

# PATIENT DEMOGRAPHICS & INSURANCE INFORMATION

Name: \_\_\_\_\_ Sex: \_\_\_ Male \_\_\_ Female  
Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
City: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Preferred Pharmacy: \_\_\_\_\_  
Phone: \_\_\_\_\_ \_ Home \_ Work \_ Other Referring Physician: \_\_\_\_\_  
Phone: \_\_\_\_\_ \_ Home \_ Work \_ Other Primary Care Physician: \_\_\_\_\_  
E-Mail Address: \_\_\_\_\_

## EMERGENCY CONTACT

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

## ACCOUNT GUARANTOR

\_\_\_ Same As Patient

Name: \_\_\_\_\_ Sex: \_\_\_ Male \_\_\_ Female  
Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
City: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_  
Phone: \_\_\_\_\_ \_ Home \_ Work \_ Other Phone: \_\_\_\_\_ \_ Home \_ Work \_ Other

## PRIMARY INSURANCE & SUBSCRIBER

\_\_\_ Same As Patient

Name: \_\_\_\_\_ Sex: \_\_\_ Male \_\_\_ Female  
Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
City: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Insurance Carrier: \_\_\_\_\_  
Phone: \_\_\_\_\_ \_ Home \_ Work \_ Other Patient's Identification #: \_\_\_\_\_  
Phone: \_\_\_\_\_ \_ Home \_ Work \_ Other Policy/Group #: \_\_\_\_\_

## SECONDARY INSURANCE & SUBSCRIBER

\_\_\_ Same As Patient

Name: \_\_\_\_\_ Sex: \_\_\_ Male \_\_\_ Female  
Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
City: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Insurance Carrier: \_\_\_\_\_  
Phone: \_\_\_\_\_ \_ Home \_ Work \_ Other Patient's Identification #: \_\_\_\_\_  
Phone: \_\_\_\_\_ \_ Home \_ Work \_ Other Policy/Group #: \_\_\_\_\_

## TREATMENT OF MINORS, PATIENTS WITH A MEDICAL POWER OF ATTORNEY or THOSE REQUIRING A CARE GIVER

A minor is considered to be a person under the age of eighteen and must be accompanied by a parent, legal guardian or court appointed custodian at each visit. Individuals with an existing power of attorney, who are no longer able to make decisions for themselves are required to have their appointed agent present at each visit. Individuals who require a care giver or reside in a care facility are required to have a care giver present throughout each visit. These requirements have been established in an effort to maximize the benefits of the care we provide and the outcomes to our patients and to comply with State laws. In the event a patient meeting any of these criteria arrive for a scheduled appointment without the required individual, the appointment will be rescheduled.

## ACCOUNT GUARANTOR AGREEMENT

I hereby authorize Waco Foot & Ankle, P.A. (WFA) to administer such treatment or procedures as are considered medically necessary on the basis of clinical findings. I request the assignment of any and all insurance benefits directly to WFA. I agree to pay any charges incurred and deemed patient responsibility and any charges not covered by insurance. I understand that the use of a check for payment is my acknowledgement and acceptance of the terms outlined in WFA's posted check acceptance policy.

Account Guarantor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Waco Foot & Ankle, P.A.

## FINANCIAL POLICY

### Insurance Copays

Insured patients are expected to present an insurance card at each visit to determine any changes in insurance eligibility or copay assignments. All insurance copayments are due and payable upon arrival for your appointment.

### Prepayment

The patient portion of financial responsibility is due prior to the scheduling of a surgery or procedure. This includes outstanding deductibles, coinsurance or any service exempted from your insurance coverage. We recognize that determining expected out-of-pocket expenses can be complicated in some insurance coverage packages and have personnel to assist you. Based on the information provided by your insurance carrier(s), we will determine the payment expectations. Once the carrier's responsibility has been determined to be satisfied, any credit on your account will be refunded from the carrier's final payment.

### Patient Statements

Patient statements are generated and mailed each month on all accounts with an outstanding patient balance. All statement balances are due in full on or before the 20th of the following month unless a formal payment plan has been negotiated and signed. Partial payments will be applied to the patient's account; however, the acceptance of partial payments will not automatically establish a payment plan of any kind and may result in the initiation of our collections process.

### Accepted Payment Types

We accept MasterCard and Visa as well as personal checks, money orders and cash.

### Check Acceptance Policy

NSF checks are automatically reprocessed with the addition of a \$25 + tax processing fee. In addition to the processing fee, the patient account will be charged with any additional bank charges as well as any additional administrative costs associated with the collection and processing of the returned check.

### Monthly Payment Solution

Affordable monthly payments can be a reality and enrollment is quick and extremely simple. To learn more about or to enroll in our payment solution, please call our business office during normal business hours. No agreement will be considered or activated without proper documentation and an original signature.

### Referrals

If your insurance carrier requires that you be referred to a specialist by your primary care physician (PCP), it is your responsibility to have your PCP obtain the referral prior to your scheduled clinic visit. We will assist you by tracking your referrals, but request your participation and cooperation as necessary.

### Medical Records

Copies of your medical records can be obtained for a nominal fee of \$30. Medical records sent to third parties at your request require a \$30 payment for the first 20 pages and \$0.15 per additional page. A Medical Records Release Form authorizing the release of your information must be signed prior to the release of information to a third party. Please allow 14 days for medical records to be prepared. Please refer to our Notice of Privacy Practices in compliance with HIPAA regulations for guidelines on how your personal health information is protected.

### Non-Standard Insurance Forms

The completion and filing of personal insurance claims forms (FMLA, AFLAC, etc..) follows receipt of a \$25 Form Completion Fee. Please allow 14 days for forms to be completed, signed and mailed after payment has been received. Each additional form request is treated and billed individually.

### Collection Agency

We retain the service of an outside Collection Agency for recovery of delinquent balances. We reserve the right to attach all additional fees associated with any effort toward collecting the delinquent account balance in its entirety including, but not limited to, attorney fees, court costs and collection fees imposed by a collection agency (43% of original balance), associated with any effort .

### Billing Questions

Patient statements are sent monthly and provide detail about dates of service and balances due. We are always happy to answer any questions or concerns about your billing or statements. Please call our business office at 254-776-6995.

This Financial Policy helps us provide quality, consistent care to our valued patients. If you have any question or need clarification of any of the above policies, please feel free to contact us. I have read and understood the above policy statement.

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Account Guarantor Name

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Account Guarantor Signature

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Date

# Welcome to Waco Foot & Ankle, P.A.

Thank you for choosing us to assist you with your healthcare needs.  
Please take a moment to answer the following questions so that we will have as much information as possible to give you the best healthcare.

## INTAKE QUESTIONNAIRE - Page 1

\_\_\_\_\_  
PRINTED PATIENT'S NAME

\_\_\_\_\_  
DATE OF BIRTH

\_\_\_\_\_  
DATE COMPLETED

**Please Answer All Questions In Detail As It Pertains To Your Current Complaint**

**Please describe in detail the reason for today's visit:**

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**Circle the face that BEST describes your current pain level:**



**If you have pain, how would you describe the type of pain you are having today?**

Burning     Tingling     Sharp     Throbbing     Aching     Dull     Stabbing     Radiating

**On the diagrams below, please mark the problem and/or painful area(s):**



**When did you first notice pain and/or discomfort?** \_\_\_\_\_

**If this was the result of an injury, please describe the injury.**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Is your current condition the result of an on-the-job injury?**     Yes     No

**Since the onset/injury, the condition seems to be:**

Unchanged     Intermittent (Comes & Goes)     Worsening     Improving     Constant

PRINTED PATIENT'S NAME

DATE OF BIRTH

What seems to aggravate your condition?

Walking Certain Shoes Exercise Heat or Cold Standing Running

Other:

What forms of treatment have you tried for your current condition?

No Treatment Physical Therapy Custom Orthotics Over-The-Counter Orthotics Stretching

Ice Heat Over-The-Counter Medication Prescription Medication Shoes Injections

Soaking Resting Elevation Compression Surgery Other:

Please check any of the following conditions you have been diagnosed with: NONE

Diabetes (Type: 1 or 2 ?) (Year Diagnosed: )

Neurological Disorder:

- Anemia, Anxiety, Arthritis, Asthma, Bipolar Disorder, Bleeding Disorder, Blood Clot, Cancer: Type:, Chronic Urinary Tract Infection, Congestive Heart Failure, COPD/Emphysema, Dementia, Depression, Dialysis, Eye Problem:, Factor V Leiden Deficiency, Fibromyalgia, GI Bleed, Gout, Heart Attack-Year:, Heart Condition:, Hepatitis (A, B or C ?), High Blood Pressure, High Cholesterol, HIV, Irritable Bowel Syndrome, Kidney Failure, Stage:, Liver Problems, Lupus, Migraines, Osteoporosis, Prior Diabetic Foot Complications, Pacemaker / Defibrillator, Peripheral Neuropathy, Peripheral Vascular Disease, Pregnancy/Possibly Pregnant, Psoriasis, Reflux/Indigestion, Restless Leg Syndrome, Rheumatoid Arthritis, Schizophrenia, Seasonal Allergies, Seizures, Sleep Apnea, Stroke, Thyroid Disorder:

Other medical condition(s) not listed:

Please list all surgeries you have had along with the year they were performed: NONE

Blank lines for listing surgeries.

Did you or any of your relatives have any anesthesia problems or surgical complications? If so, please describe:

Blank lines for describing anesthesia or surgical complications.



\_\_\_\_\_  
PRINTED PATIENT'S NAME

\_\_\_\_\_  
DATE OF BIRTH

**Do you currently have any of the following problems?**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Chills                 | <input type="checkbox"/> Wheezing           | <input type="checkbox"/> Numbness              |
| <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Constipation       | <input type="checkbox"/> Seizures              |
| <input type="checkbox"/> Fever                  | <input type="checkbox"/> Diarrhea           | <input type="checkbox"/> Tingling              |
| <input type="checkbox"/> Weight Loss            | <input type="checkbox"/> Nausea             | <input type="checkbox"/> Tremors               |
| <input type="checkbox"/> Blindness              | <input type="checkbox"/> Vomiting           | <input type="checkbox"/> Weakness              |
| <input type="checkbox"/> Contact Lenses         | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Anxiety               |
| <input type="checkbox"/> Glasses                | <input type="checkbox"/> Painful Urination  | <input type="checkbox"/> Depression            |
| <input type="checkbox"/> Difficulty Swallowing  | <input type="checkbox"/> Back Pain          | <input type="checkbox"/> Abnormal Bruising     |
| <input type="checkbox"/> Impaired Hearing       | <input type="checkbox"/> Joint Pain         | <input type="checkbox"/> Excessive Bleeding    |
| <input type="checkbox"/> Respiratory Congestion | <input type="checkbox"/> Leg Cramps         | <input type="checkbox"/> Decreased Appetite    |
| <input type="checkbox"/> Chest Pain             | <input type="checkbox"/> Stiffness          | <input type="checkbox"/> Excessive Thirst      |
| <input type="checkbox"/> Fainting Spells        | <input type="checkbox"/> Difficulty Healing | <input type="checkbox"/> Heat/Cold Intolerance |
| <input type="checkbox"/> Irregular Heart Rate   | <input type="checkbox"/> Excessive Scarring | <input type="checkbox"/> Increased Appetite    |
| <input type="checkbox"/> Leg Swelling           | <input type="checkbox"/> Itching            | <input type="checkbox"/> Weight Changes _____  |
| <input type="checkbox"/> Cough                  | <input type="checkbox"/> Rashes             |  |
| <input type="checkbox"/> Difficulty Breathing   | <input type="checkbox"/> Dizziness          |  |
| <input type="checkbox"/> Shortness of Breath    | <input type="checkbox"/> Frequent Falls     |  |

**What type of shoes do you wear most of the time?** \_\_\_\_\_

**What is your shoe size?** \_\_\_\_\_