North TX Foot & Ankle

Ronica N. Holcombe DPM - Todd Lewis DPM - Stephen Schmitz 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 the 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 highly value 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

Todd Lewis DPM

Stephen Schmitz DPM

Reminders for your visit with us:

- 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, Co-Ins or Deductible is collected at the 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

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

_______X-rays are property of North TX Foot and Ankle. If you wish to receive copies of digital XRAYS there will be a fee assessed of $12.00.

________Disability and FMLA forms that need to be completed by our staff will incur a $22.00 fee to the patient. If insurance carrier or attorney's office is requesting the forms/records, they will pay according to terms.

________For copies of medical records our office requires 10 days' notice. There is a fee of $20.00 for up to 25 pages and if it is above 25 pages the charge will be $35.00.

________*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. I will be charged a 12.00 statement fee if I fail to pay my statement in a timely manner. 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:** ______________________

NORTH TEXAS FOOT and ANKLE
1145 Kinwest Pkwy Ste. 100
Irving, Texas 75063
Phone 214-574-9255 Fax 214-574-9258

First Name: ☐ MI: ☐ Last Name: ☐

Previous Name: ☐ Generation: ☐ Gender: ☐ Female ☐ Male Age: ☐

Social Security Number: ☐ DOB : ☐ Email : ☐

Home Address: ☐ City: ☐ State: ☐ Zip: ☐

Home #: ☐ Cell #: ☐ Work #: ☐

Preferred Language: ☐ English ☐ Spanish ☐ French ☐ Italian

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

Referral Source: ☐ Family/Friend ☐ Insurance Provider List ☐ Internet Search
☐ Newspaper Ad ☐ Physician ☐ Top Doc
☐ Zoc Doc ☐ Yellow Pages Other: ☐

Primary Physician: ☐ Date Last Seen: ☐ Referring Provider: ☐

Emergency Contact: ☐ Phone Number: ☐ Relation: ☐

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

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Insurance Information

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

Primary Insurance: ☐ Policy #: ☐ Group#: ☐

Primary Insurance Policy Holder: ☐ Referral Required: ◯ Yes ◯ No (PT responsible to obtain referrals)

Secondary Insurance: ☐ Policy #: ☐ Group#: ☐

Secondary Insurance Policy Holder: ☐ Referral Required: ◯ Yes ◯ No (PT responsible to obtain referrals)

Responsible Party, if different from patient information: Name: ☐

Social Security No: ☐ DOB: ☐

Address: ☐ City: ☐ State: ☐ Zip: ☐

Phone #: ☐ E-mail: ☐ Relationship to Patient: ☐

Pharmacy information: Name: ☐ Location: ☐ Phone: ☐

City and intersection

Fax: ☐

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 Phone ______________________ Secondary Phone ______________________

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.

E-mail 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 Privacy Act at any time.

Name (PRINTED) ____

Signature ____

Date ☐

Patient History

Date ______

Patient Name ______________________________

Height: ______ Weight: ______ Shoe Size: ______ Width: ______ Occupation: ______________

Type of Exercise: ______________________ Type of Sports: ______________________

My foot problem is: ____

Nature of foot problem: ☐ Sharp ☐ Dull ☐ Sharp ☐ 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		Fainting Spells		Lower Back Problems	
Arthritis		Foot/Leg Cramps		Muscular Disorders	
Artificial Joint/Valves		Foot /Leg Injuries		Nervous Problems	
Asthma		Foot/Leg Numbness		Polio	
Bleeding Disorders		Foot/Skin Problems		Prone to Infection	
Blood Disease		Gout		Rheumatic Fever	
Bunions		Hay Fever		Shortness of Breath	
Bursitis		Hepatitis		Thyroid	
Cancer		Heart Problems		Tuberculosis	
Chemical Dependency		High Blood Pressure		Ulcers	
Circulation		High Cholesterol		Unequal Leg Length	
Depression		HIV/AIDs		Weak Ankles	
Difficulty Healing		Kidney Problems		Swelling in Ankles	
Epilepsy		Liver Disease		Other medical Problems	

Please list other medical problems here:

Check any known allergies:

- ☐ Penicillin
- ☐ Novocain
- ☐ Antibiotics
- ☐ Sulfa Drugs
- ☐ Aspirin
- ☐ Codeine
- ☐ Antibiotics
- ☐ Other Medications
- ☐ Iodine
- ☐ Shell Fish
- ☐ Bee Sting
- ☐ 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 08-01-2023

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At the North TX Foot and Ankle, we strive to provide the best and most complete patient care. 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 cannot make their surgery as scheduled will have a charge of $100.00 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