Bay Area Podiatry Associates

Patient Demographic Information

Patient's Name:		Date:
DOB:	Age:	Sex: F M
Home Address:	Marital Status: ☐ Single ☐ Married ☐ Widow ☐ Divorced ☐ Separated	
City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:
Emergency Contact:	Phone #:	Relationship:
Email Address:	Primary Care Physician:	
Employer Name:	Position:	
Primary Language:	Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic	
Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White		
Is this a work related injury? Yes No If you answered yes to the following question please inform the front desk. Please be aware that your private health insurance will not cover any work related injury.		

INSURANCE INFORMATION

Primary Insurance Co. Name:		Secondary Insurance Co. Name:	
Policy #:		Policy #:	
Subscriber's Name:	Relationship to Patient:	Subscriber's Name:	Relationship to Patient:
Subscriber's DOB:		Subscriber's DOB:	

PHARMACY INFORMATION

Pharmacy Name: Pharmacy Address:	Pharmacy Phone:

Bay Area Podiatry Associates

A Professional Association
Doctors of Podiatric Medicine
Medicine and Surgery of the Foot
***Board Certified in Foot and Ankle Surgery**
***Fellows American College of Foot and Ankle Surgeons**

Dedicated to providing the finest quality foot and ankle care.

***Kirk A. Koepsel, DPM**
***Matthew S. Rockett, DPM**
***Andrea K. Rockett, DPM**

Disclosure of Physician Ownership

Notice to Patients.

Please carefully review the information contained in this notice.

1. **Kirk A Koepsel, DPM and Matthew S Rockett, DPM have an ownership interest in Houston Physicians' Hospital.**
2. **Kirk A Koepsel, DPM has an ownership interest in NIRP.**
3. **You have the right to choose the provider of your health care services. Therefore, you have the option to use a health care facility other than Houston Physicians' Hospital or NIRP.**
4. **You will not be treated differently by your physician if you choose to obtain health care service at a facility other than Houston Physicians' Hospital or NIRP.**

If you have any questions concerning this notice, please feel free to ask your physician or any representative of Houston Physicians' Hospital or NIRP. We welcome you as a patient and value our relationship with you.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and herby understand that your physician has an ownership interest in Houston Physicians' Hospital or NIRP.

_____ _____

Signature of Patient **Signature of Parent or Guardian**

_____ _____

Print Name of Patient **Print Name of Parent or Guardian**

Date: _____

Bay Area Podiatry Associates, PA

Name_____ Date of Birth_____Date_____

PODIATRIC HISTORY

Reason for your visit: _____
_____
_____

Describe Type of Pain:
□ Dull □ Sharp □Shooting
□ Burning □ Aching
□ Throbbing □ Tingling
□ Numbness □ Cramping
□Other: _____

Location: □ Right □ Left □ Both
□ Foot □ Ankle □ Leg

Height: _____
Weight: _____
Shoe Size: _____

Duration (How long have your symptoms been present): _____Days/ Weeks/ Months/ Years

Onset: □ Slow □ Sudden □ Traumatic

If Traumatic: □ Auto □ Worker's Comp □ Other

Has Pain Become: □ Better □ Worse □ Stayed the same

Symptoms are worse:□ Morning □ All Day □Evening □ Night

Previous Treatments: _____
_____

What aggravates the condition?
_____
_____

Who is your Primary Care Physician? Last time seen? _____
_____

May we contact physician regarding your care? □ YES □ NO

MEDICATIONS

Please include prescriptions, over-the-counter medications, and vitamins (or provide a list to be photocopied):

Name: _____ Reason: _____

Name: _____ Reason: _____

Name: _____ Reason: _____

Bay Area Podiatry Associates, PA

MEDICAL HISTORY

Please mark to indicate if you have or have been treated for any of the following:

Aids/HIV__
Acid Reflux__
Anemia__
Anxiety__
Arthritis__
Artificial Heart Valve__
Artificial Joint__
Asthma__
Back Problems__
Bleeding Problems__
Bipolar Disorder__
Blood Clot/DVT__
Cancer__
Type _____
Chemical Dependency__
Chest Pain/Angina__
Circulatory Problems__
Depression__
Diabetes__
Type__ How Long__
Emphysema__
Fibromyalgia__
Gout__
Headaches__
Heart Attack__
Heart Murmur__
Hepatitis__
High Blood Pressure__
Decreased Kidney Function__
Liver Disease__
Low Blood Pressure__
Neuropathy__
Pacemaker__
Phlebitis__
Psoriasis__
Seizure Disorder__
Stroke or TIA__
Thyroid Problems__
Varicose Veins __
Other_____

Women, are you pregnant? Y N Breastfeeding Y N

MEDICATION ALLERGIES

Any allergies or adverse reaction to any medication?

_____ _____ _____

_____ _____ _____

Any allergy or adverse reaction to these materials?

Nickel_____ Tape/Adhesive _____ Latex _____

SURGICAL HISTORY

Have you been hospitalized in the last two years? _____

Why: _____ _____

_____ _____

Do you smoke? Y N #of Cigarettes/day _____

Do you drink Alcohol? Y N # of drinks/day_____ #drinks/wk _____

Signature: _____ Date: _____

Bay Area Podiatry Associates

Privacy Consent and Release

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Printed Name of Patient or Personal Representative If not self, description of Personal Representative

I understand that by signing this form, I give permission for my doctor to collect payment due from my insurance for services performed. I understand medical records remain confidential as described in the Notice of Privacy Practices.

Emergency Contact Name & Number _____

I allow release of medical information to the following: (Please check all that apply)

☐ No one except myself ☐ Spouse : _____ ☐ Other: _____

Financial Policy

Insurance

1) According to your insurance plan, you are responsible for any and all co-payments, deductibles, and co-insurances at the time of your visit.
2) It is your responsibility to keep us updated with your correct insurance information. If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.
3) It is your responsibility to understand your benefit plan with regard to, for instance, covered services and participating laboratories.
4) It is your responsibility to know if a written referral or authorizations is required to see specialists, whether prior authorization is required for a procedure, and what services are covered.

Payment

1) Self-pay patients are expected to pay for services in FULL at the time of the visit.
2) If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance for reimbursement.
3) Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within 10 business days of your receipt of your bill.
4) For scheduled appointments, prior balances must be paid prior to the visit.
5) We accept cash, checks, Visa, Master Card, Discover and American Express credit and debit.

Fees

1) If you are not able to keep an appointment, we require a 24 hour notice. There is a charge of $ 30.00 for missed office visit appointments.
2) Co-payments are due at the time of service. A $20.00 service fee will be charged in addition to your co-payment if the co-payment is not paid by the end of the next business day.
3) A $ 30.00 fee will be charged for any checks returned for insufficient funds.

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

_____ _____

Signature of Patient (Parent/Guardian) Date