Alliance Foot & Ankle Specialists —PATIENT REGISTRATION

Legal First Name **MI** **Last Name**

Date of Birth **Gender** **Marital Status** □ Never Married □ Married □ Divorced □ Domestic Partner

_____/_____/_____ □ Female □ Male

Race □ American Indian/Alaska Native □ Asian □ Black/African American □ Hispanic □ Native Hawaiian □ White

Primary Language: _____ **Ethnicity** □ Hispanic/Latino □ Not Hispanic/Latino □ Patient Declined

Physical Address **City** **State** **Zip**

Employment **Employer Name**

□ Employed □ Unemployed □ Student □ Other/Retired

Home Phone **Work Phone** **Cell Phone** **Email**

(_____) _____-_____ (_____) _____-_____ (_____) _____-_____

Mark Preferred Method of Call/Voice Mail

□ Home Phone □ Work Phone □ Cell Phone

Mark Preferred Method of Written Correspondence

In addition to AFAS Secure Pt Portal □ Email □ Postal Service

Emergency Contact Name **Relationship** □ Mother □ Father □ Friend □ Spouse □ _____ **Home Phone** (_____) _____-_____ **Cell Phone** (_____) _____-_____

Name person(s) who can have access to your records/PHI or pick up items for you:_____

Primary Care Physician **Office Phone** (_____) _____- _____

Referred By □ ER □ Friend □ Patient Pop □ Insurance □ PCP/Refer Dr □ ZocDoc □WebMD □ Yelp □ Google □ Solution Reach

Your claim is □ Compensable/Work Related □ Automobile □ Other Liability □ Not Related Work/Auto/Liability

Primary Insurance– copy of card required for claim

Insurance Name **Eligibility Phone** (_____) _____-_____

Medical Claims Address

Member ID # **Group #**

Insured Name **Relationship to Insured**

Insured Date of Birth

_____/_____/_____

Insured Employer Name **Employer/HR Phone #**

Secondary Insurance– when Medicare/Tricare is 1st/2nd

Insurance Name **Eligibility Phone** (_____) _____-_____

Medical Claims Address

Member ID # **Group #**

Insured Name **Relationship to Insured**

Insured Date of Birth

_____/_____/_____

Insured Employer Name **Employer/HR Phone #** (_____) _____-_____

Attest

I do hereby attest that this information is true, accurate, and complete to the best of my knowledge. I understand that any falsification, omission, or concealment of any material fact may subject me to all fees for services and/or other liability. I also understand that I am to notify Alliance Foot & Ankle Specialists immediately of any changes to the above information and **annually** upon the office's request.

_____ _____ _____ _____

Print Name of Patient or Legal Authorized Representative | Signature | Relationship to Patient | Date

Alliance Foot & Ankle Specialists (herein after collectively referred to as "AFAS ")

Authorization from Patient or Legal Representative

1. Consent to Treat: The undersigned consents to any initial or follow-up evaluations, examinations, x-rays, laboratory procedures, other tests, medications, medical treatment, surgery, physical therapy, home instructions, orthotics, other durable medical equipment, photographing and/or videotaping and/or other services rendered to the patient by AFAS and its providers. The undersign agrees that it is their responsibility to contact and/or schedule with AFAS for any follow up visits, other services, prescriptions and items ordered for the patient. The undersigned also understands that AFAS's providers exercise their care with reasonable skill and diligence, but make no guarantee as to the results or cure that will be attained.

2. Assignment of Benefits: I hereby irrevocably assign, transfer and convey to AFAS and any practitioner providing care and treatment to me/my child, any and all benefits and all interest and rights (including causes of action, the right to enforce payment and the right to appeal an adverse benefit determination) to which I am entitled under an employee benefit plan sponsored by my employer, all insurance policies, benefits, any third-party reimbursement, or prepaid health care plan for services rendered or products I received from AFAS.

3. Medicare Assignment: I certify that the information given by me in applying for payment under XVIII of the Social Security Act is correct and agree to complete the Medicare screening form annually. I authorize the release of information concerning me to the Social Security Administration or its intermediaries as well as any information needed for filing a Medicare claim; I request that payment and authorized benefits be made on my behalf. I assign benefits payable for services to AFAS.

4. Authorization to Release Information: I consent and authorize AFAS and its agents to release my health information for the purpose of payment, treatment, and healthcare operations to any of the following: insurance company and its affiliates, any practitioner, support staff or facility involved in my plan of care or transfer of care. In addition I understand that the potential uses and disclosures of my Health Information are detailed in the Privacy notice. The HIPAA Notice of Privacy Practices are available Online at **www.footdoc.org** Individual copies are also available in the office and posted in the lobby. I have read/had the opportunity to read my HIPAA rights, which include AFAS's fees for records.

5. Designation of Authorized Representative: I designate and appoint AFAS (and its agents) as my authorized representative and authorize it to act on my behalf to 1) request and receive a copy of the summary plan description, 2) pursue a benefit claim, 3) appeal and adverse benefit determination, and/or 4) file a legal/equitable action to recover benefits from my employee benefit plan, insurance policy, and any third-party reimbursement or prepaid health care plan. I understand and agree that my authorized representative shall have full authority to act, and receive notices, on my behalf with respect to an initial determination of the claim for health benefits relating to treatment and health care services received by me/my child at AFAS, any requests for documents relating to this claim and appeal of an adverse determination of the claim.

6. Financial Agreement: I hereby promise that premiums for my insurance are kept current. Furthermore, I agree to pay for all products received or services rendered to me/my child to the extent I am legally responsible for such payment. According to the language of the physician's insurance contract, I understand that I am responsible for all health insurance copayments, deductibles, coinsurances, OTC-over the counter convenience items and NCS-noncovered services and any other amounts that apply at the time of service or at the pre-operative appointment. Should the insurance misrepresent their coverage or delay payment of a claim greater than 45 days, as the designated responsible party, I am responsible for the for all monies owed to AFAS. I also understand that the insurance policy is a contract between me and the insurance company; therefore the policy holder should contact the insurance carrier first when there are questions regarding explanation of benefits.

The undersigned certifies that he/she has read and understands the foregoing statements 1-6, and is either the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accepts its terms. This document shall remain in force until a written revocation by me is delivered to AFAS.

_____	_____	_____	_____
Print Name of Patient or Legal Authorized Representative	Signature	Relationship to Patient	Date

Alliance Foot & Ankle Specialists (herein after collectively referred to as "AFAS ")

Notification of Office Policies and Procedures

Reading the following policies and procedures annually will keep you informed about our office.

1. **Appointments:** To allow for greater access of care, our team of physicians is available by appointment during posted hours.
2. **Emergency/after hours**: During a medical emergency, patients should call 911 or proceed to nearest emergency room. On-call physicians should be paged for post-operative complications and other urgent situations.
3. **Refills and Medication**: Refills are completed via a pharmacy request. Contact your plan regarding your drug coverage.
4. **Messages**: Phone messages received before 3 PM are usually returned daily. Emails are returned less frequently.
5. **Benefits**: AFAS will reiterate the benefits that were disclosed to us by your insurance plan. We will then collect based on the benefit level all applicable copays, deductibles, coinsurances and balances that apply at the time of service or at the pre-operative appointment. To improve accuracy, we update patient records annually.
6. **Payment**: AFAS accepts VISA, MasterCard, Cash or Checks. All checks are immediately scanned for processing. Our office does not accept temporary checks and we will contact the bank directly to verify checks over $500. We do not offer payment plans. We may offer Care Credit for our Laser Service at the 12 month extended payment plan.
7. **Insurance Claims**: AFAS files claims electronically for the patient's primary contracted plan and accepts payment via the patient's assignment. AFAS only files secondary claims for Medicare patients; non-Medicare patients may request itemized statements to file to multiple carriers.
8. **Multiple Policies**: When multiple policies exist, it is the policy holder's responsibility to inform AFAS of their primary plan. Delayed filing to the primary plan can result in violating timely filing limits, resulting in a denial of service and full patient financial responsibility.
9. **Insurance Networks**: AFAS only files claims to carriers whom we have a contractual relationship; our in-network list is available upon request or on our website. We are not contracted with any Medicare HMO replacement plans.
10. **Liability Claims**: AFAS does not accept personal injury protection, and letters of protection or other liability claims. These types of claims are to be paid in full by the patient.
11. **Non-Covered Services:** AFAS will not submit claims for non-covered items including, but not limited to cosmetic services and over the counter convenience items (OTC eg. Biofreeze, Coban, Lyncos, Mycomist, etc…)
12. **Referrals**: AFAS may refer patients to other providers, facilities, and labs.AFAS is not responsible for these entities. The patient should contact these non-AFAS providers, facilities or labs directly regarding any billing questions. The policy holder is also responsible for all insurance authorizations or managed care referrals necessary for payment to AFAS. Compliance with providers, facilities and other treatments impact patient outcomes.
13. **Missed Appointments**: A $40 charge will apply for appointments broken or canceled less than 24 hours advanced notice.
14. **Appointment Hold**: Repetitive broken appointments, non-compliance, hostile behavior, and/or financially deficient accounts will result in appointment hold and/or the termination of the Alliance Foot & Ankle Specialists Doctor-Patient relationship. 30 days' advance notice will be given should the situation result in a transfer of the patient's care.
15. **Patient Balance Statements**:AFAS will send a remainder or balance statement to the patient when the benefits have been misrepresented by the carrier. Each statement will be accessed a $15 rebilling fee for each month that it is reissued.
16. **Delinquent Accounts**: Past due accounts are subject to collection proceedings and are reported. All collection fees, attorney fees and court fees shall become the guarantor's responsibility in addition to the balance due the office.
17. **Returned Checks**: A $30.00 fee will be assessed on all returned checks. Any NSF or Closed Account will result in future services on a pre-pay cash or credit basis. The District Attorney's Office will prosecute unresolved checks.
18. **Refunds**: AFAS issues patient refunds for medical services by check or credit card within 30 days of a completed investigation of the potential overpayment, as long as other outstanding accounts have been resolved
19. **Returns/ Exchange**: Only unworn and non-custom items are returnable for a **merchandise credit only** within **14 days** of receipt, if no visible signs of wear, tear, or odor. Custom items are tailored to meet individual needs; custom items are non-returnable, non-refundable
20. **Credits: AFAS merchandise credit's can only be used towards non-custom items**
21. **Medical Records**: The cost for copied medical records and completion of disability forms will be charged to the patient and collected prior to replicating. The fees for these services are regulated by HIPAA and Texas Health and Safety Code.
22. **Secure Portal:** Patient messaging, instructions, clinical summaries and patient records are provided online.

The undersigned certifies that he/she has read and understands the foregoing 1-22 statements, and is either the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accepts its terms.

_____	_____	_____	_____
Print Name of Patient or Legal Authorized Representative	Signature	Relationship to Patient	Date

Alliance Foot & Ankle Specialists

PAST FAMILY SOCIAL HISTORY

Last Name: _____ Legal First Name: _____MI:____ DOB: _____

Allergies

□ **No Known Drug Allergies** □ Adhesive(tape) □ Amide Anesthetic □ Codeine □ Egg □ Ester Anesthetic □ Heparin
□ Iodine □ Latex □ Milk □ Oak □ Penicillins □ Salicylate (aspirin) □ Shellfish □ Sulfa □ Other: _____

Previous Procedures or Surgeries

□ **No Surgical History**	□ Cesarean section	□ Hip surgery	□ Lower extremity bypass
□ Amputation	□ Coronary bypass	□ Hysterectomy	□ Neuroma
□ Angioplasty/stent	□ Cosmetic surgery	□ Ingrown toenail	□ Pacemaker
□ Appendectomy	□ Gallblader surgery	□ Kidney transplant	□ Steroid injection
□ Blood transfusion	□ Gastric banding	□ Knee surgery	□ Tonsilectomy
□ Bunion	□ Hammer toe surgery	□ Liver transplant	□ _____

Past Medical History

□ **No Known Problems**	□ Cancer	□ GI, stomach ulcer	□ Kidney disease	□ RSD/CRPS reflex
□ Anxiety	□ DVT, blood clot	□ Gout	□ Liver disease	□ Seizure disorders
□ Arthritis	□ Dementia	□ HIV	□ MI, myocardial	□ Stroke
□ Asthma	□ Depression	□ Hepatitis	□ MRSA infection	□ Swelling of legs/feet
□ CAD, coronary artery	□ Diabetes	□ High cholesterol	□ Neuropathy	□ TB, tuberculosis
□ CHF, heart failure	□ Fibromyalgia	□ Hypertension	□ Osteoporosis	□ Thyroid disorders
□ COPD, lung disease	□ GERD, acid reflux	□ Injury of legs/feet	□ Pain of legs/feet	□ _____

Family History

□ Adopted	Alive	Deceased	Arthritis	Cancer	Cholesterol High	Dementia	Depression	Diabetes	Hypertension
□ Father	□	□	□	□	□	□	□	□	□
□ Mother	□	□	□	□	□	□	□	□	□
□ Daughter	□	□	□	□	□	□	□	□	□
□ Son	□	□	□	□	□	□	□	□	□
□ _____	□	□	□	□	□	□	□	□	□

Social History

Smoking History: □ **Never smoked**

Tobacco: □ Cigarettes □ Cigars □ Pipe □ Chew □ Dip

□ Current everyday smoker □ Current some day/social smoker

□ Former smoker □ Smoker: status unknown □ Unknown if ever

□ Heavy smoker (≥10 cig/day) □ Light smoker (≤10 cig/day)

Alcohol History: □ **No history of use**

□ Beer □ Wine □ Hard liquor □ Social □ Occasional

□ Heavy (7≥drinks/week) □ Light (≤7 drinks/week)

Recreational Drug History: □ **No history of use**

□ Have used □ Currently use □ Been treated for substance abuse

Education: □ Grade School □ High School □ College

Occupation: _____

Job requires: □ Climbing stairs □ Lifting+10 lbs □ Sitting
□ Standing □ Traveling □ Walking □ **Not employed**

Lives with: □ Children □ Friend(s) □ Grandparent(s)
□ Parent(s) □ Partner □ Pet(s) □ Roommate □ Self
□ Sibling(s) □ Spouse Other: _____

Lives in a: □ Home with stairs □ Home without stairs
□ Hospice □ Skilled nursing facility

Activities: □ Aerobics □ Baseball □ Basketball
□ Bowling □ Cycling □ Dancing □ Football □ Hiking
□ Golf □ Gymnastics □ Running □ Soccer □ Swimming
□ Tennis □ Walking □Yoga Other: _____

Print Name of Patient or Legal Authorized Representative	Signature	Relationship to Patient	Date

Alliance Foot & Ankle Specialists

CURRENT MEDICAL HISTORY

Last Name: _____ Legal First Name: _____ MI: _____

DOB: _____ Age: _____ Gender: □ Male □ Female Weight: _____ Height: _____ Shoe Size: _____

□ PCP or □ Referring Physician: _____ Phone:_____ Date Last Seen: _____

Reason for Visit with Us: _____ Date Occurred: _____

Is your condition □ Work Related □ Automobile Accident □ Other Liability □ Not Related Work/Auto/Liability

Current Problem

Location: (where) □ Bilateral □ Bottom of □ In between □ Inside of □ Left □ Outside of □ Right □ Top of

Site: (what) □ Ankle □ Arch □ Ball of foot □ Calf □ Foot/feet □ Heel □ Hip □ Leg □ Toe(s) □ Other:_____

Quality: □ Aching □ Bruised □ Burning □ Cramping □ Deep □ Dull □ Improving □ Inflamed □ Itchy
□ Numb □ Pressure □ Sharp □ Swollen □ Tender □ Tight □ Tingling □ Other:_____

Pain scale: (Circle) 0 1 2 3 4 5 6 7 8 9 10 –worst
Severity: □ Mild □ Moderate □ Severe □ Unchanged

Duration: □ Today □ #_____Days □ #_____Week(s)
□ #_____Month(s) □ # _____ Year(s)

Timing: □ After exercise □ At night □ Constant
□ In AM □ Off and on □ Recurrent □ Other:_____

Cause/Context: □ Fell □ Foot type □ Increased activity
□ Injury □ Running □ Unknown □ Other:_____

Better with: □ Compression □ Elevation □ Heat □ Ice
□ Orthotics □ Shoes □ Medication □ Rest □ Other:_____

Worse with: □ Barefoot □ Increased activity □ In shoes
□ Pressure □ Running □ Walking □ Other:_____

Also have: □ Back pain □ Dementia □ Diabetes □ Fatigue □ Headaches □ Infection □ Muscle spasm
□ Numbness □ Osteoporosis □ Over weight □ Swelling □ OTC inserts □ Weakness □ Other: _____

Current Conditions—mark NONE for each condition that does not apply

Symptoms: □ **None** □ Chills □ Decline in health □ Fever
□ Night sweats □ Weight gain □ Weight loss

Eyes: □ **None** □ Blurry vision □ Cataracts
□ Eyeglass use □ Glaucoma □ Vision loss

Ears, Nose, Throat: □ **None** □ Dizziness □ Frequent sore throat
□ Hearing impairment □ Ringing in Ears □ Sinus Infection

Heart: □ **None** □ Chest pain □ Extremity(s) cold
□ Heart murmur □ Swelling in legs □ Ulcers on legs

Respiratory: □ **None** □ Asthma □ Cough □ Short of breath
□ Sleep apnea □ Snoring □ Wheezing

Intestinal: □ **None** □ Abdominal pain □ Constipation
□ Diarrhea □ Heartburn □ Nausea □ Vomiting

Urinary, Reproductive: □ **None** □ Blood Urine □ Pregnant
□ Urinary incontinence □ Sexually transmitted disease

Musculoskeletal: □ **None** □ Artificial joints □ Gout
□ Joint pain □ Muscle cramps □ Soft tissue pain □ Weakness

Skin: □ **None** □ Eczema □ Ingrown nail □ Lesion □ Nonhealing wound □ Nail appearance change □ Rash □ Ulcer □ Wart

Neurological: □ **None** □ Memory loss □ Migraines
□ Numbness □ Paralysis □ Seizures □ Strokes

Psychiatric: □ **None** □ Anxiety □ Claustrophobia
□ Depression □ Excessive stress □ Mood swings

Endocrine: □ **None** □ Diabetes □ Excessive thirst
□ Excessive urination □ Thyroid trouble

Hematological: □ **None** □ Anemia □ Bleeding easily
□ Blood transfusions □ Easy bruising

Immunologic: □ **None** □ Allergies □ HIV
□ Recurrent Infections □ Seasonal allergies

Pharmacy and Current Medications—mark CONSENT for RX history download

□ **Consent for medication history download from pharmacy (limited to certain plans)**

Pharmacy: _____

Street: _____

City/Zip: _____

Phone: _____

Medication	Dose	Frequency	Medication	Dose	Frequency

_____ _____ _____ _____

Print Name of Patient or Legal Authorized Representative | Signature | Relationship to Patient | Date

ALLIANCE™
Foot & Ankle Specialists

COVID-19 PATIENT SCREENING FORM

Our records indicate you have an upcoming appointment with our office

Due to the COVID-19 global pandemic, we ask that you complete this form prior to arriving at our office and return it to us via email at (gvfront@footdoc.org).

We will not be able to accommodate your appointment without having received this before you arrive for your appointment.

In order to safeguard our medical office and the rest of our community, we ask that you arrive at the office wearing a face mask. You will not be allowed entry without a face mask. If we have an adequate patient protective equipment (PPE) supply, we will provide you with a face mask for a charge of $1.00.

If you are experiencing any symptoms related to COVID-19, we ask that you do not come to our office at this time. Symptoms are indicated below:

Cough, shortness of breath, or difficulty breathing

Or any two of the following:
Fever
Chills
Repeated shaking with chills
Muscle pain
Headache
Sore throat
New loss of taste or smell

This list is not all inclusive.

Please consult your medical provider if you have any other severe symptoms that concern you.

If you develop any of the following symptoms (warning signs) for COVID-19, seek emergency medical attention immediately:

Trouble breathing
Persistent pain or pressure in the chest
New confusion or inability to arouse
Bluish lips or face

If you are unable to complete this form and email it, please copy and paste the questionnaire into a composed email and send it to the email address above.

ALLIANCE™
Foot & Ankle Specialists

PATIENT QUESTIONNAIRE

1. Have you traveled anywhere recently that are locations of disease outbreak?

2. Have you been in contact with anyone who was sick?

3. Have you attended any large group functions?

4. Have you had any of the following symptoms within the last two weeks: fever, fatigue, dry cough, altered taste, altered smell, trouble breathing, productive cough (mucous in cough), or muscle pain?

5. Have you previously had the SARS-COV-2 virus (novel coronavirus)? If so, did you test positive and what test were you administered?

6. Are you over the age of 65 and/or have preexisting health conditions related to the following: diabetes, chronic lung disease or asthma, serious heart condition, immunocompromised, or chronic kidney or liver disease?

We thank you for your cooperation and will contact you if we need further information.

Thank you,

Dr. Richard Nichols, Dr. Joseph Harvey

MODERN VASCULAR®

Peripheral Artery Disease (PAD)

Referral Form	STAT / Urgent / Non-Urgent

Patient Name: _____ DOB: _____

Home Number: _____ Cell Phone: _____

Languages Spoken: _____ Caretaker/Relative Name (If applicable): _____

PAD Risk Evaluation	Score
Have Diabetes?	7
Have any wounds or ulcers on foot or lower leg?	6
Over 65 years?	6
Over 50 years?	4
EVER smoked?	5
Ever had Lower Extremity Revascularization?	5
Have history of Hypertension?	4
Ever feel resting leg pain or foot pain?	4
Is one foot ever colder than the other?	4
Have Neuropathy?	4
Have High Cholesterol?	3
Ever had a Heart Attack or Stent?	3
Total Added Score:	

If Patient Scores Above 10, refer for Vascular Evaluation

❑ Patient may be at risk for PAD & should receive a peripheral vascular evaluation.

Additional Clinical History and Symptoms (Check all that apply)

- ❑ Coronary Artery Disease
- ❑ Stroke
- ❑ Cold feet
- ❑ Pain in foot or leg at night which is relieved by sitting at side of bed or walking
- ❑ Pain when walking which is relieved on rest
- ❑ Absent Foot Pulse

Diagnosis (Check all that apply)

	RT Leg	LT Leg	Bilateral
Claudication	❑ I70.211	❑ I70.212	❑ I70.213
Rest Pain	❑ I70.221	❑ I70.222	❑ I70.223
Ulcer	❑ I70.23	❑ I70.24	
Gangrene	❑ I70.261	❑ I70.262	❑ I70.263

Please Include

- ❑ ID
- ❑ Insurance
- ❑ Demographics
- ❑ Last Office Note
- ❑ Referral (This form)

Services Requested

- ❑ **Peripheral Vascular Evaluation**
- ❑ Arterial Duplex Evaluation of Extremities
  - ❑ L ❑ R ❑ B
- ❑ **Possible CLI**
- ❑ Surgical Clearance
- ❑ ABI/TBI

This is a referral for a consultation and examination. Should the requested study demonstrate any positive findings, this shall serve as my written referral to the interventional physician for further evaluation and patient care, including any necessary additional tests or procedures.

Provider Signature: _____ Date: _____

Print Name: _____

Modern Vascular

Fort Worth, TX

Fax: (817) 989-6555

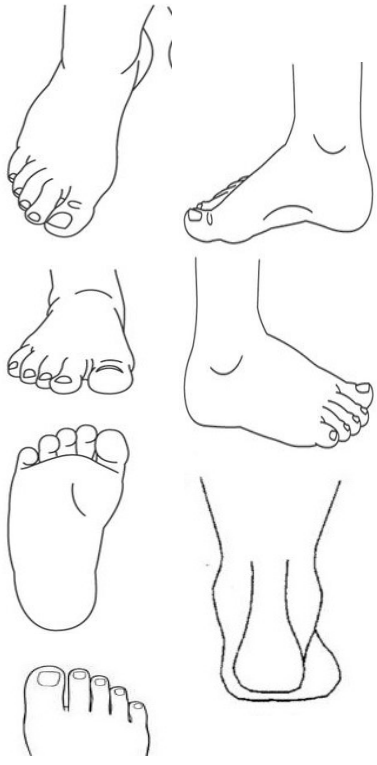
NEW PATIENT EVALUATION SHEET

Patient: _____ D.O.B.: _____ D. O.S: _____

CHIEF COMPLAINT:_____

1. **Approximately when did it start?_____**
2. **Did it begin gradually ( ), or Suddenly ( ), or Injury ( )**
3. **How long have you had the pain?_____**
4. **What is the injury date?_____**
5. **Did anything cause or contribute to the problem?_____**
   _____
6. **Have you ever had anything like this before? Yes ( ), No ( )**
7. **If so, was the problem resolved? _____**
8. **Does it radiate to any other part of the body? _____**
9. **Do you have symptoms in any other part of the body? Yes ( ), No ( )**
10. **Can you describe the sensation? Dull ( ), Sharp ( ), Burning ( ), Aching ( ), Gnawing ( ), Throbbing ( ), Shooting ( ), Constricting ( ), Fatigue ( ) Other ( ) _____**
11. **On a scale of 1 to 10 (1 is lowest, 10 is highest) what would you say your pain level is today? ___**
12. **Is the pain consistent ( ), Inconsistent( )**
13. **Is the pain getting better ( ), worse ( ), staying the same ( )**
14. **Have you found anything that makes the pain better?**
    (Such as rest, elevation, ice, over the counter products,medications)
    _____
    _____
15. **Have you previously sought professional care for this condition?___**
    _____
    _____
16. **What treatment did you receive?**
    _____
    _____
17. **Any other information we need to know about**
    _____
    _____

RIGHT



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