ETFA EAST TEXAS FOOT ASSOCIATES
(877) 747-3668 TOLL-FREE • ETFAONLINE.COM

## PATIENT INFORMATION

| Patient's Last Name | First | Middle Initial |
|---|---|---|
| | | |

| Street Address | City | State | Zip Code | Home Phone |
|---|---|---|---|---|
| | | | | |

| Cell Phone | Date of Birth | ▫ Male ▫ Female | Social Security Number | Marital Status ▫ Single ▫ Married ▫ Divorced ▫ Widowed |
|---|---|---|---|---|
| | | | | |

| Patient's Occupation | Patient's Employer | Emergency Contact Name | Emergency Phone Number |
|---|---|---|---|
| | | | |

| Employer Street Address | City | State | Zip Code | Work Phone |
|---|---|---|---|---|
| | | | | |

What type of Insurance do you have?

▫ Medicare ▫ Medicaid ▫ BC/BS ▫ Aetna ▫ Cash Pay ▫ Other:

| Policy Number | Group Number |
|---|---|
| | |

| Is Policy Holder the patient? ▫ Yes ▫ No | If not, Name of Policy Holder? | Date of Birth Policy Holder | Relationship ▫ Spouse ▫ Parent ▫ Other |
|---|---|---|---|
| | | | |

| Policy Holder Social Security Number | ▫ Male ▫ Female | Patient Email Address |
|---|---|---|
| | | |

### HOW DID YOU HEAR ABOUT US?

▫ Google ▫ Yahoo ▫ Ins. List
▫ Bing ▫ Facebook ▫ Other

▫ Doctor's Office/Clinic:
▫ Family/Friend:

### MEDICAL HISTORY

| Family Doctor: | Date Last Seen: | Pharmacy: |
|---|---|---|
| | | |

| Shoe size: | Height: | Weight: | Smoke? ▫ No ▫ Yes: ____ packs/day ▫ Ex-Smoker quit ____ years ago |
|---|---|---|---|
| | | | |

**Vaccines** Flu ▫ No ▫ Yes when? _____ Pneumonia ▫ No ▫ Yes when? _____ Alcohol? ▫ No ▫ Yes: ____ per ____

**Family Medical History** ▫ Heart Disease ▫ High Blood Pressure ▫ Diabetes ▫ Cancer ▫ Cholesterol

**Your Medical History**

Diabetes:
▫ Insulin
▫ Non-insulin

▫ Last blood glucose: ____
▫ Last Hg A1c: ____
▫ When? ____
▫ High Blood Pressure
▫ Heart Disease
▫ Asthma
▫ Bleeding Problems
▫ Kidney Disease
▫ Gout
▫ Nerve Pain Pacemaker
▫ Anemia
▫ Anxiety
▫ Depression
▫ Osteoporosis
▫ Cancer
▫ Liver Disease
▫ HIV
▫ Cholesterol UTI
▫ Seizures
▫ Osteoarthritis
▫ Rheumatoid Arthritis
▫ Blood Clots
▫ Other:

**In the last 6 months?**

▫ Weight loss
▫ Appetite change
▫ Leg cramps
▫ Blurred vision
▫ Headache
▫ Cough
▫ Palpitations
▫ Shortness of breath
▫ Heart attack
▫ Stroke
▫ Rashes
▫ Chest pain
▫ Masses
▫ Major trauma

**Allergies** ▫ None ▫ Penicillin ▫ Codeine ▫ Sulfa ▫ Iodine ▫ Anesthetics ▫ Latex ▫ Jewelry ▫ Shrimp ▫ Anti-inflammatories ▫ Other:

| Medication Name | Dose | Medication Name | Dose | Medication Name | Dose |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

Are you on blood thinners or aspirin? ▫ No ▫ Yes List:

Have you had any recent falls? ▫ No ▫ Yes When/How often:

Have you had any stents or peripheral vascular surgery? ▫ No ▫ Yes When/Surgeon:

Are you pregnant or planning a pregnancy? ▫ No ▫ Yes Explain:

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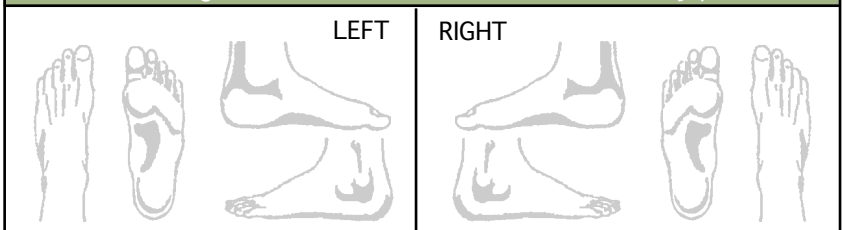
## Surgical History - Please list any surgeries you have had, include dates and surgeon's name if possible

| Name of Procedure | Date | Surgeon |
|---|---|---|
| | | |
| | | |
| | | |

Do you have any surgeries planned/pending? ▫ No ▫ Yes Details:

## Current Foot Problems:

### Mark drawings below with numbers 1 and 2 to identify problems




### Describe up to 2 main problems in greater detail below

1. Describe your problem and it's cause if you know:
My first problem is: ▫ Left foot ▫ Right foot ▫ Both feet

_____
_____
_____
_____

Is this problem work related: ▫ No ▫ Yes Date: _____

My pain/discomfort began: _____

Pain Scale: (circle) 1 2 3 4 5 6 7 8 9 10
Minimal Moderate Severe Intolerable

It occurs when: _____

Previous medical treatment(s): _____

_____
_____
_____

### Additional Problem

2. Describe your problem and it's cause if you know:
My first problem is: ▫ Left foot ▫ Right foot ▫ Both feet

_____
_____
_____

Is this problem work related: ▫ No ▫ Yes Date: _____

My pain/discomfort began: _____

Pain Scale: (circle) 1 2 3 4 5 6 7 8 9 10
Minimal Moderate Severe Intolerable

It occurs when: _____

Previous medical treatment(s): _____

_____
_____
_____

## *Medical Infromation Release Form (HIPPA Release)

▫ I acknowledge receiving a copy of the ETFA Notice of Privacy Practices and I hereby authorize the release of information including diagnosis, records, claims and examination rendered to me. This information may be released to:

▫ Spouse: _____

▫ Child(ren): _____

▫ Other: _____

▫ Information is not to be released to anyone.

* This Release of information will remain in effect until terminated by me in writing.

## Messages

Please Call: ▫ my work ▫ my home
▫ my cell number: _____

if unable to reach me:

▫ you may leave a detailed message

▫ please leave a message asking me to return your call

▫ Other: _____

I authorize the release of any medical information necessary to process this claim and request payment of benefits, government or other, be made to: ETFA

I hereby give permission to the podiatrists of ETFA to examine, treat and perform such procedures as may be necessary for the treatment of my condition.

Signed: _____

Witness: _____ Date: _____

# East Texas Foot Associates – Financial Policy Agreement

Thank you for choosing us as your podiatry care providers. We are committed to providing you with quality and affordable health care. To help you better understand patient and insurance responsibilities for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. **Knowing your insurance benefits is your responsibility**. Please contact your insurance company with any questions you may have regarding your coverage.
2. Proof of insurance. All patients must complete our patient information forms before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. Insurance and its coverage will be verified prior to patient being seen by our doctors.
3. No Insurance. If you are not insured by a plan we do business with, payment in full is expected at each visit. We do offer a discounted fee schedule for these self-pay situations.
4. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
5. Non-covered services. Please be aware that some – and perhaps all -- of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. We accept payment in the forms of cash, personal checks, money orders, cashier's checks, debit cards and credit cards.
6. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
7. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
8. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding and complying with our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Name:_____ Date:_____

Signature of patient or responsible party/Date

**HIPAA NOTICE OF PRIVACY PRACTICES**
**As required by the Privacy Regulations Promulgated Pursuant to the**
**Health Insurance Portability and Accountability Act of 1996 (HIPAA)**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

**Uses and Disclosures of Protected Health Information:** Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment.

**We may use or disclose your protected health information in the following situations without your authorization:** as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.**

You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

**Your Rights:** Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us**, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

**You may have the right to have our organization amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints:** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

**We are required by law** to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerning or objections to this form, please ask to speak with our President in person or by phone at 252-744-2426.

**Associated companies with whom we may do business**, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided.

**We welcome your comments:** Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.

**EAST TEXAS FOOT ASSOCIATES:**
**DR. MARK E. SOWELL DPM**
1400 RAGUET ST. NACOGDOCHES, TX 75965
307 COTTAGE AVE. CARTHAGE, TX 75633
Phone: (936) 559-1700 Fax: (936) 559-1713

# AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: **EAST TEXAS FOOT ASSOCIATES: DR. MARK E SOWELL**

Address: 1400 RAGUET STREET

City: NACOGDOCHES State: TX Zip Code: 75965

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Patient Signature: _____ Date Signed: _____