CENTER FOR FOOT DISORDERS

WILLIAM CAPECE, DPM

Patient Demographic Information

Name: ____

Date of Birth: ____ Sex: Male / Female

Race: ______________________________ Social Security Number: ______-______-________

Address: ____

City: _______________________________ State: _________________ Zip: ___________

Marital Status: Single / Married / Widowed / Divorced / Child

Employment Status: Employed / Unemployed / Retired / Student / Other

How did you hear about us? ____

Patient Contact Information

Preferred Phone Number: ______-______-________ Circle one: Home Cell Work

Alternate Phone Number: ______-______-________ Circle one: Home Cell Work

Email Address*: ____

**By providing your email address, you consent to receive necessary reminders or messages.*

Emergency Contact Information (Required if patient is 18 years old or younger)

Emergency Contact Name: ____

Emergency Phone: ______-______-________ Relation: _________________________

Associations (Required for ALL Medicare Patients)

Primary Care Physician: ___________________________ Phone: ______-______-________

NO SHOW POLICY

We understand that there are times when you must miss an appointment due to emergencies or obligations with work or family. However, when you do not call to cancel an appointment, you may prevent another patient from receiving much needed treatment. This same situation may arise where another patient fails to cancel and we are unable to schedule you for an appointment, due to a seemingly “full” appointment schedule.

If an appointment is not cancelled in advance, you will be charged a $25 fee; this will not be covered by your insurance company.

We will require that patients pay these balances prior to receiving any further services.

I authorize Center For Foot Disorders and/or staff to leave appointment reminders at:

Home Phone: Yes / No Cell Phone: Yes / No Work Phone: Yes / No

Signature: ____ Date: ___________________

Patient Name: ____ Date: _______________

Explain your foot/ankle problem □ Right □ Left _______________________________________

____

Describe the pain/discomfort □ Burning □ Numbness □ Sharp □ Other _____________________

____

When did the pain/discomfort begin? ____

What makes the pain/discomfort better? ____

What makes the pain/discomfort worse? ____

Any prior treatment to this problem? ____

Is the problem becoming progressively worse? ____

Please circle the level of pain you are experiencing:

0 1 2 3 4 5 6 7 8 9 10

No Pain Severe Pain

List all drug, food, and environmental allergies □ NONE

□ Penicillin	□ Aspirin	□ Anesthesia	□ Narcotic Agent/Codeine
□ Sulfa Drugs	□ Nickel/Metal	□ Radiographic Contrast Dye	
□ Shellfish	□ Peanuts	□ Other: _________________________________	

List all medications, including over the counter and supplements □ NONE

____

____

____

Pharmacy Name: ______________________________ **Phone**: ______-______-________

Is your concern work related? Yes / No

If yes, what is your occupation? ____

Is your concern a result of an injury? Yes / No

If yes, please describe ____

____

Patient Name: ____ Date: _______________

Please check all that apply, past or current. Please describe, include any family history.

□ AFIB ____________________________
□ AIDS ____________________________
□ Acne ____________________________
□ Anemia __________________________
□ Anxiety __________________________
□ Asthma __________________________
□ Back Problems ____________________
□ Blood Clots _______________________
□ Cancer ___________________________
□ Crohn's Disease ___________________
□ Diabetes Type 1 ___________________
□ Diabetes Type 2 ___________________
□ Dementia _________________________
□ Depression ________________________
□ Eczema ___________________________
□ Epilepsy __________________________
□ GERD ____________________________
□ Gout _____________________________
□ Graves Disease ____________________
□ HIV ______________________________
□ Heart Attack ______________________
□ Heart Disease _____________________
□ Heart Failure ______________________
□ Hepatitis __________________________
□ High Blood Pressure ________________
□ High Cholesterol ___________________
□ Hyperthyroidism ____________________
□ Hypothyroidism _____________________
□ Kidney Disease _____________________
□ Kidney Stones ______________________
□ Liver Disease _______________________
□ Lupus ____________________________
□ Mitral Valve Prolapse ________________
□ Neuropathy _________________________
□ Osteoarthritis ______________________
□ Osteopenia _________________________
□ Osteoporosis _______________________
□ PAD ______________________________
□ Psoriasis __________________________
□ Pulmonary Disease __________________
□ Rheumatic Fever ____________________
□ Rheumatoid Arthritis ________________
□ STD ______________________________
□ Stroke ____________________________
□ Tuberculosis _______________________
□ Ulcer (GI) _________________________
□ Ulcerative Colitis ___________________
□ Varicose Veins ______________________
□ Other: ____________________________
____
____
____

Surgical History: Have you had surgery? Yes / No If yes, please describe below

____

____

Social History: Do you have a current or past history of…

Tobacco Use: Yes / No Alcohol Use: Yes / No Caffeine Use: Yes / No Drug Use: Yes / No

Height: ____________ **Weight:** ____________ **Shoe Size:** ____________

Are you pregnant? Yes / No

If yes, how many weeks? ____________________

Patient Name: ____ Date: _______________

Are you diabetic? Yes / No

If yes, how long have you been diabetic? ___________________________________

What is your most recent A1C? ____________________________________

What is your most recent glucose? _____________________________________

Doctor you currently see for diabetes management

Name: ________________________ Phone: ______-______-________

Are you currently seeing any other physicians? Yes / No

If yes, please list…

Name: _____________________________ Phone: ______-______-________

Specialty _____________________

Name: _____________________________ Phone: ______-______-________

Specialty _____________________

Name: _____________________________ Phone: ______-______-________

Specialty ____________________

Please circle if you are experiencing any of the following…
If you are NOT experiencing any of the following, please initial here ___________

Chills Fever Weight Gain Weight Loss Dizziness Fainting Headaches Visual Changes

Nosebleeds Hearing Loss Cough Wheezing Short of Breath History of Blood Clots

Chest Pain Heart Palpitations/Arrhythmia Leg/Foot Cramping Leg/Foot Swelling

Bloody Stool Diarrhea History of Stomach Ulcers Nausea Joint Pain Joint Swelling

Muscle Pain Anxiety Depression Nervousness History of Bipolar Numbness

Tingling Increased Thirst Bleed Easily Prolonged Wound Healing Recurring Infections

Frequency when using the restroom

CONSENT FOR MEDICAL TREATMENT

I do hereby voluntarily consent to procedures and care under the specific instructions of William Capece DPM. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of treatment or examination by William Capece DPM. I acknowledge that x-ray films and/or ultrasounds may be taken for my condition at the time of my visit and will be reviewed by William Capece DPM.

All medical information provided today is correct to the best of my knowledge. I consent for medical treatment as stated above.

Signature: ____ Date: ___________________

HIPAA AGREEMENT

AUTHORIZATION TO RELEASE INFORMATION

I authorize to furnish any consulting physician, hospital, physical therapy facility, MRI facility and/or medical supplies facility, any information or copies of all medical records, consultations and prescriptions relating to my illness or injury. I authorize William Capece and/or staff to furnish medical records relating to my illness or injury to the contracted billing company to file appropriate medical information to my insurance company for reimbursement. A copy of this authorization shall be in effect and valid until rescinded in writing.

MEDICAL TRAINING

At times, we may have interns, residents, fellows, or medical/chiropractic students rotating through our office. These students follow the same rules of confidentiality and professionalism, as do all of our medical professionals. You are free to decline having a student or trainee in your office consultation by informing your nurse or physician.

CONSENT FOR RELEASE OF MEDICAL INFORMATION TO FAMILY/FRIEND

I authorize William Capece and staff to release information to the following:

Name: ____ Relationship: ____________________

Contact Number: ______-______-________

Name: ____ Relationship: ____________________

Contact Number: ______-______-________

Name: ____ Relationship: ____________________

Contact Number: ______-______-________

CONSENT TO LEAVE MESSAGES

Permission to leave messages via:

Text Message: Yes / No E-Mail: Yes / No
Home Phone: Yes / No Cell Phone: Yes / No Work Phone: Yes / No

ACKNOWLEDGMENT RECEIPT OF PRIVACY PRACTICES

I acknowledge that a copy of the Notice of Privacy Practices can be furnished upon request and that I have read (or had the opportunity to read) and understood the Notice.

Signature: ____ Date: ____________________

Patient Name: ____

PAYMENT POLICY AGREEMENT

INSURANCE COVERED ACCOUNT

Charges for services that are covered by your insurance carrier contracted with us will be filed and due in full within 45 days from the date the claim was filed per the Texas Clean Claim Law. If this fails to occur, you will be notified to assist in recovering payment from your insurance carrier.

INSURANCE FAILURE TO PAY

Failure of the insurance carrier to pay us for charges on behalf of the insured within 90 days of billing a clean claim will result in the insured assuming responsibility for the entire bill as a non-insured account. We write off billed charges discounted by contracted insurances. Any billed charges deemed non-covered are the responsibility of the insured.

PAYMENTS ARE DUE AT THE TIME OF SERVICE

All non-insured patients are expected to pay for services at the time of the visit unless prior arrangements have been made. All insured patient are asked to pay any copayment, deductible, coinsurance, or non-covered services at the time of service. Most insurance companies require patients to pay a deductible and/or coinsurance of the covered charges. Any remaining balances after the claim has been processed in full will be the patient's responsibility.

PATIENT'S RESPONSIBILITY

You are responsible for payment of your account regardless of the status of your insurance claim. In the rare instances that an account is left unpaid according to the above policy and after proper notification, will be turned over to our collection agency.

AUTHORIZATION OF INSURANCE BENEFIT PAYMENT

I authorize direct payment of medical benefits through my insurance carrier for services rendered. I understand that I will be billed and held responsible for any balances insurance does not pay. I understand that office deductibles, percentages and/or copays are due at the time of my office visit. I understand that if my condition requires surgical intervention, my insurance company will be contacted for eligibility and pre-certification. If my insurance company advises a representative for William Capece that I will be responsible for a percentage of the fee, I understand that I will be asked to pay this portion prior to my surgery.

I have review this policy entirely, and agree to its terms and conditions of treatment. A copy of this payment policy can be furnished upon request.

Signature: ____ Date: ____________________

Patient Name: ____

MEDICARE SIGNATURE ON FILE (IF APPLICABLE)

I understand that my signature request that payment be made and authorized release of medical information necessary to pay the claim submitted to Medicare. The provider agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for only the deductible, coinsurance and non-covered Medicare services. Coinsurance and the deductible are based upon the charge determination of Medicare. This authorization shall be in effect and valid until rescinded in writing.

Signature: ____ Date: ____________________

Patient Name: ____