David Haddad DPM
2001 N. Collins Blvd Ste#103
Richardson, TX 75080 972-690-5374

PATIENT DEMOGRAPHICS

First Name: _____ M.I. _____ Last Name: _____

Street Address: _____ City: _____ State: ____Zip code: _____

Patient DOB: ____/____/____Driver's License: _____State: _____Social Security #: _____

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

E-Mail Address: _____ Preferred Name: _____

Do you have an Advanced Directive: □ Yes □ No (someone designated to act on your behalf, in the event of incapacity)

Emergency Contact: _____ Relationship to Patient: _____

Cell Phone Number: (____) _____ Alternate Phone Number: (____) _____

Gender □ F □ M Marital Status □ Married □ Divorced □ Separated □ Single □ Widowed 1st Lang. □ Engl. □ Other

Pharmacy Name: _____ Phone#: _____

Pharmacy Address: _____

Primary Care Physician Name and Phone#: _____

Employed □ PT □ FT □ Retired □ Employer Name: _____

How did you hear about our practice? □ Internet (Source_____) □ Friend/Family Member: _____

INSURANCE INFORMATION

PRIMARY

Insurance Company: _____ Insurance ID Number: _____
Group Number: _____ Primary Subscriber Name: _____
Primary Subscriber Birth Date: _____ Relationship to Patient: _____

SECONDARY

Insurance Company: _____ Insurance ID Number: _____
Group Number: _____ Secondary Subscriber Name: _____
Secondary Subscriber Birth Date: _____ Relationship to Patient: _____
Financially Responsible Person if not Patient: First Name: _____ Last Name: _____

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NOTICE OF PATIENT FINANCIAL POLICY

We make every effort to coordinate with you and your insurance company regarding claims and reimbursement, it is your responsibility to understand your insurance coverage and the extent of that coverage. Insurance companies are obligated to you and not to our office. Together, we can make sure that you receive the best care possible under your insurance company guidelines and policies.

_____ (Initial) I understand that it is my responsibility to know and understand my insurance coverage.
_____ (Initial) I understand that specialist co-pays (which may be different than my Primary Care Benefits), deductibles and coinsurance are due prior to services being rendered. I understand that this is a contractual agreement with my health plan to collect co-pays and deductibles at the time of service. I understand that once the claims have been adjudicated by my insurance company, there is a possibility that I may end up receiving a balance statement or a credit.
_____ (Initial) I understand that all health plans are not the same and do not cover the same services. If my health plan determines that a service is "not covered" or that there is an exclusion on my plan, or if my plan required a referral that I did not obtain prior to being seen, I am responsible for charges for any services rendered. *Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
_____ (Initial) I understand that Nail trimming, Callus shaving and Corn removal may not be covered or billed to my insurance and and is a self-pay service of $50.00.
_____ (Initial) I understand that my insurance company may request information from me before processing a claim. It is my responsibility to comply with their request. Failure to comply may result in denial of my claim. I will be responsible for all charges incurred.
_____ (Initial) I understand that I am responsible for all insurance referrals needed to seek treatment in this office, if I have an HMO or referral required plan.
_____ (Initial) Private-Pay Patients: If you do not have insurance or we do not accept your insurance we do offer a private-pay rate for our services. The private-pay discount is the same for every patient and will not be discounted further. Payment is due at the time the services are rendered.
_____ (Initial) I understand that it is my responsibility to inform Richardson Podiatry of ANY insurance changes and authorization/referral requirements at the time of appointment. If Richardson Podiatry is not informed, I will be responsible for any charges denied.
_____ (Initial) There are **no refunds** for supplies purchased in the office, such as Orthotics and all over the counter products. Unfortunately, not every supply prescribed works for all patients, but we strive to ensure we make every effort to have a satisfactory outcome.
_____ (Initial) I understand that I will be billed for any amounts due by me (co-payments / co-insurance amounts / deductibles) and that I have a financial responsibility to pay these amounts. (We strive to accurately quote your out-of-pocket costs, but sometimes your plan processes the claim differently. The quote that we provide is not a guarantee of payment but an approximate estimate of your out of pocket due**).** I understand that I will be provided with three (3) statements for any balance due after insurance payment. I further understand that if I have not made payment within 30 days of the third statement being mailed, my account will be sent to collections.
_____ (Initial) 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 my responsibility in addition to the balance due to Richardson Podiatry.
_____ (Initial) I understand that if I present an insufficient funds check (NSF check) for payment on my account, I will be charged a **$35 NSF** fee. I further understand that to rectify my account, I will be required to pay with either cash, a money order, cashier's check, or credit card.
_____ (Initial) I understand that there is a **$30 fee** to complete disability paperwork (FMLA). If additional disability forms require completion, I understand that an additional $30 fee (payable prior to compilation) is required.
_____ (Initial) I understand that I need to cancel my appointment **48 hours** prior to my scheduled appointment time, or I will be charged a fee of **$ 50.00** for a same day cancellation or no-show fee.
_____ (Initial) I understand that I need to cancel my scheduled surgery **72 hours** prior to my scheduled surgery date to avoid a **$150.00** surgery cancellation fee.
_____ (Initial) I consent _____or do not consent ____ and authorize Richardson Podiatry to use clinical photographs and videos for educational or promotional purposes.

It is our goal to partner with you in your care and financial obligations to our office. We will make every attempt to assist you to ensure that we not only provide excellent customer service, but to ensure that your plan processes your claims according to your policy guidelines. If you have any additional questions, please contact the Practice Manager.

Patient's Name (Print): _____ Signature Patient/Guardian: _____

Signature of Responsible Party: _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date of Birth: _____/_____/_____), Today's Date: _____

The Notice of Privacy Practices (NPP)contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information according to the Health Information Portability and Accountability Act (HIPAA).

Uses and Disclosures of Health Information. We will use and disclose your health information to treat you or to assist other health care providers in treating you. We will also use and disclose your health information to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care.
- For certain limited research purposes.
- For purposes of public health and safety.
- To Government agencies for purposes of their audits, investigations and other oversight activities.
- To Government authorities to prevent child abuse or domestic violence.
- To the FDA to report product defects or incidents.
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders.
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.
- To a collection agency and may provide protected health information to that agency in the event you do not satisfy your financial responsibilities.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information.
- To receive an accounting of certain disclosures we have made regarding your health information.
- To request restrictions as to how your health information is used or disclosed.
- To request that we communicate with you in confidence; • To request that we amend your health information.
- To receive notice of our privacy practices.

I, _____ (Print Name of Patient or Legal Representative), acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read and understood the Notice. This authorization may be revoked by me at any time in writing. If I have a question, concern or complaint regarding our privacy practices, I understand that I can contact the office at (972) 690-5374 and speak to the Practice Manager.

In addition, I authorize the following people access to my personal health information upon request (including leaving a detailed message): Name/Relationship/Phone: _____

Signature of Patient or Legal Representative: _____ Date: _____

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COMPREHENSIVE HEALTH REVIEW

Patient Name: _____ Date of Birth: _____ Today's Date: _____

HISTORY OF PRESENT ILLNESS

What is your specific foot/ankle problem? _____

When did the problem begin? _____

Which foot/ankle is involved? □Right □Left □Both

The problem is: □Improving □Worsening □Unchanged

First visit to a doctor for this problem? □ Yes □No

What aggravates the problem? _____

Have you had a similar problem in the past? □ Yes □No

What improves the problem? _____

How was the problem onset? □ Sudden □ Gradual

Is the problem painful? □Yes □No

The problem is worst: □AM □PM □At Rest □With Activity

If so, rate your current pain: (none) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Describe the pain:

□Sharp □Burning □ Clicking □Aching □Throbbing □Tingling

□Dull □Shooting □Cramping □Itching □Popping □Stabbing □Other: _____

Describe previous treatments: _____

Is this from an injury? □Yes □No If so, is it work-related? □Yes □No Describe: _____

PAST MEDICAL HISTORY

Are you diabetic? □Yes □ No If yes, name of physician managing diabetes _____ Date last seen _____

□Diabetes: Type □1 □2
Duration: ____ years
Last Blood Sugar _____ HbA1c ___

Have you been treated for or have a history of any of the conditions below:

□**None of these**	□Warts	□Foot/Leg Ulcer	□Liver Disease (Hepatitis)	□Stroke
□Corns/Callouses	□Neuroma	□ Heart Disease/Heart Attack	□Lower back pain	□Thyroid Condition (□Hi □Lo)
□Broken Bones in Foot	□Blood Clot/DVT	□Arch Pain	□Lung Condition	□Seizure Disorder/Epilepsy
□Gout	□Cancer Type_____	□High Cholesterol	□Hepatitis	□Sickle Cell Disease/Trait
□Cramps in Leg/Feet	□Cellulitis/Skin Infection	□Arthritis (Osteo / Rheum)	□Psychiatric Disorder/Depressior	□ High/Low Blood Pressure
□Hammer/Mallet Toes	□Ankle Fracture o sprain	□Bunions	□Neuropathy Type: _____	□Osteomyelitis/Bone Infection
□Fungal Nails	□Excessive/Easy Bleeding	□Kidney Disease (Dialysis)	□Charcot	□Pulmonary Embolism
□Leg Cramps/Leg Pain at Rest	□Gait/Ambulatory issues		□Poor Circulation	□Anemia

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PAST SURGERIES

□Foot/Ankle Surgery:
_____
□Joint Replacement: _____
□Open Heart/Bypass Surgery
□Hysterectomy: □Tubal ligation
□C-Section
□Stent Placement: □Heart □Leg
□Cosmetic Surgery: _____
□Appendix □Gallbladder □Tonsils/Adenoids
□Leg Bypass □Open Fracture Repair
□Carotid Surgery □Vein Surgery
□Hernia repair □Thyroid □Back surgery
□Other: _____
□**None**

FAMILY HISTORY

Mother •Father •Sister •Brother •Grandparent

Cancer □M □F □S □B □GP
Diabetes □M □F □S □B □GP
Gout □M □F □S □B □GP
Heart Disease □M □F □S □B □GP
High Blood Pressure □M □F □S □B □GP
Chronic Arthritis □M □F □S □B □GP
Anesthesia Complications □M □F □S □B □GP
Foot Problems □M □F □S □B □GP
Other: _____ □M □F □S □B □GP

_____□M □F □S □B □GP

_____□M □F □S □B □GP

Do you have Vascular Grafts?_____ Do You have joint implants? _____ Slow healing? _____

Do you have replacement Heart Valves? _____ Do you have a pacemaker? _____

Are you under chemotherapy? _____ Have you been tested for HIV/AIDS? _____ Date: _____Result: _____

Are you currently pregnant? _____ Abnormal Bleeding issues? _____ Malignant Hyperthermia? _____

SOCIAL HISTORY

Occupation: _____ I Stand _____ % of My Day
□I Drink Alcoholic Beverages How much/often? _____ I Exercise Each Week: □ 0 days □ 1-2 days □ 3+ days
□I Use or Have Used Tobacco Products Type: _____Packs/Day _____ Years _____ When stopped? _____
List Sports/Activities: _____ □ My foot/ankle problem limits my activities
□ I Use or Have Used Drugs that are Illegal_____
I Live With: □No One □Spouse □Children □Parents □Other

ALLERGIES

□None □Adhesives/Tape □Aspirin □Codeine □Cor sone □Sulfa Drugs □Iodine □Latex □ Local Anesthesia □Penicillin
□Seafood/Shellfish

STATISTICS
Age _____ Height _____ Weight _____ Shoe Size _____

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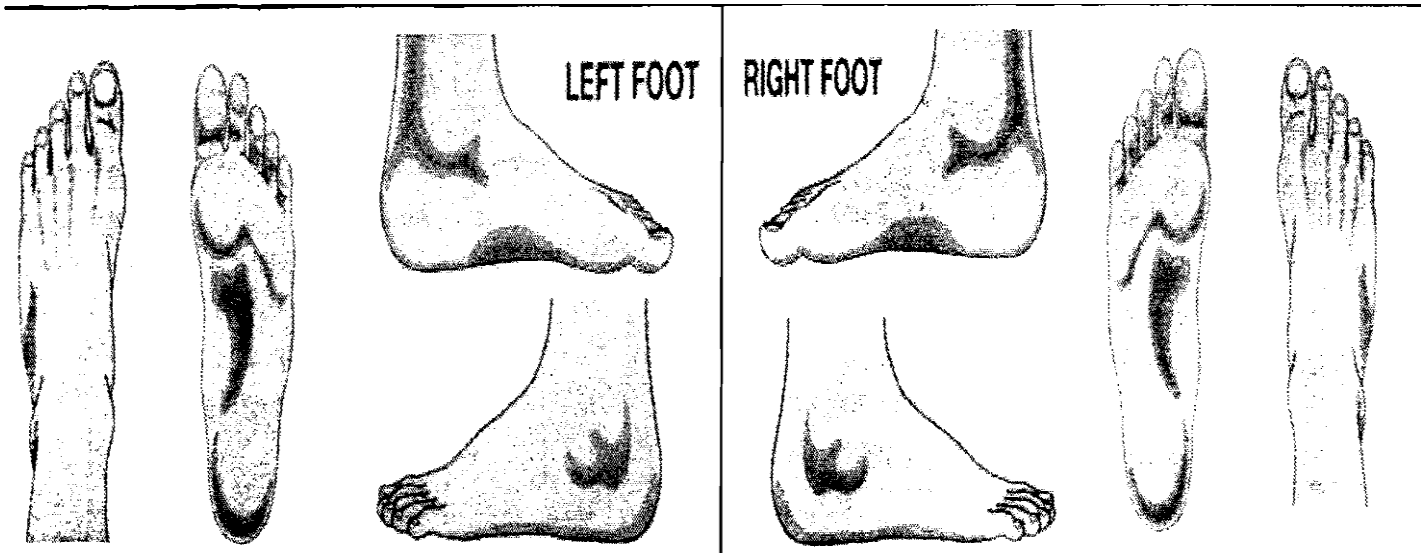
MEDICATIONS (include RX meds, OTC meds, and vitamins)

Medication	Dosage	Medications	Dosage	Other

CURRENT SYMPTOMS: Please mark areas of discomfort on the diagrams below that are related to your visit.



When did the pain or symptoms begin: _____.

Describe the problem: _____.

Accident Related: Yes/ No Work Related: Yes/ No Sports Related: Yes/ No

The pain is worse when walking_____ and/or when at rest_____.

Previous medical treatment or home remedies: _____.

Does any type of modalities or treatment help with the discomfort? _____.

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CURRENT SYMPTOMS CONTINUE:

Do you currently wear Orthotics or shoe inserts? Yes/ No Have you previously worn them? Yes/ No

Did they help? Yes/ No Percent of hours spent on your feet? _____.

Do you get leg cramps? Yes/ No At night? Yes/ No

Does foot pain limit your desired activities? Yes/ No Do you have pain in calves or buttocks when walking? Yes/ No

Is the pain relieved by stopping or standing still? Yes/ No Do you have difficulty walking? Yes/ No

Please list the sports or activities you participate in: _____.

SIGNATURE ON FILE AND PERMISSION TO TREAT

The above information is true to the best of my knowledge. I consent to care and treatment that may be prescribed by David Haddad DPM, Richardson Podiatry and its staff under standard of care and best practices. I certify that I have disclosed the most accurate insurance information available at the time of service and assign benefits directly to Richardson Podiatry, that may be otherwise payable to me for service(s) rendered. I understand that insurance is filed as a courtesy, and it is my responsibility to be fully informed of my plan benefits and that I am financially responsible for all charges whether paid by my insurance or denied due to policy guidelines or provisions. I authorize the use of my signature below on all insurance submissions. I further authorize Richardson Podiatry and its staff to use my health care information and may disclose medical records to my insurance company and their agents for the purpose of obtaining payment for services, determining eligibility or benefits, and appealing denied services until fully adjudicated.

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Patient's Name (Print): _____

Signature Patient/Guardian: _____ Date: _____

Signature of Responsible Party _____ Date: _____

Relationship (if not Patient): _____