

North TX Foot & Ankle

Ronica N. Holcombe, DPM Mitchell N. Williams, DPM

1145 Kinwest Pkwy Ste 100
Irving, TX 75063
Phone 214-574-9255
Fax 214-574-9258

Welcome to North Texas Foot and Ankle!

Attached is our Patient Registration Package. Please complete these forms to help us maintain accurate contact and medical records. If you printed these forms from our website, you may fax them to us at 214-574-9258 prior to your appointment, or bring the completed original forms with you to your appointment along with the other items requested below.

We realize that you have a choice of where to be treated. We also understand and respect the great deal of trust in your physician. We want to provide you with the most up to date information and treatment options regarding your skin care health. We do appreciate and value the trust you have placed in us.

North Texas Foot and Ankle specializes in treatment of all foot and ankle disorders. Our team of board-certified doctors and trained office staff work together to meet your podiatric needs five days a week. We desire to assist you in receiving the best of what today's medicine has to offer. We are highly committed to quality patient care with an emphasis on individual attention for each patient. Providing the best service, in a comfortable, private atmosphere is extremely important to us. We assure you, we will do our best to give you total satisfaction.

We value highly the relationship with our patients. We especially value patient feedback. Therefore, we will ask you to communicate to us your experiences at our practice. Your feedback matters because it helps us continue to serve you and our other patients with the highest level of care possible. If you have any questions or concerns, please do not hesitate to ask any member of our team.

Warmest Regards,

Ronica Holcombe, DPM
Mitchell Williams, DPM
and Staff!

REMINDERS OF REQUIRED ITEMS **FOR YOUR VISIT**

- **Insurance Cards** If you have health insurance, we cannot see you without making a copy of your insurance card.
- **Written Referral** from your Primary Care Physician if required by your insurance plan.
- **Co-pay or Deductible** is collected at the time of visit
- **Cosmetic procedure fees** are due at time of visit
- **Completed Patient Registration Package**
- **Driver's License or State Issued Photo ID**

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Patients, or legal guardians of patients under the age of eighteen, MUST sign and date below before medical care can be rendered.

Release of Medical Information

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications, and prescriptions electronically to your pharmacy.

Signature: _____ Date: ____/____/____

Financial Policy

Payment is required for all services at the time they are rendered unless the patient is in an insurance plan with which we participate. For those patients, applicable co-payments and deductibles will be collected for services rendered. Once our office has received payment from your insurance, if for some reason insurance decides to pay your charges at a higher benefit level than what was quoted to our office at the time of service; we will then issue the patient a refund for the over payment amount or apply a credit on the account. **In an effort to ensure the most accurate refund amount please be advised that our office cannot issue any refunds until all line items have been finalized by your insurance.**

We accept payment in the form of cash, check, and all major credit cards.

Missed Appointments

For appointments which are missed or cancelled with less than 24 hour notification, there may be a \$25.00 missed appointment fee added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Returned Checks

All NSF checks will be charged a \$25.00 processing fee. We will only accept cash or money orders to replace an NSF check. Your signature below signifies your understanding and willingness to comply with this policy.

Additional Fees:

Xrays are property of North TX Foot and Ankle. If you wish to receive copies of digital XRAYs there will be a fee assessed of \$10.00.

Disability forms that need to be completed by our staff will incur a \$15.00 fee.

For copies of Medicals our office requires 10 days notice. There is a fee of \$20.00 for up to 25 pages and \$35.00 dollars any pages after that.

I have read and understand the financial policy statement. I agree to make in-full prompt payment to North TX Foot and Ankle when billed for any and all charges not covered or paid by valid insurance benefits for and in consideration of services rendered. Further, I authorize payment directly to North TX Foot and Ankle for medical insurance benefits payable to me under the terms of my policy but not to exceed the balance due for services performed for my treatments.

In addition to the above, if I am a Medicare patient, I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or

carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature: _____ Date: ____/____/____

Privacy Practices (HIPAA)

By signing below, I authorize North TX Foot and Ankle, and whoever may be employed or assistant in administration to administer care as is deemed necessary.

Signature: _____ Date: ____/____/____

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How did you find us?

Family/Friend - Name: _____

Insurance Provider List

Internet Search

Newspaper Ad

Physician - Name: _____

Yellow Pages

Other _____

PATIENT INFORMATION

Last Name: _____

First Name: _____ MI: _____

Previous Name: _____
(Maiden name, former married name, etc.)

Home Address: _____
(No PO boxes)

City: _____

State: _____ Zip Code: _____

Number for appointment reminders and test results: (_____) _____

May we leave a message at this number? Yes No

Secondary Phone: (_____) _____ Work Phone: (_____) _____

Preferred Language: English Spanish French Italian

Date of Birth: _____ Male Female

Marital Status: Single Married Divorced Widowed
 Legally Separated Partner

Social Security Number: _____

Race: Native American African American Asian White
 Hispanic Pacific Islander Other Unreported/Refused

Ethnicity: Hispanic/Latino Not Hispanic/Latino Unreported/Refused

Primary Care Physician: _____
(First and Last Name)

Phone number: (_____) _____ City: _____

Did a doctor's office send you to us for a specific problem? Yes No

If YES, name of referring provider: _____

Responsible Party, if different from patient information above: (statements will be addressed to the responsible party)

Name: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Date of Birth: _____ Male Female

Phone: (_____) _____ Email: _____

Relationship to patient: _____

Adult Emergency Contact:

Name: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Phone: (_____) _____ Alt. Phone: (_____) _____

Relationship to patient: _____

INSURANCE INFORMATION: If the patient is not the primary policy holder, the Responsible Party section above must be completed.

Self Pay (no insurance)

Patient IS the policy holder

Patient IS NOT the policy holder

Primary Insurance Co.: _____ Policy Number _____

Secondary Insurance Co.: _____ Policy Number _____

Does your insurance plan require you to have a referral to see a specialist? No Yes I don't know

NOTE: It is the patient's responsibility to get any required referrals. Failure to do so may result in denied claims and the patient will be responsible for all services rendered.

SUBSCRIBER INFORMATION (REQUIRED if patient is not the primary insurance policy holder):

Name: _____

Social Security #: _____ Date of Birth: _____

Employer Name: _____

PHARMACY INFORMATION:

Name: _____

Location (City and Intersection): _____

Phone: (_____) _____

Patient or Responsible Party **Signature of Agreement** _____ Date _____

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Authorization to Leave a Voicemail

Please provide number(s) **ONLY IF** you approve us to leave **DETAILED** information related to appointments, billing, test results, diagnosis, and procedures on your voicemail.

Primary (_____) _____ Secondary (_____) _____

Authorization to Send an Email Message

Please provide an email address below **ONLY IF** you approve us to send **DETAILED** information regarding your appointment, billing, test results, diagnosis, and procedures in an email.

Email address: _____

Personal Representative Authorization for Medical Release Form

Under HIPAA requirements, we are not allowed to discuss any of your health information with anyone else without your consent.

I authorize this facility to speak to the following family members or my personal representative regarding

- All medical information, including but not limited to: appointments, billing, test results, diagnosis, and procedures.
- Only the following types of information: _____

The above medical information shall only be released to the following person(s):

1. _____ Relationship: _____ Phone number: _____
2. _____ Relationship: _____ Phone number: _____
3. _____ Relationship: _____ Phone number: _____

Authorization to Send a Text Message

Please provide a number **ONLY IF** you approve us to leave **DETAILED** information related to appointments, billing, test results, diagnosis, and procedures in a text message. (_____) _____

By signing below I understand and agree to all stated and filled in above; I also understand my rights are protected by the Privacy Act (HIPAA) and that I may request a copy of this Act at any time.

Name (**PRINTED**) _____

Signature _____

Date _____

Patient History

Date: _____

Patient Name: _____ Age: _____

Height: _____ Weight: _____ Shoe Size: _____ Width: _____ Occupation: _____

Type of Exercise: _____ Type of Sports: _____

My foot problem is: _____

Nature of foot problem: Sharp___ Dull___ Ache ___ Burning ___ Other _____

Location of pain: _____ Duration: _____

Reason for onset: _____

Pain Course: Comes/Goes___ Constant ___ Progressive ___ Worsening ___ Improved___

What makes the pain worse: _____

What types of treatments have you tried: _____

Was condition treated by a Doctor: Yes___ No ___ Doctor Name: _____

Any other foot problems: _____

Any foot surgeries: Yes___ No ___ When: _____ Where: _____

Diabetic: Yes___ No ___ Insulin Dependent Yes___ No ___ Diet control Yes___ No ___

Average sugar: _____ Date of last checkup: _____

Doctor seen for diabetes: _____ Office number: _____

Primary care Doctor: _____ Office number: _____

Social History

Do you use tobacco: Yes___ No ___ Amount _____ For_____ Years___ Months___

Do you drink alcohol: Yes___ No ___ Amount _____ For_____ Years___ Months___

Patient History

Check any known conditions you have, or had previously:

Anemia		Foot / Leg Cramps		Nervous Problems	
Arthritis		Foot / Leg Injuries		Polio	
Artificial Joints / Valves		Foot / Leg Numbness		Prone to Infection	
Asthma		Foot / Skin Problems		Rheumatic Fever	
Bleeding Disorder		Gout		Shortness of Breath	
Blood Disease		Hay Fever		Smoker	
Bunions		Hepatitis		Stomach Ulcer	
Bursitis		Heart Problem		Thyroid	
Cancer		High Blood Pressure		Toenail Problems	
Chemical Dependency		High Cholesterol		Tuberculosis	
Circulation		HIV / AIDS		Ulcers	
Depression		Kidney Problems		Unequal Leg Length	
Difficulty Healing		Liver Disease		Weak Ankles/Swelling	
Epilepsy		Lower Back Problems		Other Medical Problem (list below)	
Fainting Spells		Muscular Disorders			

Please list other medical problems here: _____

Check any known allergies:

Penicillin		Aspirin		Iodine	
Novocain		Codeine		Shell Fish	
Antibiotics		Antibiotics		Bee Sting	
Sulfa Drugs		Other Medications		Tape	

Please list all current medications you are taking: _____

Please list previous surgeries, or hospitalizations: _____

Family History

Mother: Alive____ Deceased____ List her health conditions: _____

Father: Alive____ Deceased____ List his health conditions: _____

Please list any other information that you may feel necessary for us to know: _____

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Surgery Cancellation Policy Effective 11/1/11

Patients, or legal guardians of patients under the age of eighteen, MUST sign and date below before medical care can be rendered.

At the North TX Foot and Ankle we strive to provide the best and most complete patient care. In an attempt to preserve patient care, we have a Surgery Cancellation Policy that allows us to schedule appointments for all patients. When a surgery is scheduled, that extended period of time has been set aside for you. When it is missed, that time cannot be used for surgery for another patient, or filled with appointments for patients that urgently need the care.

We request that you please give our office 24 hour notice in the event that you need to reschedule or cancel your surgery with the physician or physician assistant. This allows other patients in need of care to be scheduled in that appointment time. It also makes it possible to reschedule your appointment more efficiently. Patients failing to provide 24 hours notice that they can not make their surgery as scheduled will have a charge of \$50.00 added to their account. Please note that this charge is the financial responsibility of you, the patient, and will not be paid by your insurance company. We thank you for your cooperation in this manner so that each patient can receive the treatment and medical attention that they need and deserve.

I have read and understand the Medical Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I, _____ (print name), have read, understand, and will comply with the North TX Foot and Ankle's Surgery Cancellation Policy.

Printed Name of the Patient

Relationship to Patient (if patient is a minor)

Signature of Patient or Responsible Party if a Minor

Date