plan, I understand that I must fulfill this obligation. INSURANCE RELEASE/AUTHORIZATION: I understand that for medical/legal purposes and by the Texas State Law, x-rays and medical records taken/created by this office are the property of Highlands Foot & Ankle, LLC not mine. I also understand that all charges for services are due and payable at the time services are rendered. Highlands Foot & Ankle. LL.C accepts cash, checks, debit cards, MasterCard, Visa, and Discover. There can be, up to a $55.00 NFS (fee may change at any time with or without notice) fee for returned checks and must be taken care of in a timely fashion (21 days) or charges may be filled against me. I agree to be responsible for all the above. where it applies to me. This must be signed to see the doctor.

HIPPA

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US. I UNDERSTAND THAT I MAY HAVE A COPY IF I CHOOSE. A covered entity may disclose PHI to certain parties to facilitate treatment, payment, or health care operations without a patient's express written authorization. Any other disclosures of PHI require the covered entity to obtain written authorization from the individual for the disclosure. In any case, when a covered entity discloses any PHI, it must make a reasonable effort to disclose only the minimum necessary information required to achieve its purpose. Highlands Foot & Ankle, LLC has the right to discuss minimal information with family but does not approve to give certain information to employers unless we receive a signed document from the patient of legal age.

I have seen a copy of the "Notice of Privacy Practice Act" & know that this signed copy will be placed in my EMR chart

I have read all above sections and the HIPAA agreement and understand that with my signature I agree to the above terms and conditions. I certify that I have provided truthful and accurate information.

Signature: _____ Date: _____ *This must be signed to see the doctor*