Sweeney Foot and Ankle Specialists

Please fill out all information completely!

Date: _____

Personal Information

Name:_____

Last First Middle Initial Language Spoken

Date of Birth:_____**Age:**_____**Weight:**_____ **Height:**_____**Shoe Size:** _____

Gender: M or F **Race:** _____**Ethnicity:**_____**Social Security #:** _____

(e.g., White, Asian, Hispanic) (e.g., Hispanic, Latin, Other)

Home Address:_____**City:**_____**State/Zip:**_____

Phone 1:_____**Phone 2:**_____

May we leave phone messages? Yes or No **Email:**_____

@gmail @yahoo @aol @sbcglobal @hotmail

Occupation:_____**Employer Name:** _____

Address:_____**City:**_____**State/Zip:** _____

Work #_____**Extension:** _____

Who may we thank for referring you to our office? _____

Medical History

What is the reason for today's visit?_____

Name of your Primary Care Physician?_____**Phone #**_____**Last Visit:**_____

Have you ever been seen by a foot specialist prior to today? Yes or No **Name of specialist:** _____

Please list ALL medications you are currently taking:_____

_____

Do you have any allergies to medications? _____

Please list all previous surgeries and dates:_____

Have you ever had the following?

Y N Liver Problems	Y N High Blood Pressure	Y N Thyroid
Y N Tuberculosis	Y N Epilepsy	Y N Depression/ Anxiety
Y N Kidney Problems	Y N Rheumatic Fever	Y N Bipolar
Y N HIV	Y N Heart Problems	Y N Fibromyalgia
Y N Stomach Ulcer	Y N Diabetes	Y N Rheumatoid Arthritis
Y N Difficulty in Healing	Y N High Cholesterol	Y N Blood Clots/Disorders
Y N Shortness of Breath	Y N ADD/ADHD	

Any Health issues not listed? _____

Pharmacy: _____ **Phone #** _____ **Location:** _____

Smoke? Yes or No **Drink?** Yes or No

I acknowledge that I was provided a copy of the 'Notice of Privacy Practices' and that I have read (or had the opportunity to read if I so chose) and understood the notice. This notice has been posted on our website and is available at our facility in our waiting area.

_____ _____

Signature of Patient/Parent/Guardian **Date**

PATIENT CONSENT FORM

Disclosure of Physician Ownerships: Please be informed that Dr. Sweeney and the physicians of Sweeney Foot and Ankle Specialists have direct and indirect financial ownership relations and may receive remuneration directly or indirectly from entities of: Shenandoah Imaging and VIP Surgical Center. Decisions regarding the recommendations, referrals, or any other form of arrangement for utilization by patients of your physician of specific services or facilities are made with regard to the best interest of each individual patient. You have the right to choose the provider of your health services. You will not be treated differently by your physician if you choose to obtain other health care services. If you have any questions concerning this notice, please feel free to ask your physician.

By signing below, I certify that I have read and understand this policy.

Patient/Guardian Signature: _____ Date: _____

Assignment of Benefits: I authorize by my initials and signature below for the office of Sweeney Foot and Ankle Specialists to release any medical, surgical, demographic information necessary for determining the extent of any responsible third-party coverage, guarantor coverage and for processing an insurance claim on my behalf in order to receive payment for services rendered. I understand that I am financially responsible for any services or supplies not covered by my insurance or other health benefit plan which may include but are not limited to copay, coinsurance and deductible amounts. _____**(initials)**

Consent to treat: My initials and signature below are an acknowledgement that I voluntarily consent to medical treatment and procedures that may be performed on me during all healthcare visits now and in the future that is deemed medically necessary in order to treat the condition or conditions by the providers of Sweeney Foot and Ankle Specialists and this includes, but is not limited to medical treatment, physical therapy, surgical care, x-rays, medications, laboratory tests and/or other services which may be ordered by the physician participating in my care. _____**(initials)**

Acknowledgment of Notice of Privacy Practices: I hereby acknowledge receipt by my initials and signature, before any medical services were provided, that I was offered a copy of the "**Notice of Privacy Practices"** that provides information about how we may use and disclose protected health information. I was also given the opportunity to ask any questions regarding such notice. The notice contains a Patients' Rights section describing a patients' rights under law. I understand that my personal and health operations information may be disclosed for the purpose of treatment, payment and health operations as disclosed in the notice. I also understand that this authorization remains valid until otherwise rescinded by my written request, however, such revocation shall not affect any disclosures we have already made in reliance on your prior request. This practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPPA) of 1996. _____**(initials)**

Consent for Prescription Drug Monitoring Program: I understand and grant permission by my initials and signature below, for the provider to search my prescription history as it's required and states in section (22 TAC 170.3) of the Texas Administrative Code when providing medical attention in the treatment of chronic pain. _____ **(initials)**

Communication: I understand and acknowledge by my initials and signature below, that by providing my landline/cell phone numbers and email address, that I give authorization to contact me at the phone numbers and email address I provided regarding any outstanding balances or appointment reminders and any other information by using electronic and automated technology with the contact information I provided. The authorization also applies to any landline/cell phone or email address I may acquire in the future. _____ **(initials)**

Authorization For Release of Protected Health Information: I authorize Sweeney Foot and Ankle Specialists to discuss my medical history, diagnosis, treatment and prognosis with those listed below. Please list the name and relationship of who you would like to release information to below:_____
_____

Signature of Patient/Responsible Party: **Date:**

_____ _____

OFFICE AND FINANCIAL POLICIES

Welcome and thank you for choosing Sweeney Foot and Ankle Specialists for your foot health concerns. We are dedicated to providing you with the highest quality medical care in an efficient, timely, and effective manner. An essential element of your care and treatment is understanding your financial responsibilities. We hope that providing you with our policies in advance, we can prevent any misunderstanding or frustration at the time of your visit.

Your insurance policy is a contract between you and your insurance company. It is your responsibility to confirm with your insurance company that the physician is currently under contract with your plan. As a courtesy, we will file your insurance claim for you. We will allow 60 days from the date the claim is filed for the insurance to pay the entire claim. If the insurance carrier does not pay within this time, you will be responsible for the entire balance.

We participate with most insurance plans; each plan contains unique rules which must be followed by the patient. Please familiarize yourself with the particular benefits and rules of your health care plan. Certain health insurance plans require that you obtain a referral authorization from your Primary Care Physician before visiting a specialist's office like ours. You are responsible for obtaining this referral authorization and keeping track of the number of visits allowed as well as the start/end dates of your referral authorization. You are responsible for deductibles, co-insurance, non-covered services and any other charges insurance may not cover. An Insurance Waiver may be required to acknowledge understanding of your responsibility for non-covered services. You will be sent statements on a monthly basis regarding any monies owed.

Please check all of your personal information over carefully so that we may preserve the integrity of our data. **Please report all address, insurance and telephone changes immediately.** If updated insurance information is not provided to us in a timely manner, balance in full will become the patient's responsibility.

Payment is required at the time of service for any amounts which will be applied to copay, deductible or coinsurance. In addition, some services or supplies may not be covered by your insurance. We will do our best to obtain accurate benefit information from your insurance carrier. However, we are sometimes given incorrect information by insurance companies, especially regarding such services as custom-casted foot orthotics, routine foot care and durable medical equipment. Any services denied by your insurance carrier will be your responsibility.

WE ARE NOT ABLE TO ACCEPT ANY RETURNS OR OFFER REFUNDS ON ANY DURABLE MEDICAL SUPPLIES OR CUSTOM MOLDED ORTHOTICS.

We require a 24-hour advance notice if you must cancel your appointment. Our office will make every attempt to remind you of your scheduled appointment, but it is ultimately the patient's responsibility to cancel or reschedule when necessary. Our office reserves the right to charge a $45.00 fee for failure to inform our office of an appointment cancellation.

If you arrive more than 15 minutes past your scheduled appointment time, you will be rescheduled so that other patients are not inconvenienced.

If surgery is cancelled within two weeks of the surgery date you will be billed a cancellation fee of $250.00. We require a two week notice of cancellation because insurance companies require two weeks for pre-certification. If the cancellation is due to an insurance issue or illness, the fee will not apply.

A deposit/surgical estimate will be collected for your surgery at the time of your pre-op visit. Once the surgery is scheduled your insurance carrier will be notified. Verification of surgical benefits, deductible amount, and coinsurance amount will be confirmed. The amount is figured to the best of our ability, but we can never be sure of what the insurance will pay until the claim has processed. Pre-certification will be done should your policy require it. Your surgeon fee is separate from the surgical facility, anesthesia, lab work, any pre-op testing, pathology, and Durable Medical Equipment (DME)

There is a $25.00 charge per form to fill out disability and insurance forms. Please mail or leave them at the front desk along with your payment. Forms will not be completed until payment is received. Please allow 5 working days for

processing. There is a $5 fee for copying x-rays and $15.00 for medical records. There is a $45.00 fee accessed for returned checks.

I have read, understand and agree to the above office and financial policies. I hereby attest that I have given and agree to provide current demographic and insurance information and authorize release of information necessary for insurance filing and precertification by signing this statement.

_____

Signature of Patient/Responsible Party **Date**