North TX Foot & Ankle

Ronica N. Holcombe, DPM-Todd Lewis DPM
Sara Millar DPM

1145 Kinwest Pkwy Ste 100
Irving, TX 75063
Phone 214-574-9255
Fax 214-574-9258

Welcome to North Texas Foot and Ankle!

Attached is our Patient Registration Package. Please complete these forms to help us maintain accurate contact and medical records. If you printed these forms from our website, you may fax them to us at 214-574-9258 prior to your appointment, or bring the completed original forms with you to your appointment along with the other items requested below.

We realize that you have a choice of where to be treated. We also understand and respect the great deal of trust in your physician. We want to provide you with the most up to date information and treatment options regarding your skin care health. We do appreciate and value the trust you have placed in us.

North Texas Foot and Ankle specializes in treatment of all foot and ankle disorders. Our team of board-certified doctors and trained office staff work together to meet your podiatric needs five days a week. We desire to assist you in receiving the best of what today's medicine has to offer. We are highly committed to quality patient care with an emphasis on individual attention for each patient. Providing the best service, in a comfortable, private atmosphere is extremely important to us. We assure you, we will do our best to give you total satisfaction.

We value highly the relationship with our patients. We especially value patient feedback. Therefore, we will ask you to communicate to us your experiences at our practice. Your feedback matters because it helps us continue to serve you and our other patients with the highest level of care possible. If you have any questions or concerns, please do not hesitate to ask any member of our team.

Warmest Regards,

Ronica Holcombe, DPM
Todd Lewis DPM
Sara Millar DPM
and Staff!

REMINDERS OF REQUIRED ITEMS FOR YOUR VISIT

- **Insurance Cards** If you have health insurance, we cannot see you without making a copy of your insurance card.
- **Written Referral** from your Primary Care Physician if required by your insurance plan.
- **Co-pay** or **Deductible** is collected at the time of visit
- **Cosmetic procedure fees** are due at time of visit
- **Completed Patient Registration Package**
- **Driver's License or State Issued Photo ID**

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Patients, or legal guardians of patients under the age of eighteen, MUST sign and date below before medical care can be rendered.

Release of Medical Information

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications, and prescriptions electronically to your pharmacy.

Signature _____ Date [ ]

Financial Policy

____ Payment is required for all services at the time they are rendered unless the patient is in an insurance plan with which we participate. For those patients, applicable co-payments and deductibles will be collected for services rendered. Once our office has received payment from your insurance, if for some reason insurance decides to pay your charges at a higher benefit level than what was quoted to our office at the time of service; we will then issue the patient a refund for the over payment amount or apply a credit on the account. In an effort to ensure the most accurate refund amount please be advised that our office cannot issue any refunds until all line items have been finalized by your insurance. We accept payment in the form of cash, check, and all major credit cards.

____ Patient financial responsibilities that remain unpaid could be sent to Collections. There will be a $25.00 charge plus collection fees for all charges sent. Late fee of $25.00 will also be charged for statements past 30 days

Missed Appointments

____ For appointments which are missed or cancelled with less than 24 hour notification, there may be a $25.00 missed appointment fee added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Returned Checks

____ All NSF checks will be charged a $25.00 processing fee. We will only accept cash or money orders to replace an NSF check. Your signature below signifies your understanding and willingness to comply with this policy.

Additional Fees:

____ Xrays are property of North TX Foot and Ankle. If you wish to receive copies of digital XRAYS there will be a fee assessed of $10.00.

____ Disability forms that need to be completed by our staff will incur a $15.00 fee.

____ Any self pay items returned are subject to a $5.00 restocking fee.

____ For copies of Medicals our office requires 10 days notice. There is a fee of $20.00 for up to 25 pages and $35.00 dollars any pages after that.

____ If your account is sent to collections you will be charged 33% of balance due to NTFA. This will be added to your bill.

____ Statements sent each month. There will be a $12.00 charge for each additional statement sent after the first, if there is no payment made.

____ I have read and understand the financial policy statement. I agree to make in-full prompt payment to North TX Foot and Ankle when billed for any and all charges not covered or paid by valid insurance benefits for and in consideration of services rendered. I understand I will be charged a 12.00 late fee if I don't pay my statements in a timely manner. Further, I authorize payment directly to North TX Foot and Ankle for medical insurance benefits payable to me under the terms of my policy but not to exceed the balance due for services performed for my treatments.

____ In addition to the above, if I am a Medicare patient, I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or

carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature _____ Date _____

Privacy Practices (HIPAA)

____ By signing below, I authorize North TX Foot and Ankle, and whoever may be employed or assistant in administration to administer care as is deemed necessary.

Signature _____ Date _____

Disclosure

Dr. Ronica Holcombe, a North Texas Foot and Ankle physician, also has a financial interest in Texas Orthopedic Services, a company that distributes orthopedic implants.

Texas Orthopedic Services 5148 Village Creek Drive, Ste. 400, Plano, TX 75093 972-248-3553

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1145 Kinwest Pkwy Ste. 100
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First Name: MI: Last Name:

Previous Name: Generation: Gender: ☐ Female ☐ Male Age:

Social Security Number: DOB : Email :

Home Address: City: State: Zip:

Home #: Cell #: Work #:

Preferred Language: ☐ English ☐ Spanish ☐ French ☐ Italian

Race: ☐ Native American ☐ African American ☐ Asian ☐ White ☐ Hispanic
☐ Pacific Islander ☐ Other ☐ Unreported/Refused

Referral Source: ☐ Family/Friend ☐ Insurance Provider List ☐ Internet Search
☐ Newspaper Ad ☐ Physician ☐ Top Doc
☐ Zoc Doc ☐ Yellow Pages Other:

Primary Physician: Date Last Seen: Referring Provider:

Emergency Contact: Phone Number: Relation:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Insurance Information (*It is the patient's responsibility to get any referrals. Failure to do so may result in denied claims and the patient will be responsible for all services rendered*).

Primary Insurance: Policy #: Group#:

Primary Insurance Policy Holder: Referral Required: ◯ Yes ◯ No (PT responsible to obtain referrals)

Secondary Insurance: Policy #: Group#:

Secondary Insurance Policy Holder: Referral Required: ◯ Yes ◯ No (PT responsible to obtain referrals)

Responsible Party, if different from patient information: Name:

Social Security No: DOB:

Address: City: State: Zip:

Phone #: E-mail: Relationship to Patient:

Pharmacy information: Name: Location: Phone:
City and intersection

Fax:

Patient or Responsible Party Signature of Agreement _____ Date _____

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Authorization to Leave a Voicemail

Please provide number(s) **ONLY IF** you approve us to leave **DETAILED** information related to appointments, billing, test results, diagnosis, and procedures on your voicemail.

Primary Phone _____ Secondary Phone _____

Authorization to Send an Email Message

Please provide an email address below **ONLY IF** you approve us to send **DETAILED** information regarding your appointment, billing, test results, diagnosis, and procedures in an email.

E-mail address: _____

Personal Representative Authorization for Medical Release Form

Under HIPAA requirements, we are not allowed to discuss any of your health information with anyone else without your consent.

I authorize this facility to speak to the following family members or my personal representative regarding

☐ All medical information, including but not limited to: appointments, billing, test results, diagnosis, and procedures.

☐ Only the following types of information: _____

The above medical information shall only be released to the following person(s):

1. _____ Relationship: _____ Phone number: _____
2. _____ Relationship: _____ Phone number: _____
3. _____ Relationship: _____ Phone number: _____

Authorization to Send a Text Message

Please provide a number **ONLY IF** you approve us to leave **DETAILED** information related to appointments, billing, test results, diagnosis, and procedures in a text message. _____

By signing below I understand and agree to all stated and filled in above; I also understand my rights are protected by the Privacy Act (HIPAA) and that I may request a copy of this Act at any time.

Name **(PRINTED)** _____

Signature _____

Date _____

Patient History

Date

Patient Name _____

Height: _____ Weight: _____ Shoe Size: _____ Width: _____ Occupation: _____

Type of Exercise: _____ Type of Sports: _____

My foot problem is: _____

Nature of foot problem: ☐ Sharp ☐ Dull ☐ Sharp ☐ Ache ☐ Burning Other: _____

Location of Pain: _____ Duration: _____

Reason for onset: _____

Pain Course: ☐ Comes/Goes ☐ Constant ☐ Progressive ☐ Worsening ☐ Improved

What makes the pain worse: _____

What types of treatments have you tried: _____

Was condition treated by a Doctor? ◯ Yes ◯ No Doctor Name: _____

Any other foot problems: _____

Any foot surgeries? ◯ Yes ◯ No When: _____ Where: _____

Diabetic: ◯ Yes ◯ No Insulin Dependent: ◯ Yes ◯ No Diet control: ◯ Yes ◯ No

Average sugar: _____ Date of last checkup: _____

Doctor seen for diabetes: _____ Office number: _____

Primary care Doctor: _____ Office number: _____

Social History

Do you use tobacco? ◯ Yes ◯ No Amount: _____ For: Years: _____ Months: _____

Do you drink alcohol? ◯ Yes ◯ No Amount: _____ For: Years: _____ Months: _____

Patient History

Check any known conditions you have, or had previously:

Anemia	☐	Foot / Leg Cramps	☐	Nervous Problems	☐
Arthritis	☐	Foot / Leg Injuries	☐	Polio	☐
Artificial Joints / Valves	☐	Foot / Leg Numbness	☐	Prone to Infection	☐
Asthma	☐	Foot / Skin Problems	☐	Rheumatic Fever	☐
Bleeding Disorder	☐	Gout	☐	Shortness of Breath	☐
Blood Disease	☐	Hay Fever	☐	Smoker	☐
Bunions	☐	Hepatitis	☐	Stomach Ulcer	☐
Bursitis	☐	Heart Problem	☐	Thyroid	☐
Cancer	☐	High Blood Pressure	☐	Toenail Problems	☐
Chemical Dependency	☐	High Cholesterol	☐	Tuberculosis	☐
Circulation	☐	HIV / AIDS	☐	Ulcers	☐
Depression	☐	Kidney Problems	☐	Unequal Leg Length	☐
Difficulty Healing	☐	Liver Disease	☐	Weak Ankles/Swelling	☐
Epilepsy	☐	Lower Back Problems	☐	Other Medical Problem	☐
Fainting Spells	☐	Muscular Disorders	☐	(list below)	

Please list other medical problems here:

Check any known allergies:

☐ Penicillin	☐ Aspirin	☐ Iodine
☐ Novocain	☐ Codeine	☐ Shell Fish
☐ Antibiotics	☐ Antibiotics	☐ Bee Sting
☐ Sulfa Drugs	☐ Other Medications	☐ Tape

Please list all current medications you are taking:

Please list previous surgeries or hospitalizations:

Family History

Mother: ○ Alive ○ Deceased

List her health conditions:

Father: ○ Alive ○ Deceased

List his health conditions:

Please list any other information that you may feel necessary for us to know:

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Surgery Cancellation Policy Effective 11/1/11

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At the North TX Foot and Ankle we strive to provide the best and most complete patient care. In an attempt to preserve patient care, we have a Surgery Cancellation Policy that allows us to schedule appointments for all patients. When a surgery is scheduled, that extended period of time has been set aside for you. When it is missed, that time cannot be used for surgery for another patient, or filled with appointments for patients that urgently need the care.

We request that you please give our office 24 hour notice in the event that you need to reschedule or cancel your surgery with the physician or physician assistant. This allows other patients in need of care to be scheduled in that appointment time. It also makes it possible to reschedule your appointment more efficiently. Patients failing to provide 24 hours notice that they can not make their surgery as scheduled will have a charge of $100.00 added to their account. Please note that this charge is the financial responsibility of you, the patient, and will not be paid by your insurance company. We thank you for your cooperation in this manner so that each patient can receive the treatment and medical attention that they need and deserve.

I have read and understand the Medical Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I, _____ (print name), have read, understand, and will comply with the North TX Foot and Ankle's Surgery Cancellation Policy.

_____ _____

Printed Name of the Patient | Relationship to Patient (if patient is a minor)

_____ _____

Signature of Patient or Responsible Party if a Minor | Date