Greater Houston Foot Centers - New Patient Form

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Birth Date: ____/____/____

Home # (____) _____ Cell # (____) _____ Work # (____) _____

Emergency Contact: _____ Phone: (____) _____ Relationship: _____

E-Mail: _____ Social Security Number: _____

Family Physician: _____ Phone Number: (____) _____

Last visit date: _____ Fax Number: (____) _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Employer: _____ Employer Address: _____

__FULL TIME__PART TIME __NOT EMPLOYED __SELF-EMPOYED__RETIRED __ACTIVE MILITARY DUTY __STUDENT

Pharmacy: _____ Pharmacy Phone Number: (____) _____

HOW DID YOU HEAR ABOUT US: **Doctor Referral** ☐ **Insurance** ☐ **Friend/Family** ☐ **Internet/Google** ☐

Referred by: _____ Other: _____

RELEASE OF PERSONAL INFORMATION TO THE PATIENT'S DESIGNEES

I authorized medical staff members of this practice to discuss my medical history, diagnosis, treatment and prognosis with other medical providers and organizations that participate in care and with those listed below.

Name Phone Number Relationship

_____

_____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits and services rendered, without obtaining my signature on each and every claim to be submitted for myself and/or my dependents. I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____, hereby authorize _____ to pay and hereby assign directly to Greater Houston Foot Centers all benefits. I further acknowledge that any insurance benefits, when received by and paid to Greater Houston Foot Centers will be credited to my account in accordance with the above said assignment.

Agreed & Authorized: _____ **Date**: _____

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What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.) _____

_____

Have you ever been to a Podiatrist before
☐Yes ☐No

If yes, please list

Name _____

Last visit _____

Is there any personal or family history of diabetes?
☐Yes ☐No

Your occupation _____

Cigarette/Tobacco use _____

Years smoked _____

Please indicate which foot problems you now have or have had in the past.

Ankle Pain	☐Yes	☐No
Athlete's Foot	☐Yes	☐No
Bunions	☐Yes	☐No
Corns and Calluses	☐Yes	☐No
Cramps or Numbness in Feet or Legs	☐Yes	☐No
Flat Feet	☐Yes	☐No
Foot or Leg Cramps	☐Yes	☐No
Heel Pain	☐Yes	☐No
Ingrown Toenails	☐Yes	☐No
Plantar Warts	☐Yes	☐No
Swelling in Ankles or Feet	☐Yes	☐No
Tired Feet	☐Yes	☐No

Athletic activities in which you participate (please list and indicate frequency) _____

_____

MEDICAL HISTORY:

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐Yes	☐No	Dialysis	☐Yes	☐No	Low Blood Pressure	☐Yes	☐No			
Allergies to Anesthetics	☐Yes	☐No	Ear Problems	☐Yes	☐No	NeuropathyPhlebitis	☐Yes	☐No			
Allergies to Medicine or Drugs	☐Yes	☐No	Epilepsy	☐Yes	☐No	Psychiatric Care Radiation	☐Yes	☐No			
Anemia	☐Yes	☐No	Eye Problems	☐Yes	☐No	Treatment	☐Yes	☐No			
Angina	☐Yes	☐No	Fainting	☐Yes	☐No	Rash	☐Yes	☐No			
Arthritis	☐Yes	☐No	Foot or Leg Cramps	☐Yes	☐No	Respiratory Disease Rheumatic	☐Yes	☐No			
Artificial Heart Valves or Joints	☐Yes	☐No	Gout	☐Yes	☐No	Fever Shortness of Breath	☐Yes	☐No			
Asthma	☐Yes	☐No	Headaches	☐Yes	☐No	Sinus Problems	☐Yes	☐No			
Back Problems	☐Yes	☐No	Heart Disease	☐Yes	☐No	Special Diet	☐Yes	☐No			
Bleeding Disorders	☐Yes	☐No	Hemophilia	☐Yes	☐No	Stroke	☐Yes	☐No			
Cancer	☐Yes	☐No	Hepatitis or Jaundice	☐Yes	☐No	Swelling in Ankles, Feet	☐Yes	☐No			
Chemical Dependency	☐Yes	☐No	High Blood Pressure	☐Yes	☐No	Swollen Neck Glands Tired Feet	☐Yes	☐No			
Chest Pain	☐Yes	☐No	High Cholesterol	☐Yes	☐No	Tuberculosis	☐Yes	☐No			
Chronic Diarrhea	☐Yes	☐No	Hyperthyroidism	☐Yes	☐No	Ulcers	☐Yes	☐No			
Circulatory Problems	☐Yes	☐No	Hypothyroidism	☐Yes	☐No	Varicose Veins Venereal	☐Yes	☐No			
Cirrhosis	☐Yes	☐No	Kidney Problems	☐Yes	☐No	Disease Weight Loss, unexplained	☐Yes	☐No			
Diabetes	☐Yes	☐No	Liver Disease	☐Yes	☐No						

Surgeries you have had _____

_____

Hospitalization other than for the surgeries listed _____

_____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? ☐Yes ☐No

If yes, please explain _____

_____

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Date of: Most Recent Medical Exam _____

Date of Hemoglobin- A1C (HGB-A1C) _____ Results _____

Blood Transfusions (dates): _____ General Anesthesia: _____

Injuries and Fractures (types & dates): _____

FAMILY HISTORY (check if anyone in your family has had or had the following)

	MOTHER	FATHER	SILBINGS	CHILDREN	OTHER RELATIVE
CANCER					
DIABETES					
HEART DISEASE					
ARTHRITIS					
OSTEOPOROSIS					
AGE (IF LIVING)					

ALLERGIES

☐ Adhesive/Tape ☐ Codeine ☐ Other _____ ☐ Penicillin
☐ Anticoagulant Therapy ☐ Demerol ☐ Local Anesthetics ☐ Seafoods
☐ Aspirin ☐ Iodine ☐ Novocaine ☐ Sulfa

SOCIAL HISTORY

Do or Did you smoke cigarettes? ☐Yes ☐No If Yes, packs per day?_____Stop date: _____
Drink alcohol regularly? ☐Yes ☐No Do you exercise regularly? ☐Yes ☐No
Allergies to any medication? ☐Yes ☐No If Yes, which medications? _____
Place of Birth? _____ Unusual Occupational Exposures? _____

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

GREATER HOUSTON FOOT CENTERS
ABEER M FOTEH DPM, PA
FINANCIAL AGREEMENT

Thank you for choosing our practice. First and foremost we are committed to the success of your medical treatment and plan of care. Please understand that payment of your bill is part of this treatment and care.

1. **OFFICE VISITS & OFFICE SERVICES**: Patient's health insurance plans state that payments including co-pay's and deductibles are to be collected at the time of service. Our staff will review any deductibles and out of pocket expenses you are responsible for as outlined by your insurance plan, and will be collected at the time of service. We try our best to make the portion you are responsible to pay as exact as possible. However, please keep in mind the calculated amount is an estimated cost. Unfortunately there is always the possibility that after your insurance pays its portion, we may owe you a refund or you may still have a balance which will be due promptly. Patients seen at the wound care clinic are still responsible for paying their co-pay, you may call our office and pay via phone. Please be aware that not all services are covered with different insurance plans. You are responsible for knowing what services are or are not covered. **YOU ARE RESPONSIBLE TO KNOW YOU'R BENEFITS**.
2. **REFERRAL**: You are responsible for knowing, if a referral is required. If you have an HMO plan you are responsible to have your Primary Care Physician send a referral to our office.
3. **SURGERY**: Our office will complete any pre-certification or authorization if required by your insurance company. A member of our staff will review any deductibles and out of pocket expenses you will be responsible for as outlined by your insurance plan. We do require 100% of the cost to be paid prior to the procedure being performed; this amount will depend on your policy. Please note that the physician charges are separate from the facility therefore you still have to pay us. The amount you pay will be posted to your account as a pre-surgical deposit. We try our best to make the portion you are responsible to pay as exact as possible. However, please keep in mind the calculated amount is an estimates cost. Unfortunately, there is always the possibility that after your insurance pays its portion we may owe you a refund or you may still have a balance due.
4. **CANCELATIONS**: twenty-four (24) hour notice is required for all patients cancelling or rescheduling office visits, office procedures require forty-eight (48) hours. If our office does not receive notifications there will be a charge of;
    i. $30 -NO SHOW
    ii. $25- CANCELATION
    iii. $50- CANCELATION/ NO SHOW FOR PROCEDURES ONLY
    Remember, this charge is ***not billable*** to your insurance company; this is your full responsibility
5. **BILLING**: Your insurance policy is a contract between you, and the insurance company. We are NOT a party to that contract. **If you do not inform our office of any changes on your insurance coverage or company changes, you will be responsible for the full amount**. If there is an issue with your insurance and we cannot resolve it for you, we will give you a notification. It is your responsibility to resolve the issue with your insurance company within 10 days. We will help the best we can but ultimately you will be responsible for any unpaid charges.
6. **PAYMENTS:** We accept payment by Cash, Visa, MasterCard, Discover, American Express or Check. **Please be aware that there will be a charge of $30 for any check returned.** If you are in need of a payment plan please notify our staff and we will set up a contract. If the contract is not upheld, further legal action will be taken. Any unpaid services over 90- days old will be given to outside collection agency with additional collection fees. **You are responsible for any collection fees, legal fees, or courts cost incurred in the collection process and will be added to your balance**. This agency will report your failure to pay to the THREE (3) national credit reporting agencies.

ACKNOWLEDGEMENT: I have read, understand and agree to the terms listed above

- "In the event that outside collection and/or legal costs are incurred by this office to obtain payment due, I will be liable for any costs incurred, as I am responsible for any collection fee, legal fee and/or courts cost."
- "I authorize my insurance benefits be paid directly to Abeer M Foteh D.P.M/ GREATER HOUSTON FOOT CENTERS"
- "I authorize Abeer M Foteh D.P.M/ GREATER HOUSTON FOOT CENTERS to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim"

SIGNATURE OF PATIENT OR GUARDIAN DATE

PRINT NAME OF PATIENT DOB DATE

Medication List

Patients Name:_____ DOB:_____

Pharmacy Name:_____Pharmacy #:_____

MEDICATION	MG	DOSAGE	DOCTOR	REASON

DATE:_____

Abeer M Foteh D.P.M

Greater Houston Foot Centers

DME/Orthotics/shoes/etc. Financial agreement

Our policy is to assist each patient in receiving the maximum benefit possible from his or her particular insurance plan and to secure full payment at the time of the delivery if you have a financial responsibility.

Each person's insurance policy defines the terms of coverage for Durable Medical Equipment (DME), Diabetic Shoes, Prosthetics and/or Custom Orthotics. Your policy defines the deductibles, coinsurance, out of pocket costs, medical necessity, and/or if authorization is required. We recommend that you become familiar with your individual policy terms and limitations. Our office will gladly inquire information from your insurance company and help you understand your coverage and responsibility. Please be aware that it will not be a **guarantee of coverage**, final coverage will be known once the explanation of benefits have been received from your insurance.

I agree to the following terms

- For custom items, half of the financial responsibility is required before production of your item will begin and, the second half when items are picked up.
- If I order Custom Orthotics and decide not to get them for any reason there is a $85 casting fee that is non-refundable
- Dispensed office products purchased in the office are **non refundable**
- I consent to the prescribed treatment and am ultimately responsible for the balance of my account for any professional services rendered and prosthetic/ orthotic products provided regardless of my insurance status.
- All information and documentation provided to **Greater Houston Foot Centers** is true and accurate to the best of my knowledge.
- In the event that legal action is required by **Greater Houston Foot Centers** to enforce my obligation for the charges, I will be responsible for all the reasonable attorney fees, court costs and other collection expenses associated with enforcement of the charges incurred.

SIGNATURE OF PATIENT OR GUARDIAN DATE

PRINT NAME OF PATIENT DOB DATE

GREATER HOUSTON FOOT CENTERS

DR. ABEER M. FOTEH, D.P.M.
1666 W. BAKER RD SUITE C
BAYTOWN, TX 77521
PHONE: 281-837-8371--- FAX 281-837-8374

PATIENT CONSENT FOR USE AND DISCLOURSE OF PROTECTICED HEALTH INFORMATION

I hereby give my consent for Dr. Abeer Foteh to use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and Health Care Operation (TPO). (Dr. Abeer Foteh Noticed of Privacy Practices provides a more complete description of such uses and disclosures).

I have the right to review the Notice of Privacy Practice prior to sighing this consent, Dr. Abeer Foteh reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Abeer Foteh' s office at 1666 W. Baker Rd Baytown, TX 77521.

With this consent, Dr. Abeer Foteh may call my home or other alternative locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance issues and any calls pertaining to my clinical care including laboratory results among others.

With this consent, Dr. Foteh may mail to my home address or other alternative locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements, as long as they are marked Personal and Confidential.

With this consent, Dr. Abeer Foteh e-mail to may home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements, I have the right to request that Dr. Abeer Foteh restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is not bound by this agreement.

By signing this form, I am consenting to DR. ABEER FOTEH use and disclosure of my PHI to care out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this disclosure in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Dr. Abeer Foteh may decline to provide treatment to me.

_____

Signature of Patient and /or Legal Guardian

_____ _____

Print Patient Name Date