

FOOT CARE ASSOCIATES

SLOAN GORDON, DPM, FACFAS

BOARD CERTIFIED SURGERY AND DISEASES OF THE FOOT & ANKLE • WOUND CARE • SPORTS MEDICINE
American Board of Podiatric Surgery

St. Luke's Hospital – Sugar Land
1327 Lake Pointe Pkwy., #520
Sugar Land, Texas 77478

Memorial Hermann Southwest
7737 Southwest Fwy., #500
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427 West 20th St., #703
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www.myfootdoc.com – sgordondoc@sbcglobal.net

*Fmr Chief – Section of Podiatric Surgery
Memorial Hermann Healthcare System - Southwest*

Dear New Patient,

Welcome to my office. I know choosing a physician is an important and sometimes hard decision. At times it is difficult to obtain accurate information regarding a physician's qualifications. This information is important to determine if the physician deserves your confidence and trust. Understanding this, I would like to take this opportunity and tell you a little about my background and my approach to patient care.

I graduated from the New York College of Podiatric Medicine in 1982. I did my residency training at the West Haven Veterans Hospital/Yale University Medical Center in New Haven, Connecticut after graduation. Because my brother lived in Houston, Texas, I made the decision to relocate. I have been here since that time and take pleasure in all our city has to offer.

I am Board Certified in foot and ankle surgery by the American Board of Podiatric Medicine and I am Fellowship trained and a Fellow of the American College of Foot and Ankle Surgeons. I enjoyed the position of Chief, Podiatric Surgery, Department of Surgery, Memorial Hermann Southwest Hospital from 1988 for 21 years. I remain an active member of the MHSW staff and still treat inpatients, outpatients and see patients in the Emergency Center. I serve on the Joint Quality Review Committee and the Pharmacy and Therapeutics Committee.

I believe good communication is important to both patient and physician. I think of myself as an 'old fashioned' doctor with up to date skills and technology. I encourage my patients to ask questions during their visits and even by electronic mail (Email). I will do my best to answer these questions, explain your condition and discuss treatment options.

It's a privilege to be able to help my patients and receive their trust. I look forward to treating all your foot care needs.

Warmest regards,

Sloan Gordon

Sloan Gordon, DPM, FACFAS

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: Female Male **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 _____ STATUS: MARRIED SINGLE DIV WIDOW SEP. S/O

SPOUSE / PARENT / GUARDIAN SOC. SEC. NO. _____

SPOUSE EMPLOYER _____ SPOUSE OCCUPATION _____

EMERGENCY NOTIFY (NAME) _____ RELATIONSHIP: _____ PHONE
NUMBER _____

REFERRED BY _____ HMO / PPO BOOK YELLOW PAGES INTERNET

PRIMARY CARE PHYSICIAN _____ PHONE # _____ DATE OF LAST EXAM _____

Government guidelines require that we collect the following data. Please make **TWO** selections below one answer in each category.

Race: Black White Native American Asian/Pacific Islander Other Refused

Ethnicity: Hispanic Non-Hispanic Refused

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. # _____

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PATIENT CONSENT FOR THE DISCLOSURE OF INFORMATION (HIPAA)

In order to continue to provide you with the quality care you have become accustomed to in our office, as well as operate in an efficient manner, we will need to access your private health care information for the purposes of **treatment, payment, and operations** (such as quality assurance). In using this information this office will comply with all state and federal laws pertaining to your privacy rights, including the Privacy & Security protections provided to you by the Health Insurance Portability and Accountability Act ("HIPAA").

Specifically, we will need to disclose your private information under the following circumstances:

- **Sharing information for the purpose of treatment:** We will share information with all members of your treatment team, both within this office and with other providers (personal and institutional) in order to provide you quality care and the educational/wellness programs specified in your insurance plan.
- **Sharing of information for the purpose of payment:** We will share all necessary information with your insurer(s), payor(s), government entities (such as Medicare, Medicaid, etc.), and their representatives (including, but not limited to) benefit determination and utilization review as well as representatives involved in the billing process (including but not limited to) claims representatives and billing companies.
- **Sharing information for purposes of operations:** We will share information necessary for ongoing operations of this office, including (but not limited to) credentialing process, peer review, accreditation, and compliance with all federal and state laws.

Your consent for use and disclosure of information as described may be revoked in writing at any time. Please notify the office/Privacy Officer if you ever decide to revoke your consent.

Your signature indicates your consent has been given freely. You understand that you may revoke this consent at any time if that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissible.

Patient's Name (printed): _____

Patient's Signature: _____

Date Signed: _____

ACKNOWLEDGEMENT FORM

Acknowledgement of Receipt of Privacy Notice: I have read a copy of Dr. Sloan Gordon's, Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law.

Due to the Notice of Privacy Policies, our office will not be able to disclose any of your confidential medical information to any one you deem necessary unless you give us written authorization to do so. Example: husband/wife calls on (patient's) behalf to obtain results or obtain update on patients health, if the (patient) has not given our office written authorization to disclose this information to his/her spouse; our office will not be able to disclose this information to the family member. If you wish to disclose your medical information to your family, friends or other treating physicians, please do so by giving us the appropriate names in writing.

I authorize appointment reminders and/or messages regarding my health status, including, diagnosis, treatment options, billing and payment information to be delivered on my behalf to the following people and physicians.

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Physician: _____ Tel/Fax: _____

I give authorization: _____ Date: _____

Patient signature

PLEASE DO NOT RELEASE ANY OF MY MEDICAL INFORMATION TO ANY FAMILY MEMBERS.

I DO **NOT** give authorization: Signature _____ Date: _____

CONSENTS/SIGNATURE PAGE

- > 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.
- > As your physician, I believe you are entitled to make informed decisions regarding your medical care. To assist you in making an informed decision, I provide this notification that I hold an ownership interest in St. Luke's Sugar Land Partnership LLP, doing business as St. Luke's Sugar Land Hospital. I ask you to sign below indicating your receipt of this notification. By my signature below, I hereby acknowledge that I have received notification of Dr. Gordon's ownership interest in St. Luke's Sugar Land Partnership LLP d/b/a St. Luke's Sugar Land Hospital.
- > I state that the above is true and accurate. I understand that if a referral is required for my office visit or outpatient testing, it is my responsibility to obtain one from my PCP. I also understand that if I do not obtain one, my appointment may be rescheduled or I can sign a waiver and pay for my entire visit at the time of service. If labs or diagnostic tests are necessary, it is my responsibility to make sure the facility that performs the service is in my network or I may use my out of network benefits and pay at a higher level.

Each person signing this consent is financially responsible for charges not collected by this assignment.

Signature _____
Date _____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim.

Signature: _____ Date _____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits directly to the physician and I request payment of any government benefits to the party accepting assignment.

Signature: _____ Date _____

I have read the Financial Policy and agree to all terms as described:

Signature: _____ Date _____

I have read the Cancellation/No Show/ Medical Records/Refills policy and agree to all terms described:

Signature _____ Date _____

Confidential History & Medical Information New Pt Existing Pt **Ins:** _____

1. Explain your foot/ankle problem Right Left _____

2. Describe the pain/discomfort: Burning Numbness Sharp Other _____

3. When did the pain/discomfort begin? _____

4. What makes the pain/discomfort better: _____

5. What makes the pain/discomfort worst: _____

6. List all medications/herbs/vitamins: NONE _____

7. List all drug, food and environmental allergies and describe reaction: NONE

<input type="checkbox"/> Penicillin _____	<input type="checkbox"/> Aspirin _____	<input type="checkbox"/> Narcotic Agent / Codeine _____
<input type="checkbox"/> Anesthesia _____	<input type="checkbox"/> Shellfish _____	<input type="checkbox"/> Sulfa Drugs _____
<input type="checkbox"/> Nickel / Metal _____	<input type="checkbox"/> Radiographic Contrast Dye _____	
<input type="checkbox"/> Other _____		

8. **PAST MEDICAL AND FAMILY HISTORY: ■ Who is your PCP?** _____

Condition	Self	Family	Condition	Self	Family
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Circulation Problems	<input type="checkbox"/>	<input type="checkbox"/>	Nails Disorders	<input type="checkbox"/>	<input type="checkbox"/>
How long have you been diabetic? _____			Nerve Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Avg Glucose _____	<input type="checkbox"/>	<input type="checkbox"/>	Obesity	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
Foot Problem(s)	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary Disease	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	STD	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intest Problems	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Injury Trauma - Major	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>

9. **Surgical History:** Have you had surgery? Yes—if yes, describe below No
Surgery / Date: _____

10. **Social History:** (Only check what is pertinent to you)

Do you have a history of:	Yes	No		Yes	No
Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>	Caffeine Use	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Use	<input type="checkbox"/>	<input type="checkbox"/>	Drug Use	<input type="checkbox"/>	<input type="checkbox"/>

11. Do you exercise? Yes No _____

12. Occupation: _____ Is your problem work related? Yes No

13. Are you currently pregnant? Yes No _____

14. Height: _____ Weight: _____ Shoe Size: _____

ALL OF THE INFORMATION PROVIDED TODAY IS CORRECT TO THE BEST OF MY KNOWLEDGE:		
Signature: _____	Print Name: _____	Date: _____

Review of Systems

Please check any of the following that you are **currently experiencing** or have **recently experienced**.

Constitutional			
<input type="checkbox"/> Fever	<input type="checkbox"/> Chills	<input type="checkbox"/> Sweats	<input type="checkbox"/> Weight Change
Head, Eyes, Ears, Nose and Throat			
<input type="checkbox"/> Wear Contact Lenses	<input type="checkbox"/> Dentures	<input type="checkbox"/> Wearing Eyeglasses	
<input type="checkbox"/> Double Vision	<input type="checkbox"/> Cataract	<input type="checkbox"/> Dizziness	
<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Sore Throat	
<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Problems with eyesight	<input type="checkbox"/> Ringing in the Ears	
Cardiovascular			
<input type="checkbox"/> Chest Pain / Discomfort	<input type="checkbox"/> Cardiovascular Symptom	<input type="checkbox"/> Heart Murmur	
<input type="checkbox"/> Swelling lower extremity	<input type="checkbox"/> Leg Pain with Exercise	<input type="checkbox"/> Palpitations	
Hematologic/Lymphatic			
<input type="checkbox"/> Bleeding Problem	<input type="checkbox"/> Swollen Glands	<input type="checkbox"/> Lymphoma	
<input type="checkbox"/> Anemia	<input type="checkbox"/> Skin Lump - Location		
Respiratory			
<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Previous Pulmonary Disease	
<input type="checkbox"/> Exposure to TB	<input type="checkbox"/> Cough	<input type="checkbox"/> Pulmonary Symptoms	
Gastrointestinal			
<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Diarrhea	
<input type="checkbox"/> Decrease in Appetite	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Constipation	
Endocrine			
<input type="checkbox"/> Often Thirsty	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Thyroid Disease	
<input type="checkbox"/> Urinary Symptoms	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Prior Kidney Disease	
Musculoskeletal			
<input type="checkbox"/> Musculoskeletal symptoms	<input type="checkbox"/> Feeling weak	<input type="checkbox"/> Joint Pain, Arthralgia	
<input type="checkbox"/> Weakness of limbs	<input type="checkbox"/> Prior Fracture		
Nervous System			
<input type="checkbox"/> Ataxia	<input type="checkbox"/> Speech Difficulties	<input type="checkbox"/> Headache	
<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Confusion/ Disorientation	<input type="checkbox"/> Fainting	
<input type="checkbox"/> Convulsions			
Skin			
<input type="checkbox"/> Rash	<input type="checkbox"/> Ulcer	<input type="checkbox"/> Lesions	<input type="checkbox"/> Sun Sensitivity
<input type="checkbox"/> Color Change	<input type="checkbox"/> Slow Healing	<input type="checkbox"/> Infections	<input type="checkbox"/> Cracking
<input type="checkbox"/> Eczema (Pruritus)	<input type="checkbox"/> Growth	<input type="checkbox"/> Hair Loss	
Allergic, Immunologic History			
<input type="checkbox"/> Dermatitis	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Lupus	<input type="checkbox"/> Collagen Vascular
Psychiatric			
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Tension	<input type="checkbox"/> Depression	

None of the above conditions apply:

Signature: _____

Date: _____

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CANCELLATIONS/NO SHOWS, MEDICAL RECORDS & REFILLS

In order for our office to be able to continue providing quality patient care and service, it has become necessary to implement the following changes to scheduling, medical records requests, and refills. The following information contains guidelines that we have added to our current office policies. Please read carefully and sign/date to acknowledge your understanding and cooperation with our new procedures:

NO/SHOWS and CANCELLATIONS: Since we have many patients who are patiently waiting to be seen in our office, it has become necessary to adopt a policy for those who cancel without notice or do not show up for his/her appointment. We ask for 2-BUSINESS DAYS notice in order to reschedule or cancel an appointment so that another patient may be contacted in time and scheduled. Please review our "3-STRIKE" policy:

- 1st strike – patient is verbally reminded of our policy.
- 2nd strike – patient is billed \$25.00.
- 3rd strike – patient is reminded of policy, placed on a 'waiting list' to be seen on a specific day. You will not receive a specific appointment time. At the discretion of the doctor, you can be dismissed from the practice.

We understand that emergencies arise. Please contact our office at your very earliest convenience if there is a possibility that you will not be able to make your appointment or would like to reschedule your appointment for a future date.

MEDICAL RECORDS FEES:

- Insurance requests and other entities (w/proper consent from the patient) = \$50.00
- Patient requests (over 5pgs.) = \$15.00

REFILLS: Please notify our office at least 3 DAYS prior to needing a prescription refill. This will ensure that our office has ample time to receive and process your refill request without delay and ensure you receive your medication in a timely manner.

By signing this document, I acknowledge I have read, understand, and will adhere to Dr. Gordon's policies and procedures regarding NO/SHOWS, CANCELLATIONS, MEDICAL RECORDS, and REFILLS.

SIGN ON SIGNATURE PAGE

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FINANCIAL POLICY

In order, for our office to be able to continue to deliver the quality of care that you are accustomed to, it has become necessary to make some changes in our financial policies. The following list contains guidelines that have become part of making your visit to Dr. Gordon's office as pleasant as possible, while providing you with the highest quality of care.

ALL PATIENTS ARE REQUIRED TO READ AND SIGN A COPY TO BE RETAINED IN YOUR CHART.

1. We ask that you present your insurance card(s) at each visit. It is your responsibility to provide us with **ALL** the correct information to ensure proper billing to your insurance company(ies).
2. If you have a change of address, telephone numbers, or employer, please notify the receptionist and we will be happy to update your records.
3. We will collect your deductible, co-payment, co-insurance, or charges for non-covered services **at the time of your visit**. If you have a balance after an insurance payment from a previous visit, we will also ask for that payment. We accept cash, checks, money orders, Visa, MasterCard, and American Express.
4. If we do not participate with your insurance, we will file your claim(s) as a courtesy; however, you will be expected to pay for your services **at the time of your visit**.
5. If your insurance company denies our charges, or does not pay us in a timely manner, you will be billed for the entire balance. You will be expected to pay your balance in full within 30 days or call our billing department to make payment arrangements. If payment is not received in a timely manner, your account may be subject to more aggressive collection methods.
6. **MEDICARE PATIENTS:** Dr. Gordon is a participating provider with Medicare Part B and we will bill Medicare for all of your covered charges. If you have a supplemental insurance, we will also bill that for you. If payment is not received from your supplemental insurance within 45 days of being submitted, we will bill you for the balance due. If you do not have a supplemental insurance, the 20% Medicare does not cover will be collected from you at the time of service. Each year you will be expected to pay the allowed amount of your charges until your Medicare annual deductible has been met.
7. **MANAGED CARE (HMO, PPO) PATIENTS:** If we participate with your plan, we will bill your insurance for you, however, your co-pay will be collected up front, no exceptions. If your plan requires you to choose a primary care physician, it is your responsibility to make sure your insurance company has your physician on file, and it is your responsibility to obtain a referral from your PCP prior to your visit with us. If we do not have a valid referral at the time of service, you will be responsible for payment that day. If we do not participate with your plan, we will verify your **out of network** benefits and file your charges. Your payment of the portion of the bill the insurance will not cover will be expected from you at the time of service. Our office will contact you to let you know your benefits prior to your appointment.
8. **SELF-PAY PATIENTS:** Patients without medical coverage will be expected to pay **at the time of service**. If you will not be able to pay in full, you must contact our billing department prior to seeing Dr. Gordon to make payment arrangements.

Remember, whether you do or do not have medical insurance, you are ultimately financially responsible for payment of your charges. If you have any questions regarding our financial policy, please contact our billing department.

SIGN ON SIGNATURE PAGE