

# WELCOME TO FOOT CARE ASSOCIATES

*Surgery and Diseases of the Foot & Ankle – Sports Medicine – Wound Care*

## CONFIDENTIAL PATIENT REGISTRATION

NAME OF PATIENT \_\_\_\_\_ AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ Sex: **M** **F** Today's Date \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_  
CITY STATE ZIP

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL OR PAGER # \_\_\_\_\_

PATIENT SOCIAL SEC. # \_\_\_\_\_ E-MAIL \_\_\_\_\_ DRIVER LIC. # \_\_\_\_\_

PATIENT EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

WORK ADDRESS \_\_\_\_\_ WORK PHONE ( ) \_\_\_\_\_  
CITY STATE ZIP

SPOUSE / PARENT / GUARDIAN NAME \_\_\_\_\_ MARITAL STATUS: M S D W SEP.

SPOUSE / PARENT / GUARDIAN SOC. SEC. NO. \_\_\_\_\_

SPOUSE EMPLOYER \_\_\_\_\_ SPOUSE OCCUPATION \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

**EMERGENCY NOTIFY (NAME)** \_\_\_\_\_ **PHONE NUMBER** \_\_\_\_\_

REFERRED BY \_\_\_\_\_  HMO / PPO BOOK  YELLOW PAGES  INTERNET

## INSURANCE

### PRIMARY INSURANCE:

Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Name of Insured \_\_\_\_\_ Insured Work # \_\_\_\_\_ Insured Birth date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Insured Soc. Sec. # \_\_\_\_\_

### SECONDARY INSURANCE:

Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Name of Insured \_\_\_\_\_ Insured Work # \_\_\_\_\_ Insured Birth date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Insured Soc. Sec. # \_\_\_\_\_

## CONSENTS

- I hereby give FOOT CARE ASSOCIATES – Dr. Sloan Gordon permission to examine and treat my feet. I agree to be responsible for all medical bills.
- In consideration of services rendered, I hereby irrevocably assign and transfer to Dr. Sloan Gordon, for myself and my dependents, all right, title and interest in the benefits payable for services rendered by the doctors provided in any insurance policy(ies) under which I or any of my dependents are insured. Said irrevocable assignment and transfer shall be for the purpose of granting Dr. Sloan Gordon an independent right of recovery in any policy(ies) of insurance, to which benefits may be payable for this treatment but shall not be construed to be an obligation of Dr. Sloan Gordon to pursue any such right of recovery.
- I hereby authorize and direct all insurance company(ies) under which I am insured to pay directly to the doctors all benefits due under said policy(ies) by reason of services rendered therein. I will pay Dr. Sloan Gordon for all charges incurred or alternatively, for all charges in excess of the sums actually paid by said policy(ies).
- I also irrevocably assign to Dr. Sloan Gordon all right, title and interest in benefits payable out of any third party action against any other person, entity or insurance company, under which I may be entitled to recover.
- Each person signing this consent is financially responsible for charges not collected by this assignment.

Patient, Parent or Guardian's Signature X \_\_\_\_\_ Date \_\_\_\_\_

MEDICAL

EXPLAIN YOUR PROBLEM? \_\_\_\_\_ HOW LONG? \_\_\_\_\_

PAIN INTENSITY (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe) | ANY TREATMENT? Anti Inflammatory Phys. Therapy Injection
STUDIES PERFORMED? MRI CAT SCAN X-Rays Nerve Study Bone Scan HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_
ANY PREVIOUS INJURIES, AUTO ACCIDENTS, WORK INJURIES? \_\_\_\_\_
ANY ADJUSTERS, LAWYERS OR OTHER DOCTORS INVOLVED? \_\_\_\_\_

MEDICINES YOU TAKE \_\_\_\_\_

DO YOU HAVE ANY ALLERGIES? [ ] None Known LATEX / RUBBER DYES / IODINE CODEINE LOCAL ANESTHETICS PENICILLIN
ASPIRIN SULFA NOVOCAINE TAPE FOODS OTHER \_\_\_\_\_

FAMILY DOCTOR / PCP \_\_\_\_\_ DATE OF LAST EXAM \_\_\_\_\_

NOTE: IF MY HEALTH OR MEDICATION CHANGES, I WILL NOTIFY THE DOCTOR AT MY NEXT VISIT.

PATIENT HISTORY: Do you have or have you ever had: circle or [x]

- ANEMIA ARTHRITIS ASTHMA ANKLE/LEG SWELLING BLOOD PROBLEM BLOOD TRANSFUSION BRONCHITIS BRUISE EASILY CANCER
CHEST PAIN COUNSELING DIABETES EMPHYSEMA EPILEPSY / SEIZURE FOOT ULCER GOUT HEARING PROBLEM HEART MURMUR
HEART TROUBLE HEPATITIS HIGH BLOOD PRESSURE HIV / AIDS KIDNEY PROBLEM LEG CRAMPS LIVER PROBLEM LOW BACK PAIN LOW BLOOD SUGAR
PASSING OUT PHLEBITIS / CALF PAIN POOR CIRCULATION PROLONGED BLEEDING PRONE TO INFECTION PSYCHIATRIC CARE RHEUMATIC FEVER SHORT OF BREATH SICKLE CELL
STOMACH ULCER STROKE THYROID PROBLEM TUBERCULOSIS (TB) UNEQUAL LEG LENGTH VARICOSE VEINS WEAK ANKLES [ ] OTHER

FEMALES: Any chance you might be pregnant? [ ] Yes [ ] No BODY PIERCINGS OR TATTOOS? [ ] Yes [ ] No

PREVIOUS HOSPITALIZATION / SURGERY / ILLNESS [ ] No [ ] Yes (Explain)

Table with 2 columns: Year, Illness / Operation / Hospitalization / Complications

- FAMILY HISTORY: AIDS / HIV ARTHRITIS ALCOHOLISM BLEEDER CANCER
DIABETES HEART DISEASE HEPATITIS HIGH CHOLESTEROL HYPERTENSION
MIGRANES MENTAL ILLNESS OSTEOPOROSIS STROKES OTHER \_\_\_\_\_

SOCIAL HISTORY
Do you smoke? Cigarettes / Pipe / Cigar Amount / day \_\_\_\_\_ # years \_\_\_\_\_ Quit date \_\_\_\_\_
Do you drink alcohol? Type \_\_\_\_\_ Amount/day \_\_\_\_\_ # years \_\_\_\_\_ Quit date \_\_\_\_\_
Recreational drugs? Type \_\_\_\_\_ Amount/day \_\_\_\_\_ # years \_\_\_\_\_ Quit date \_\_\_\_\_

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

I plan to pay today by: [ ] Cash [ ] Check [ ] Visa [ ] Mastercard [ ] Amex [ ] Discover

We are sorry, but we cannot accept a credit card for charges of less than \$25.00. Thank you. ☺

# FOOT CARE ASSOCIATES

SLOAN GORDON, DPM, FACFAS

A PROFESSIONAL ASSOCIATION

BOARD CERTIFIED SURGERY AND DISEASES OF THE FOOT & ANKLE • SPORTS MEDICINE

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## FOOT CARE ASSOCIATES—FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We strive to provide the best care possible for all our patients. As such, we would like to make you aware of our financial policies. Should you have questions about the information provided here, feel free to discuss them with our staff.

Our practice participates in most insurance plans and, as a courtesy to our patients; we will submit your insurance claims. However, this does not eliminate your financial obligation to pay for care rendered and to obtain all necessary authorizations and referrals. Additionally, it is your obligation to inform us of all insurance changes. Failure to do so will result in you being responsible for any denied charges.

Payment of your co-pay is required at the time of EVERY visit. Additionally, you must keep your account current. Outstanding balances resulting from your responsibility for the deductible or coinsurance will also be collected at the time of a visit. Past due balances are subject to collection proceedings.

If you are covered by an HMO or any Managed Care plan, it is YOUR responsibility to obtain a referral from your primary care doctor prior to your visit with us. If we do not receive a valid referral at the time of service, you will be responsible for paying all charges that day. If you do not have any insurance, you will be required to pay in full at each visit. If necessary, we will provide an estimate of the days' charges to you. Sorry, we do not offer payment plans for this.

We accept all major credit cards, personal checks and cash as payment for services. When receiving statements from our office you may send back the payment coupon with a check or credit card information or you may choose to call our office and provide credit card information over the telephone.

While we do not charge for missed appointments, we would appreciate it if you would notify us when you cannot keep an appointment. That will allow us to serve all of our patients better. Repeated no shows (more than three consecutive) will necessitate that we assess a \$50 fee for your reserved time slot.

We may charge \$25 for completing forms you may need either for your employer or for disability insurance or for any other reason. We request that you give us adequate time to complete these forms. We are not able to complete them during the course of a visit; however, we will make every effort to return them to you as quickly as possible.

In the event that your check is returned to us, there is a charge of the \$25 bank fee that we will pass along to you.

Occasionally, we will refer you to outside sources for additional care such as labs, physical therapy or imaging. You will pay these facilities directly for any services they provide to you since they are completely separate from our office. In the event that you schedule surgery with us you may also receive bills from the facility, the anesthesia group and others who provide services during surgery. You will pay them directly as well.

Thank you for reviewing this information. If you have any questions, please do not hesitate to ask.

✍ Please sign and date below. ✍

Printed Name of Patient/Responsible Party: \_\_\_\_\_

Signature of Patient/Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Initial that you have received a copy of this document.

**FOOT CARE ASSOCIATES: Dr. Sloan Gordon ☆ 713-988-6600**

**Consent to the Use and Disclosure of Health Information  
for Treatment, Payment, or Healthcare Operations**

Name

DOB

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my healthcare information:

Please specify your restrictions:

Signed By  Date   
Signature of Patient or Legal Representative

Witness Signature

**OFFICE USE ONLY**

Accepted  Denied

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date