Irene Hernaez, DPM
Family Foot Center, PLLC
16659 S W Freeway Ste. #201 – Sugar Land, TX 77479
Phone – 281-937-0077 - Fax –1- 877-231-0556

PATIENT INFORMATION

Name: ________________________________ Date of Birth: _____ / _____ / _________

Address: ____

City: ______________________ State: ___________ Zip _______________

Phone No: _____________________________ Cell/Work/Other #: ______________________

Email: _____________________________ Gender: Male Female Smoker: YES NO

May we leave a message: Patient Spouse Name: ______________________

Race: _______________ Ethnicity: ____________________ Preferred Language: __________________

Form of Contact: Phone Email text Marital Status: single married full time student

Who referred you? (ie. Newspaper, phone book, Doctor's name, etc.) ______________________

Who is your Primary Care Doctor? ____

What is your foot problem today? ____

____

Please list all medications you are taking (dosages are not necessary): ______________________

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Are you allergic to any of the following: Penicillin Aspirin Codeine Cortisone Iodine

Sulfa Drugs Novocain Tape Other: ______________________

Do you have any medical conditions? Please check all that apply:

Diabetes	High Blood Pressure	Poor Circulation
Heart Problems	Liver Problems	Kidney Problems
Cancer	Anemia Other: ______________________	

Pharmacy & Location of Store: ____

Please list any surgeries you have had; with estimated date: ______________________

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Please provide insurance card and picture ID so a copy can be made, or indicate your method of payment.

Your signature gives us permission to treat you, bill your insurance, and share pertinent medical information with other health care providers who may be involved with your care.

Patient/guardian signature: ______________________________ Date: _______________

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PRIVACY PRACTICES

Your medical information will be maintained in a confidential manner, as required by law. However, we may use your information as necessary for treatment, payment, and health care operations.

Treatment includes sharing information among health care providers involved in your care. For example, we may share information about your condition with the pharmacist to discuss medications or with radiologists or other consultants in order to make the diagnosis. We may need to use your medical information as required by your insurer or HMO to obtain payment for your treatment.

OTHER USES OF YOUR MEDICAL INFORMATION:

- Family members or close friends who are involved in your care or payment for your treatment.
- Disaster relief
- Appointment reminders
- As required by law
- Public health issues, disease prevention, reporting child abuse / neglect
- Reporting reactions to medications, notice of recalls.
- Audits, inspections, investigations, and licensure
- Lawsuits
- Military authorities, if you are a member of the Armed Forces
- National Security and Intelligence Activities

YOUR RIGHTS:

- You may request limitations on your medical information. We are not required to agree, but if we do agree, a signed consent will be obtained by our office and we will comply unless information is needed to provide you with emergency treatment.
- You may request communications in a certain way or location, but you must be specific as to how and / or where.
- Your have the right to request a copy of your medical records with a signed request on file.
- We may charge a fee for copying, mailing, and supplies.
- You may request a list of disclosures of your medical information that have been made to persons or entities other than for health care treatment.

Thank you for choosing us as your podiatrist. We are committed to your successful treatment. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which may require you to read and sign prior to any treatment.

COMMERCIAL INSURANCE:

Your insurance policy is a contract between you and your insurance. We will file your insurance claims as a curtesy to you. However, we require copays and deductibles to be paid at the time the service is rendered. We will make every effort to verify your insurance eligibility, co-pays, and / or deductibles at the time of your visit. However, we cannot take the responsibility for incorrect information provided to us by your insurance. Many times we do not speak to an insurance representative, instead we are dealing with the automated and / or internet to provide us with accurate information. We will honor only the information provided to us at the time of insurance verification. This is regardless of whether you have had previous medical care from other providers, or if you believe you have met your deductible.

MEDICARE PATIENTS:

As you are aware, Medicare only covers 80% of the allowed expense. If you do not provide proof of a secondary insurance at the time of treatment, then the 20% co-insurance will be collected. As a **SPECIALIST – PODIATRIST** we are required to list your primary care doctor, or other doctor to whom you see regularly. His / Her name is required to be listed on the claim along with the last date that you saw that doctor. **THIS INFORMATION IS REQUIRED BY MEDICARE. IF YOU CANNOT PROVIDE YOUR DOCTOR'S NAME, THEN A DEPOSIT MAY BE COLLECTED.** If and when Medicare reimburses us, you will then receive a refund. **IF YOU HAVE QUESTIONS REGARDING MEDICARE'S REQUIREMENTS, PLEASE CALL THEIR CUSTOMER SERVICE LINE, AND THEY CAN ASSIST YOU.**

I HAVE READ AND UNDERSTAND THE ABOVE THE POLICY. MY SIGNATURE BELOW INDICATES THAT I AGREE TO COMPLY WITH THIS POLICY.

PATIENT SIGNATURE:______________________________ DATE:__________________