# PLEASE READ

# PRIOR TO FILLING OUT

## New Patient Paperwork

**For**

## Foot Specialists of Shreveport-Bossier

We will **only be able to see you for the reason stated** when you called for your appointment. We make our schedule according to what you tell us, and we do not have time to add additional problems.

Please **do not attempt to add additional issues.** If you have other issues, please notify the front desk, and we will be happy to schedule another appointment to accommodate you. If we need to change the focus of your appointment, please let the front desk know.

Signature for acknowledgement:

_____

# FOOT SPECIALISTS OF SHREVEPORT-BOSSIER

*PODIATRIC MEDICINE AND RECONSTRUCTIVE FOOT SURGERY*

J. E. Toups, Jr., DPM, FACFAS
Bryan W. Randolph, DPM, FACFAS
Rebecca McGaha, DPM,AACFAS

## *Welcome to Our Office*

This sheet provides us with information vital to your health and will aid our office in accurately filing your insurance forms. Be assured that this information will remain strictly confidential. Please take a moment to fill out both sides of this form.

**Patient Information** **Today's Date**_____

Patient's Full Name _____

Marital Status: (circle) Single Married Widowed Divorced Sex: (circle) Male Female

Ethnicity: (circle) White Black/African-American Bi-racial Asian Arab Hispanic/Latino

Social Security # _____ Birth Date _____ Age _____

Street Address _____ Home Ph. ( ) _____

City, State, Zip_____ Cell Ph. ( ) _____ Work Ph. ( ) _____

Employer _____ Occupation _____

Employer's Address _____

**Responsible Party** (if other than patient) Name _____

Date of Birth _____ SSN _____ Home Ph. ( ) _____

Street Address _____ City, State, Zip _____

Employer's Address _____ Work Ph. ( ) _____

**Medical Information**

Family Doctor _____ Last Visit _____

Are you in good general health? Yes No Medical Problems _____

_____

In case of emergency, please call (Name/Relationship): _____ Ph. ( ) _____

**Referring Physician :** _____

**Per medical regulatory laws, the next two questions are required.**

Height_____ Weight _____

So we may better contact you, please provide a valid E-mail address: _____

# AUTHORIZATION TO RELEASE MEDICAL BENEFITS

I authorize the release of all medical information necessary to process insurance claim(s), and I hereby assign and authorize direct payment of all medical and/or surgical benefits including major medical, private insurance, and other health plans to Foot Specialists of Shreveport-Bossier.

Please remember that medical insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some insurance companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid by your insurance.

**Copayments for HMO's, PPO's, and other managed care plans must be paid at the time of service.** Balance billing patients for their co-pays is a violation of our managed care contracts and will not be allowed. If the patient does not have the co-pay at the time of visit, the patient may reschedule the appointment in order to meet the co-payment requirement.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. An account is considered delinquent after 30 days from the date of service or from the dates services were denied or paid by the insurance carrier.

To the extent necessary to determine liability of payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record.

This Assignment will remain in effect until revoked by me in writing. A signed photocopy of this Assignment is to be considered as valid as an original.

Signature of responsible party _____ Date _____

FOOT SPECIALISTS OF SHREVEPORT-BOSSIER
*PODIATRIC MEDICINE AND RECONSTRUCTIVE FOOT SURGERY*

J. E. Toups, Jr., DPM, FACFAS
Bryan W. Randolph, DPM, FACFAS
Rebecca McGaha, DPM, AACFAS

# PATIENT HISTORY

Name: _____ Date: _____

Please describe the foot problem for which you came to be treated. (Include foot, ankle, knee, thigh, and hip complaints.)

_____

_____

Please indicate by circling yes or no which foot problems you now have or have had in the past:

| | | |
|---|---|---|
| Ankle Pain | Yes | No |
| Athlete's Feet | Yes | No |
| Bunions | Yes | No |
| Corns and Calluses | Yes | No |
| Flat Feet | Yes | No |
| Foot or Leg Cramp | Yes | No |
| Heel Pain | Yes | No |
| Ingrown Toenails | Yes | No |
| Numbness in Feet or Legs | Yes | No |
| Plantar Warts | Yes | No |
| Swelling in Ankles or Feet | Yes | No |
| Tired Feet | Yes | No |
| Ulcers or Non-healing Wounds | Yes | No |

Have you ever been to a Podiatrist before? Yes: _____ No: _____
If yes, please list:
Name: _____ Last visit: _____

Is there any personal or family history of diabetes? Yes: _____ No: _____

Your occupation: _____

Cigarette/Tobacco use _____ Years smoked: _____

Athletic activities in which you participate (please list and indicate frequency):

_____

## MEDICAL HISTORY

**Please circle "Yes" or "No" to indicate if you have had any of the following:**

| | | |
|---|---|---|
| AIDS/HIV | Yes | No |
| Allergies to Anesthetics | Yes | No |
| Allergies to Medicines or Drugs | Yes | No |
| Anemia | Yes | No |
| Angina | Yes | No |
| Arthritis | Yes | No |
| Artificial Heart Valves or Joints | Yes | No |
| Back Problems | Yes | No |
| Bleeding Disorders | Yes | No |
| Cancer | Yes | No |
| Chemical Dependency | Yes | No |
| Chest Pain | Yes | No |
| Chronic Diarrhea | Yes | No |
| Circulatory Problems | Yes | No |
| Diabetes | Yes | No |
| Ear Problems | Yes | No |
| Epilepsy | Yes | No |
| Eye Problems | Yes | No |
| Fainting | Yes | No |
| Gout | Yes | No |
| Headaches/Migraines | Yes | No |
| Heart Disease | Yes | No |
| Hemophilia | Yes | No |
| Hepatitis or Jaundice | Yes | No |
| High Blood Pressure | Yes | No |
| Kidney Problems | Yes | No |
| Liver Disease | Yes | No |
| Low Blood Pressure | Yes | No |
| Phlebitis | Yes | No |
| Psychiatric Care | Yes | No |
| Radiation Treatment | Yes | No |
| Rash | Yes | No |
| Respiratory Disease | Yes | No |
| Rheumatic Fever | Yes | No |
| Shortness of Breath | Yes | No |
| Sinus Problems | Yes | No |
| Special Diet | Yes | No |
| Stroke | Yes | No |
| Swollen Neck Glands | Yes | No |
| Tuberculosis | Yes | No |
| Varicose Veins | Yes | No |
| Venereal Disease | Yes | No |
| Weight Loss, unexplained | Yes | No |

**Please list any surgeries you have had:**

_____
_____
_____

**Please list any hospitalizations other than surgeries:**

_____
_____

**Family Physician:** _____
**Date of Last Visit:** _____

**Are you now or have you been under any other doctor's care for any reason over the last 2 years?**
**Please circle** Yes No

**If yes, please explain:**

_____
_____

## MEDICATIONS

**Please include prescriptions, over-the-counter medications, and vitamins:**

_____
_____
_____
_____
_____
_____
_____

**Pharmacy Name (s):** _____
**Pharmacy Phone (s):** _____

**Do you take oral contraceptives?**
**Please circle** Yes No

## ALLERGIES

Please circle "Yes" or "No" to indicate if you have any of the following allergies:

| | | |
|---|---|---|
| Adhesive/Tape | Yes | No |
| Anticoagulant Therapy | Yes | No |
| Aspirin | Yes | No |
| Codeine | Yes | No |
| Demerol | Yes | No |
| Iodine | Yes | No |
| Local Anesthetics | Yes | No |
| Novocaine | Yes | No |
| Penicillin | Yes | No |
| Seafood | Yes | No |
| Sulfa | Yes | No |

**Other Allergies:**

_____
_____

## CONSENT:

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may

be deemed necessary in the diagnosis and/or treatment of my feet.

**Patient's Signature: _____**

**Date Signed: _____**

FOOT SPECIALISTS OF SHREVEPORT-BOSSIER
*PODIATRIC MEDICINE AND RECONSTRUCTIVE FOOT SURGERY*

J. E. Toups, Jr., DPM, FACFAS
Bryan W. Randolph, DPM, FACFAS
Rebecca McGaha, DPM, AACFAS

# Designated Personal Representative Form

Patient Name: _____
Please Print

A personal representative is a person or entity authorized by the patient to act on his or her behalf. This form allows Foot Specialists of Shreveport-Bossier to share protected health information (PHI) with your designated personal representative. This designation should **not** be considered a general Power of Attorney.

Authorization provided by this form must be revoked in writing and notice should be mailed to Foot Specialists of Shreveport-Bossier, 7821 Youree Drive, Shreveport, LA 71105.

**Person(s) or Entity(ies) being designated as my personal representative:**

NAME: _____

ADDRESS (address, city, state, zip): _____

PHONE NUMBER: _____ DATE OF BIRTH: _____

Effective date of designation: _____ Termination date of designation: _____
(If no term date is specified, authorization will continue until terminated.)

Relationship to Patient:
☐ Attorney ☐ Family Member ☐ Facility
☐ Power of Attorney ☐ Guardian ☐ Other

**My representative's access to my records is:**

☐ Full access
☐ Restricted access (if restricted, please complete the sections below for access permissions)

**Restricted Access Permissions:**

☐ General medical information
Obtain copies of my protected health information
☐ Financial information
Lab and/or diagnostic testing

**PATIENT SIGNATURE:** _____
**PRINT PATIENT NAME:** _____
**DATE:** _____

## Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front staff or supervisor.

As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office. Unless other arrangements have been made in advance by you or your health insurance carrier, payment for office services are due at the time of service. We will accept Visa, MasterCard, Discover, cash or check.

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.

We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.

If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be “not covered” or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.

All account balances are required to be paid in full prior to you being scheduled for or having surgery. Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees, and court fees shall be your responsibility in addition to the balance due this office.

There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

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

Printed Name of Patient/Responsible Party: _____ Date: _____