Dr. Russell Pendleton, DPM **Dr. Caroline Stancukas, DPM**

PLEASE PRINT PATIENT INFORMATION

PATIENT NAME: LAST		FIRST			MIDDLE INTIAL:
ADDRESS		CITY		STATE	ZIP CODE
SS#	DOB	RACE	MARTIAL STATUS	PREFERRED LANGUAGE	SEX: M/F
CELL PHONE:		HOME PHONE:		WORK PHONE:	
EMERGENCY CONTACT:		PHONE #:		RELATIONSHIP:	
HOW DID YOU HEAR ABOUT US?		REFERRING DR NAME:			
PREFERRED PHARMACY:		CITY:		PHONE #:	
PRIMARY CARE DR:		DATE OF LAST VISIT:			
PCP ADDRESS:		PCP PHONE #:			
EMPLOYER:		POSITION:			
EMAIL:					

REPOSIBLE PARTY IF PATIENT IS A MINOR/PRIMARY HOLDER ON INSURANCE

(ONLY IF DIFFERENT FROM ABOVE)

NAME:		RELATIONSHIP TO PATIENT:	DOB:
ADDRESS:	CITY:	STATE:	ZIP:

Advanced Foot and Ankle Associates, PLLC

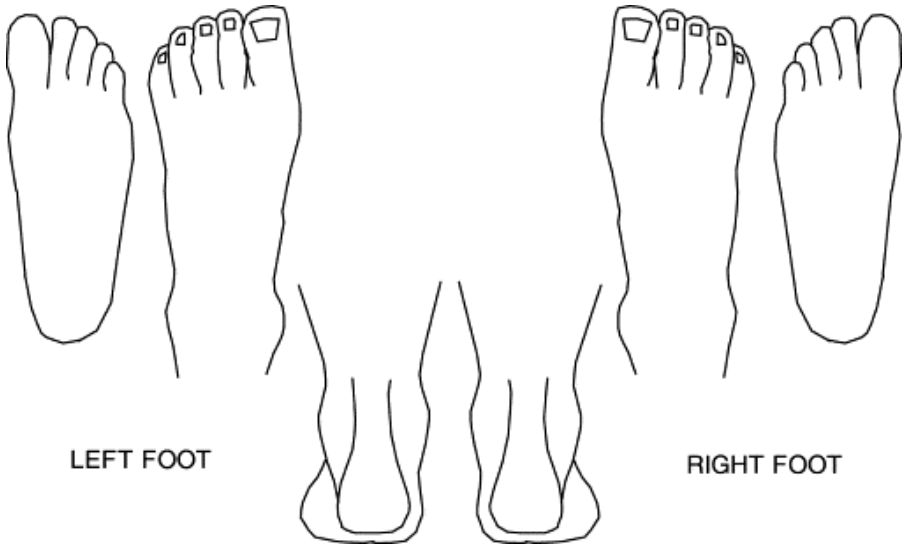
WHAT BRINGS YOU INTO OUR OFFICE TODAY?

PROBLEM 1:	PROBLEM 2:

PAIN SYMPTOMS, CIRCLE ALL THAT APPLY:

NO PAIN SHARP DULL BURNING ACHING THROBBING

FOOT CONDITION: PLEASE USE PICTURE TO MARK LOCATION(S) OF CONCERN



PLEASE CHECK IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING: (CHECK ALL THAT APPLY)

□ ALZHEIMER/MEMORY LOSS
□ ANEMIA
□ ANXIETY
□ ARTHRITIS TYPE: _____
□ ASTHMA
□ BLEEDING DISORDERS
□ HISTORY OF CANCER
IF YES TYPE: _____
□ DEPRESSION
□ DIABETES
□ FAINTING/DIZZINESS
□ SEXUALLY TRANSMITTED DISEASE
□ CHANGES IN WEIGHT/ENERGY
□ EMPHYSEMA
□ FOOT ULCER(S)
□ FOOT INFECTION(S)
□ GLAUCOMA/CATARACTS
□ GOUT
□ HEART PROBLEM(S)
□ HEPATITIS
TYPE: _____
□ HIGH BLOOD PRESSURE
□ HIGH CHOLESTROL
□ KIDNEY DISEASE/PROBLEMS
□ LIVER DISEASE/PROBLEMS
□ LUNG DISEASE/PROBLEMS
□ NEUROPATHY
□ OSTEOPOROSIS
□ SKIN DISORDERS
□ STROKE/SIEZURES
□ STOMACH ULCER/REFLUX
□ SWELLING IN FEET OR ANKLES
□ THYROID CONDITION
□ TUBERCULOSIS

CONTINUED……..

Advanced Foot and Ankle Associates, PLLC

PLEASE ANSWER TO THE BEST OF YOU KNOWLEDGE:

DO YOU TAKE BLOOD THINNERS (I.E…. COUMADIN, PLAVIX, ASPIRIN) ? PLEASE LIST

_____

HAVE YOU EVER HAD AN ALLERGIC REACTION TO SULFA DRUGS? _____
DO YOU HAVE A FAMILY HISTORY OF OSTEOPROSIS? _____
WHEN WAS YOUR LAST BONE DENSITY? _____ WHERE? _____

SURGICAL & HOPITALLZATION HISTORY: DATE:

□ AMPUTATION (S) _____
□ HIP REPLACEMENT _____
□ KNEE REPLACEMENT _____
□ CARDIAC SURGERY _____
□ FOOT LEFT OR RIGHT _____
□ OTHER _____

FAMILY HISTORY OF ILLNESS:

_____

SOCIAL HISTORY: DO YOU OR HAVE YOU EVER USED THE FOLLOWING: IF SO, HOW OFTEN?

TABACCO: _____
ALCOHOL: _____

MEDICATION HISTORY: IF YOU HAVE A **LIST** YOU MAY ATTACHED AND WE WILL MAKE A COPY

MEDICINE NAME:	STRENGTH:	DOSAGE:

ALLERGIES TO MEDICATIONS: _____

*I OR MY LEGAL GUARDIAN OR PARENT AUTHORIZE ADVANCE FOOT AND ANKLE ASSOCIATES TO PROVIDE MEDICAL CARE REASONABLE.

_____ _____
Signature of Patient/ Responsible Party/ Legal Guardian Physician Signature

CONTINUED……..

Advanced Foot and Ankle Associates, PLLC

Please read over carefully. If you agree please initial in each paragraph then sign and date at the bottom.

AUTHORIZATION TO RELEASE INFORMATION

_____ I authorize Advanced Foot and Ankle Associates to release all medical inforamtion (including, but not limited to, information on phychiatric condition, sickle cell anemia, alcohol and drug abuse, and HIV or communicable disease) requested by my health insurance carrier, Medicare or any other third-party payer(s). I I authorize Advanced Foot and Ankle Associates to release all medical to my referring physician and my primary (family) physician. I authorize Advanced Foot and Ankle to contact my insurance company or health plan administrator and obtain all pertinent finanical information concerning coverage and payment under my policy. I direct the insurance company or health plan adminstrator to release such information to Advanced Foot and Ankle Associates.

_____ I agree that these provisions will remain in effect until provided written revocation to Advanced Foot and Ankle Associates.

Please complete this section with the names of any person, other than yourself that you would like to have access to your medical information. If there are no names listed we will only be able to speak with you regarding your healthcare. Please consider if you want family member or friends to have any access to your health information.

I authorize the release of medical information to the following people:

Name: _____ Relationship: _____
Name: _____ Relationship: _____

ASSIGNMENT OF BENEFITS

_____ I hereby assign Advanced Foot and Ankle Associates any insurance or other third-party benefits available for health care services provided to me. I understand that Advanced Foot and Ankle Associates have the right to refuse or accept assignments of such benefits. If these benefits are not assigned to Advanced Foot and Ankle Associates, I agree to forward to Advanced Foot and Ankle Associates all health insurance and other third-party payment that I receive for services rendered to me immediately upon receipt.

ELIGIBILITY WAIVER

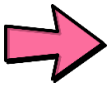
_____ I understand that my eligility for coverage may not be able to confirmed at this times. I wish to receive medical service from Advanced Foot and Ankle Associates. If determined that I am not eligible for coverage, I understand that I will be responsible for payment of all service provided.

CLINIC SUMMARY

_____ I elect to receive clinical summary updates only upon request. We will provide clinical summary updates to you after each office visit and evaluation automatically unless noted above.

_____ _____
Signature of Patient/ Responsible Party/ Legal Guardian DATE

CONTINUED……..



Advanced Foot and Ankle Associates, PLLC

FINANCIAL POLICY

Thank you for choosing our physicians for your health care needs. We are committed to providing the very best medical care and successful treatment. The following is a statement of our Financial Policy, which you must read, agree to, and sign prior to treatment. Our Financial Policy applies to all services rendered by our physicians, whether inpatient or outpatient. In order to bill for your services, we must have you complete this form at least once a year.

Practice Payment Policy Guidelines:

- Patients/guardians are financially responsible for all charges, regardless of third-party involvement.
- Full payment is due at the time of service, unless prior insurance billing arrangements have been made.
- Patients with insurance will be required to pay all 'out-of-pocket' financial obligations at time of services.
- We accept: Cash, Check, and the following credit cards: Visa/ Master Cards/ Discover

Patient Responsibilities and Financial Policies:

Provide Accurate Information: You have a responsibility to provide accurate and complete information about your health history, mailing address, health insurance and other billing information. If any information changes – name, address, phone, insurance coverage, etc. – you must inform this practice immediately. Insurance denials or billing errors due to patients supplied information will results in the transfer of the account balance to the patient's immediate financial responsibility.

Know Your Insurance Coverage, Benefits and Referral Requirements: Your health insurance is a contact between you and your health insurance plan(s). Patients are responsible for understanding their health insurance coverage(s), benefits and referral requirements to receive diagnostic and therapeutic services from our physicians. Patients are responsible for securing the necessary written referrals, pre-authorizations or pre-certifications
from your primary care physician or health plan to service rendered. If we have not received the necessary authorizations prior to your appointment, the appointment will be rescheduled. Please, present your Insurance ID card to our staff upon registration for each office visit.

Prescription Monitoring Program: You allow your physician to access information from the Prescription Monitoring Programs in the event it is necessary to validate the appropriate use of controlled substance for legitimate medical purposes while deterring the misuse, abuse, and diversion of controlled substances.

Self-Pay Patients: Patients without insurance coverage are expected to pay for services received in full at time of service, unless a satisfactory payment agreement has been arranged with our billing manager prior to services being rendered.

Patient with Private Insurance/ Medicare Coverage: Our Physicians participate with the Medicare Programs, and with CareFirst, Aetna, Cigna and Tricare Standard Insurance Companies. We will file claims(s) to the insurance companies we contact with, provide that you authorize the 'assignment of benefits' below for payment directly to our practice. For participating Insurance plans, the practice will accept payment base on contractual agreements. For plans in which we do not participate (i.e., there is no contractual agreement), the practice will expect full payment from the patient at the time of service. Any coverage or payment dispute is a member between the insurance policy holder and the Insurance Company.

Practice Payment Agreement:
I understand that I am financially responsible for all charges regardless of third-party involvement. I agree to pay any deductible, co-insurance, co-payment, or services deemed as "non-covered" by my insurance carrier at the time of services. If my insurance has not paid on my account in 75 days, the outstanding services will become my responsibility for immediate payment (unless Medicare). Should any balances arise due to insurance deductible, co-insurance, co-payment, termination of coverage, or non-payment at time of service and/or any other reason; I agree to pay all charges within 30 days of services rendered. I understand that failure to pay outstanding balances or make payment arrangements within 90 days will result in the amount due being considered delinquent and subject to legal action or assignment to collection agency. I further understand that failure to pay delinquent accounts may result in a finance charge assessment of 1.75% per month /21% APR, and the possible dismissal of the patient from the Practices care. I agree to pay a $25.00 returned check fee for each instrument tendered by me but returned to this facility. I agree to pay a $5.00 billing fee for each payment, including co-insurance and co-payment, not made at time of visit. I agree to pay a fee for each missed appointment that is not cancelled in advance. Copies of my medical records can be obtained with advanced written notice in accordance with the Privacy Rule and the Code of Texas, with an administration charge of $10.00 and a per page charge of $0.50 for the first 50 pages and $0.25 per page thereafter, plus actual costs associated with postage expenses. Completion of special forms has a minimum charge of $10.00 per form.

Authorization and Assignment of Insurance Benefits:
I permit a copy of this authorization and signature to be used in place of this original on all insurance claims submissions and for the release of any medical records and/or other records and information, as stated herein, whether manual, electronic or telephonic. I authorize the Practice to apply for benefits for services rendered to myself or minor child under any health insurance policies providing benefits and do hereby also assign and authorize payment of benefits from my insurance company to the Practice (including benefits payable under Title XVIII of the Social Security Act and/or any other governmental agency.) I irrevocably authorize all such payments to the practice. I authorize the Practice to contact the employer or insurance company regarding insurance information, existence of insurance and coverage of my benefits.

In consideration for medical services rendered, I acknowledge receiving notice of the financial policy and agree to pay for said medical services according to the above terms. My signature below indicates that I have read and agree to the above policy.

_____ _____

Signature of Patient/ Responsible Party/ Legal Guardian DATE

COMPLETED!!!!