Southwestern Foot & Ankle Associates, P.C.
3880 Parkwood Blvd, Suite 602
Frisco, TX 75034
Phone: 972-335-9071 Fax: 972-335-8920
Dr. Thomas H. Tran

Date:_____ Home Phone ( )_____

Patient Information (Please Print) Email: _____

Name: _____ SS/Patient ID # _____
Last Name First Name Middle Initial

Address_____ Cell Phone ( )_____

City_____State_____Zip_____

Sex ☐ M ☐ F Age_____Birthday_____ ☐ Married ☐ Widowed ☐ Single ☐ Separated ☐ Divorced

Patient Employer_____Occupation_____

Employer address_____Employer phone ( )_____

Primary Physician Name:_____Phone Number: ( ) _____

Address:_____Fax ( )_____ Email: _____

Primary Insurance:_____

Person Responsible for Account_____
Last Name First Name Middle Initial
Relation to Patient_____Birthday_____Soc. Sec. # _____

Address (If different from patient's)_____Phone ( ) _____

City_____State_____Zip _____

Person Responsible Employed by _____Occupation_____Bus. Phone ( )_____

Business Address_____City_____Zip Code _____Insurance Name_____

Contact # ( )_____Group #_____Subscriber #_____

Additional Insurance:_____Is Patient covered by additional Insurance? ☐ Yes ☐ No

Subscriber name_____Relation to Patient_____Birthday_____

Address (If difference from patient's)_____

City _____State _____Zip _____

Subscriber Employed by _____Business Phone ( )_____

Insurance Company _____Soc. Sec. # _____

Contract # _____Group # _____Subscriber # _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with_____
Name of Insurance company (ies)
and assign directly to Dr. Thomas H. Tran all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named physician may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Guardian or Personal Representative Date

_____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to patient

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Patient Financial Responsibility Statement

In order to maintain our fees at the lowest possible level, it is important that we have a good understanding with our patients regarding financial responsibility. We hope that this summary will be helpful toward the end.

We understand that your health coverage is provided through _____.

It is your responsibility to get any referrals from your primary care doctors if you are enrolling with HMO (Health Maintenance Organization) insurance carrier before seeing the doctor, otherwise you will be responsible for the full payment at the time of service for your visit and all associated charges.

You must pay any co-payment and applicable deductible amounts at time of service.

Cash paid patients are responsible for the full payment at the time of service.

There will be a $35.00 service fee charge for a returned check.

Copy of patient's medical records requires a $ 25.00 fees. Copy of patient's X-ray requires $ 50.00 fees. These fees must be paid BEFORE the copy is made. Please allow 7 to 10 business days for completion.

I authorize the practice to submit durable medical equipments (e.g. Ankle Foot Orthoses, Orthotics, Walking Boots, Diabetic Shoes) as medically necessary to my medical insurance.

There will be **NO REFUND** or **RETURN/EXCHANGE** on the customized Ankle Foot Orthoses (AFO), Orthotics, and Dr. Comfort Shoes.

Although, benefits may be verified at the time of service, any payment collected may not reflect the full patient responsibility. Please understand that financial responsibility for medical services rests between you and your health plan. While we are pleased to be of service by filling your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies this claim, you will then become responsible for this bill. It is your responsibility as the patient to pay the denied amounts in full.

Our primary mission is to provide you with quality, cost effective, medical cares. Together we are trying to adapt to the changing way that health care is financed and delivered. Again, we value you as a patient and our priority is to provide you with the best possible cares. We are please to welcome you to our practice.

Attorney's Fees and Costs of Collection: Patient shall reimburse the Doctor on demand for any court costs, attorney's fees, fees of collection agents, and related costs and expenses incurred in collection and attempting to collect any amounts due from Patient hereunder.

I have read and understand my obligations and I acknowledge that I am fully responsible for payment of any service not covered by my insurance carrier.

_____

Patient/Legal Guardian Signature Date

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Podiatry Consent Form

PATIENT NAME: _____

SOCIAL SECURITY #: _____ **DATE OF BIRTH:** _____

PATIENT AND/OR LEGAL GUARDIAN MUST REVIEW AND COMPLETE THE FOLLOWING INFORMATION

I hereby give consent to **Southwestern Foot & Ankle Associates, P.C.** and its medical staffs to examine, treat, and perform such procedures as they deem necessary for treatment of the above named person. I also give permission for medical information obtained by **Southwestern Foot & Ankle Associates, P.C.** to be released to other health care facilities if necessary for medical referral purposes.

I authorize the release of any medical information needed in order to process this claim and request payment of Medicare/Medicaid (or any other third party reimbursement, public or private) for which I may be eligible. Benefits are payable to the physician or supplier requesting payment of this claim. I agree to pay any co-payment, deductible, or any other charges for services rendered not covered by my insurance benefits.

Attorney's Fees and Costs of Collection: Patient shall reimburse the Doctor on demand for any court costs, attorney's fees, fees of collection agents, and related costs and expenses incurred in collection and attempting to collect any amounts due from Patient hereunder.

I have read and /or had explained to me the above information. My signature below indicates my agreement.

☐ There was **NO** accident involved on today's visit.

The incident/accident took place at: _____

The date of the incident/accident happened: _____

_____ _____
Signature of Patient or Legal Guardian Date of Service

_____
Relationship to Patient

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PATIENT HISTORY

Patient Name:_____ **Date**:_____

Chief Complaint: _____

Past Medical History: _____

_____

_____

_____

_____

Past Surgical History:_____

_____

_____

Medicines:_____ **Dosages**:_____

_____

_____

_____

_____

_____

_____

Allergies:_____

_____

_____

_____

Family History:

[ ] Diabetes	[ ] Heart Disease	[ ] Hypertension	[ ] Atherosclerosis
[ ] Arthritis	[ ] Tuberculosis	[ ] Cancer	

Social History:

Tobacco_____ Alcohol_____ Drugs _____ Pregnancy (if female age12-50)_____

Marital Status_____Occupation_____ Body Habits _____

Shoes Size:_____ Weight: _____ Height:_____

Vital signs (sitting):_____

Patient's signature:_____

MEDICAL HISTORY REVIEW OF SYSTEMS

Patient's Name:_____ **Date**: _____

Please check any of the following that currently apply to you:

Constitutional:
[] Fever [] Head injury [] Dizziness

Eyes:
[] Glasses [] Glaucoma [] Cataracts [] Double/blurred vision

Ear/Nose/Mouth/Throat:
[] Loss of balance [] Ringing in ears [] Poor hearing [] Nasal surgery [] Nose bleeds
[] Mouth sores [] Dry mouth [] Sore throat [] Difficulty swallowing

Cardiovascular:
[] Shortness breath [] High blood pressure [] Varicose veins [] Chest pain [] Leg pain
[] Palpitations [] Irregular heartbeat [] Peripheral vascular disease

Respiratory:
[] Shortness of breath [] On exertion [] Lying down [] Cough up blood [] Appetite loss
[] Bloody spit [] Chills [] Night sweats [] Weight loss [] Anorexia
[] Productive, prolonged cough [] Fever of unknown origin

Gastrointestinal:
[] Nausea [] Vomiting [] Heart burn [] Stomach pain [] hepatitis
[] Gallbladder disease [] Hernia type _____ [] Unexplained weight loss/gain

Genitourinary:
[] Incontinence [] Reduced urine flow [] Blood in urine [] Kidney disease
[] Burning during urination [] Sexually transmitted disease
[] change in the number of times you have to urinate at night

Bones/Muscles:
[] Arthritis [] Gout [] Muscle weakness [] Paralysis
[] Unsteady on your feet [] Difficulty walking/standing/sitting

Skin/breast (men too):
[] Rash [] Unexplained bruises [] Lumps [] Breast pain
[] Nipple discharge [] Change in contour [] Open sores? Where _____

Neurological:
[] Seizures [] Loss of sensation [] Tingling [] Numbness [] Tremors

Psychological:
[] Mood swings [] Unusually stressed [] Depressed [] Memory loss [] Anxiety

Endocrine:
[] Unusually tired [] Recent hair loss [] Hormone medicine [] Change I hair color/texture
[] Unexplained weight loss [] Recent intolerance for cold or heat [] Unusually hungry or thirsty

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Patient's Emergency Contact Information

Emergency contact Person # 1: _____ Relationship to patient: _____

Home Address: _____
Street City State Zip

Home Phone: (_____)_____ Work Phone: (_____) _____ Cell Phone: (_____) _____
Area Code Area Code Area Code

Emergency contact Person # 2: _____ Relationship to patient: _____

Home Address: _____
Street City State Zip

Home Phone: (_____)_____ Work Phone: (_____) _____ Cell Phone: (_____) _____
Area Code Area Code Area Code

Emergency contact Person # 3: _____ Relationship to patient: _____

Home Address: _____
Street City State Zip

Home Phone: (_____)____ Work Phone: (_____) _____ Cell Phone: (_____) _____
Area Code Area Code Area Code

Home Health Agency Name (if any): _____

Home Health Agency Address: _____
Street City State Zip

Home Health Agency Phone number: (_____) _____ Fax (_____)_____

Cancellation, Medical Record/X-ray copy, Disability & Family leaves of absence paper Policy

All appointments must be cancelled at least 24 hours in advance. You will be charged for appointment not cancelled at least 24 hours in advance. Insurance companies do not cover this expense. This will be the sole responsibility of the patient. Copy of Patient's medical records requires **$ 25.00** fees, and copy of X-rays requires **$50.00** fees which must be paid before the copies are made. Please allow 7-10 working days for completion.
Disability & family leaves of absence paper requires **$25.00** fees that must be paid before the copies are made. Please allow 7-10 working days for completion.

HIPAA Authorization

Please Check all that apply.

☐ I authorize Southwestern Foot & Ankle Associates, P.C. to use the contact information, phone numbers and email address listed on the front of this form to discuss or disclose information regarding any matters relating any matters relating to my appointments, insurance, physician referral information, and lab results.

☐ I authorize Southwestern Foot & Ankle Associates, P.C. to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, insurance, physician referral information, and lab results.

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

I acknowledge receipt of this Notice of Privacy Rights that I have reviewed and give permission to Southwestern Foot & Ankle Associates, P.C. to use and disclose my health information in accordance to it.

_____ _____ _____
Date Print Name Patient, Responsible Party or Guardians Signature