

NEW BRAUNFELS PODIATRY

WELCOME TO OUR PRACTICE

PATIENT INFORMATION

All information will be confidential.

We are not a Worker's Compensation Provider.

We do not file Texas Worker's Comp cases or motorcycle/motor vehicle Accident claims.

Patient Name _____ Age: _____

Social Security # _____ - _____ - _____ Date of Birth: _____

Gender: Male Female Marital Status: Single Married Separated Divorced Widowed

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____

Work Phone # _____ Email: _____

Employer _____ Position _____

Primary insured's name if other than patient _____ D.O.B. _____

Pharmacy: _____ Location: _____

Who is Your Primary Care Doctor? _____

How did you hear about our practice? _____

Emergency Contact: _____ D.O.B. _____

Relationship: _____ Phone: _____

To the best of my knowledge, the questions on the forms have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of Patient, Parent or Guardian _____ D.O.B. _____ Date _____

I have read a copy of the New Braunfels Podiatry Associates, LLC Notice of Privacy Practices.

Patient/Guardian Signature _____ Date _____

Authorization to Release Medical Information to Designated Individuals

I wish the following individual(s) to have access to my medical information:

_____ D.O.B _____
_____ D.O.B _____

ALL INSURED PATIENTS

I request that payment of authorized insurance benefits be made to J. Jacob Ransom, D.P.M. or New Braunfels Podiatry Associates, LLC for any services furnished to me by that physician. I authorize any holder of medical information about me at New Braunfels Podiatry Associates, LLC to release said information to the insurance entity requesting it.

Patient/Guardian Signature _____ Date _____

SMS / Text Messaging Authorization (Optional)

New Braunfels Podiatry Associates, LLC may communicate with patients via SMS (text messaging) regarding:

Appointment reminders and confirmations

Scheduling or rescheduling notices

Office closures or updates

Billing notifications

Limited care coordination messages

Text messaging is provided for convenience and is not intended for medical emergencies. If you are experiencing a medical emergency, call 911 immediately.

Opt-In Authorization

By signing below, I authorize New Braunfels Podiatry Associates, LLC to send SMS/text messages to the mobile number listed on my patient demographic form. I understand that standard message and data rates may apply.

Text messages are not always encrypted and may carry privacy risks. Anyone with access to my phone may view these messages. I may withdraw consent at any time.

Patient/Guardian Signature _____ Date _____

Opt-Out Option

I decline SMS/text messaging communications.

You may also opt out at any time by replying STOP to any message or by notifying our office in writing.

Staff Use Only (If Signature Not Obtained)

Our office made a good faith effort to obtain Acknowledgement of Receipt of our Notice of Privacy Practices, but it could not be obtained for the following reason:

___ Patient refused to sign.

___ Emergency situation prevented obtaining signature.

___ Language barrier prevented obtaining signature.

___ Other _____

Name _____ Last, First _____ DOB _____ Date _____

What is your specific foot/ankle problem? _____

Current Prescription Medications

Consent to obtain RX History from pharmacy

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Allergies

No Known Drug Allergies

Yes No Penicillin

Yes No Aspirin

Yes No Codeine

Yes No Adhesive Tape

Yes No Sulfa

Yes No Local Anesthetic

Yes No Other _____

Past Medical History

Diabetes # years _____

Yes No

Asthma

Yes No

Heart Disease

Yes No

Aids or HIV

Yes No

High Blood Pressure

Yes No

Tendency to form large scars

Yes No

Cardiologist: _____

Yes No

Kidney Problems

Yes No

Arthritis: Type _____

Yes No

High Cholesterol

Yes No

Thyroid Problems _____

Yes No

Bleeding Problems

Yes No

Gout

Yes No

Alcoholism

Yes No

Any other disease (please list) _____

Previous Surgeries

1. _____
2. _____
3. _____
4. _____

Social History

Occupation _____

Tobacco: Non Smoker Current Past Quit Date _____

Alcohol: Non Drinker Social Daily

Height _____ Weight _____

Have You Experienced Any of These Symptoms Recently?

General

General good health lately

Yes No

Fever/Chills

Yes No

Respiratory

Shortness of breath

Yes No

Past anesthesia difficulties

Yes No

Cardiovascular

Palpitations/Arrhythmias

Yes No

Chest Pain

Yes No

Swelling of feet or ankles

Yes No

Gastrointestinal

Stomach ulcers

Yes No

Reflux

Yes No

Intolerance to Aspirin/NSAIDS

Yes No

Endocrine

Excessive thirst or urination

Yes No

Musculoskeletal

Joint pain/stiffness

Yes No

Muscle pain/cramps

Yes No

Integumentary

Rash or itching

Yes No

Varicose Veins

Yes No

Neurological

Tremors

Yes No

Numbness/Tingling

Yes No

Hematologic/Lymphatic

Bleeding tendency

Yes No

Past transfusion

Yes No

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 office staff.

- As our patient, you are responsible for all authorization/referrals needed to seek treatment in this office.
- **We are NOT a worker's compensation insurance provider. We do not file Worker's Comp cases or motorcycle/motor vehicle accident claims.**
- **Is this a work related or a vehicle accident injury?** Yes No
- Payment for services rendered will be due at the time of service. We will accept VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, CASH AND CHECKS. **Checks and Cash are our preferred payment method.** There will be a **3.99%** convenience usage charge applied to patients on all debit or credit card transactions.
- 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 insurers and other health plans to accept an assignment of benefits. We will bill the insurers/health plans that we have an agreement with, but we require you to pay the copay, deductible and coinsurance at the time of service for your treatment.
- 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 authorization, you will be responsible for the complete charge.
- You must inform the office of all insurance changes, authorization and referral requirements. In the event the office is not informed, you will be responsible for any charges denied by your insurance.
- Surgical procedures require pre-payment. You will be informed in advance of your cost estimate. This estimate is never a guarantee of payment or coverage. Payment will be due five days prior to the surgery.
- Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due to 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: _____