LOUETTA FOOT AND ANKLE SPECIALISTS, P.A.

Brad Bachmann, D.P.M Michelle Stern, D.P.M. Amy Walsh, D.P.M. Tyson Fiala, D.P.M.

WELCOME TO OUR OFFICE!

(Please print / then fill out and bring to your appointment)

Patient information:

Name: ______________________________ Sex: M F

First middle last

Date of Birth: ______________ Age: ______ SS# ______________ Marital Status: S M W D

Address: ______________________________

City: ______________________ State: __________ Zip: ____________

Home#: ______________________ Cell#: ______________________

Work#: ______________________ Email: ______________________

Student status: Part-time Full-time N/A **Employment status:** Part-Time Full-Time N/A

Primary Language spoken: ☐ English ☐ Spanish ☐ Other______________

Race: ☐ White ☐ Black/African American ☐ Amer. Indian/Alaska ☐Asian ☐Other ☐Decline

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Decline

Guarantor (Person responsible for payment for MINORS ONLY)

Name: ______________________ **Relationship:**______________

Guarantor date of birth: ______________ **Guarantor Social Security#:**______________

How did you learn of our office?______________ ______________________

Full Name of Primary Care Physician: ______________________

Does this PCP treat you for diabetes? ☐**N/A** ☐Yes ☐No, if **NO** , please list physician below:

____

Name of former Podiatrist: ______________________

Emergency contact - Name: ______________________ # ______________

Pharmacy name: ______________________ **Pharm#** ______________

Address: ______________________**City/Zip code:** ______________

☐ *I PREFER WRITTEN PRESCRIPTIONS, I UNDERSTAND THAT FAILURE TO PROVIDE A PHARMACY FOR ELECTRONIC PRESCRIPTIONS MAY CAUSE A DELAY IN FUTURE NEW OR REFILL PRESCRIPTIONS.*

I have read all the information and answered to the best of my ability. I understand and agree that, regardless of insurance status, I am ultimately responsible for all services and charges incurred. I have read all information provided to me regarding health and finances and understand my responsibility as a patient. I certify that all information I have provided is true and factual. I will notify you of any changes of the above information.

______________________ ______________________ __________

Signature of Patient or Parent/Guardian Printed Name Date

MEDICAL HISTORY FORM

Name: ______________________________ DOB: _______________ Sex: M F

Age: __________ Height: __________ Weight: ________ lbs. Shoe Size: __________

Occupation: ________________________ Employer: ________________________

HISTORY OF PRESENT ILLNESS:

Reason for today's visit: ____

Date of onset/injury: _______________ Symptoms: ______________________________

Location of Symptom(s): ______________________________ RT LT Both

Circle each characteristic that best describes your problem:

QUALITY: Sharp / Dull / Throbbing / Aching / Burning / Cramping / NONE

SEVERITY: Mild / Moderate / Severe / NONE

FREQUENCY: Infrequent / Intermittent / Constant / Hourly / Daily / Weekly / NONE

TIMING: During Activity / After Activity / Walking / Running / Stairs / Other: ________ NONE

CONTEXT: Fall / Sprain / No Trauma / Other: ____________ / NONE

SYMPTOM RELIEF: Rest / Heat / Cold / Elevation / Stretching / Medication / Injection / NONE

SYMPTOM AGGRAVATION: Activity / Position Change / Repetitive Motion / Fatigue / Other / NONE

****I have experienced pain in:** ☐ Knees ☐ Lower Back ☐ Hip

Have you experienced this problem before? Yes No **Current Pain Level: _____/10**

Describe treatment (if any) and response for current problem: ______________________________

____

Have you had any diagnostic tests for this problem? Yes No if yes, what? ____________________

Has a physician recommended surgery for this problem? ______________________________

How many hours per day do you spend on your feet? ______________________________

What type of shoes do you wear daily? ______________________________

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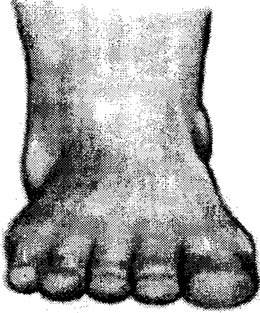
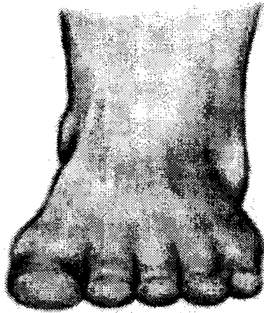
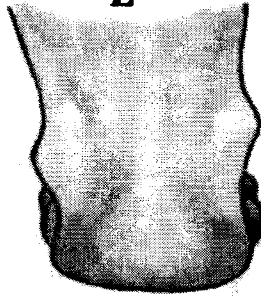
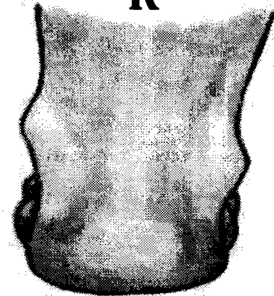
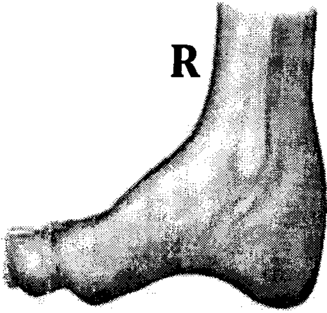
(Please place an X on the areas where you are having pain or would like to be examined)

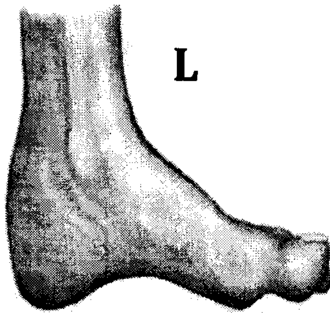


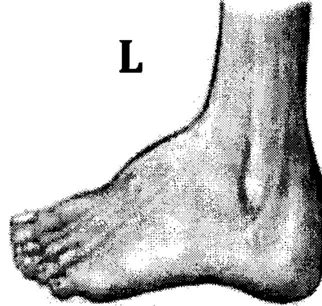


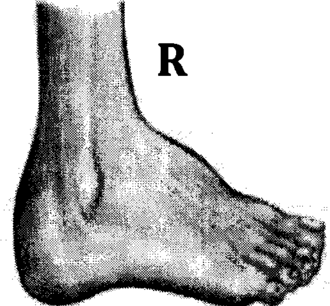


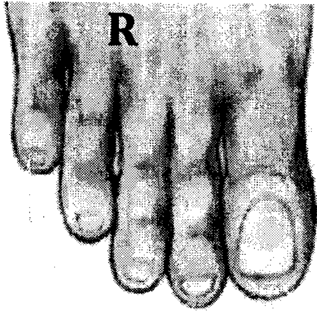


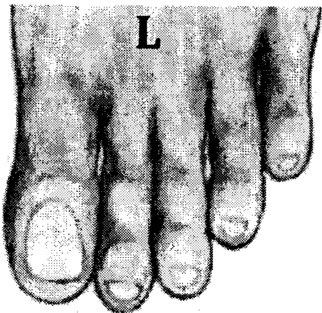












Are you or do you think you are pregnant? ☐ n/a ☐ No ☐ **Yes.... If yes, how many weeks?** ______

Has the patient received a **flu vaccination** for the **current** season? ☐Yes ☐No **Date received**: ____________

If **No**, what was the reason? _____ Patient allergy _____Patient declined_____ Vaccine unavailable

For patients 65 years or older:

Do you have a living will or someone to make decisions on your behalf? ☐N/A ☐Yes ☐No

Have you had a pneumonia vaccination? ☐N/A ☐Yes ☐No

ALLERGIES: *(medications, food, substances)* ☐ **NO KNOWN DRUG ALLERGIES**

☐Adhesive Tape ☐Codeine ☐Morphine ☐Sulfa Drugs ☐Food: __________

☐Aloe ☐Iodine ☐Novocain ☐Other: __________ ☐ Food: __________

☐Aspirin ☐Latex ☐Penicillin ☐Other: __________ ☐ Food: __________

MEDICATIONS: ☐**NONE**

(Name, dosage, how many times daily. Please include any over-the-counter Medications including vitamins)

Attach a medication list if you have more than 6 medications

1. ____________________ 4. ____________________
2. ____________________ 5. ____________________
3. ____________________ 6. ____________________

PAST SURGICAL HISTORY & HOSPITALIZATIONS: *(within 5 years)*

Procedure/Illness *Physician* *Approx. Month & Year*

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

SOCIAL HISTORY:

Tobacco/nicotine/E-cig/Vape Use: ☐Yes... cigs/times per day: ______ : ☐No, **Never** ☐No, Former Smoker

Alcohol Use: ☐Never ☐Social ☐Occasional ☐Moderate ☐ Heavy ☐Recovering Alcoholic

Exercise: ☐Moderate ☐ Never ☐Often

To the best of my knowledge, the above information is accurate and complete. I understand it is my responsibility to in my doctor if I, or my child, ever have a change in health.

____________________ ____________________ __________

Signature of Patient or Parent/Guardian Printed Name Date

REVIEW OF SYSTEMS: Are you **currently** (today) experiencing any of the following signs or symptoms? If yes, please describe:

SYMPTOMS	Yes	No	Describe all "Yes" responses
Eyes (e.g. blurred vision, double vision, loss of vision)	☐	☐	________
Ears, Nose, throat (e.g. sore throat, earache, ringing)	☐	☐	________
Cardiovascular (e.g. chest pain, palpitations, ankle swelling)	☐	☐	________
Respiratory (e.g. shortness of breath, bronchitis, asthma)	☐	☐	________
Gastrointestinal (e.g. ulcer, gastritis, GI bleed, jaundice)	☐	☐	________
Genitourinary (e.g. burning, bleeding, difficulty urinating)	☐	☐	________
Musculoskeletal (e.g. joint, muscle, back pain)	☐	☐	________
Skin (e.g. acne, psoriasis, cellulitis)	☐	☐	________
Neurological (e.g. numbness, tingling, weakness)	☐	☐	________
Mental Health (e.g. depression, anxiety, memory loss)	☐	☐	________
Endocrine (e.g. weight loss/gain, excess thirst/urination)	☐	☐	________
Hematologic (e.g. bleeding/clotting disorder, anemia)	☐	☐	________

PAST MEDICAL and FAMILY HISTORY:

Have your or an immediate family relative **(Mother, Father, Sister, Brother ONLY)** been diagnosed with any of the following? **Please circle applicable disease/condition**

DISEASE / CONDITION	**SELF**	**FAMILY**	**Family Member**
Anemia/Sickle Cell Anemia	☐	☐	________
Angina/ Heart Attack / Cardiomyopathy	☐	☐	________
Arthritis/Osteoporosis	☐	☐	________
Asthma/ COPD / Emphysema	☐	☐	________
Bleeding/Clotting Disorder	☐	☐	________
Cancer	☐	☐	________
Diabetes Mellitus	☐	☐	________
GERD/ Ulcers/ Colitis	☐	☐	________
Hepatitis/Liver/Gall Bladder	☐	☐	________
High Blood Pressure	☐	☐	________
High Cholesterol	☐	☐	________
HIV/AIDS	☐	☐	________
Kidney failure/Stones	☐	☐	________
Psoriasis/Eczema	☐	☐	________
Psychiatric/ mental Disorder	☐	☐	________
Stroke / TIA / Seizures	☐	☐	________
Thyroid/Endocrine Problem	☐	☐	________
Tuberculosis	☐	☐	________

~ PLEASE READ THIS DOCUMENT IN FULL BEFORE SIGNING & INITIALING ~

Cancellation/Missed Appointment Policy: Our goal is to provide quality medical care in a timely manner. In order to do so, we have to implement an appointment/cancellation policy. This policy enables us to better utilize available appointments for our patients need of medical care.

Cancellation of an appointment: In order to be respectful of the medical needs of other patients, please be courteous and call Louetta Foot & Ankle promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least **24 hours** in advance, and calling early in the day is appreciated. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care. **(_________INITIAL)**

How to cancel your appointment: To cancel appointments, please call **281-370-0648 or 281-351-5599**. If you do not reach the receptionist, you may leave a detailed message with the answering service by pressing **"0"**. If you would like to reschedule your appointment, please be sure to leave us your phone number and let us know the best time to return your call. **(_________INITIAL)**

Late cancellations:
Late cancellations will be considered as a "no-show" or missed appointment. **(_________INITIAL)**

"No-show" Policy: A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. "No-shows" inconvenience those individuals who need access to medical care in a timely manner. A failure to be present at the time of a scheduled appointment will be recorded in the patients chart as a **"missed appointment"** and will result in a **fee of $50** billed to the patients account. By signing below, I acknowledge that I am responsible for the $50 fee if I fail to meet my appointments. **(_________INITIAL)**

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the physician and I am financially responsible for non-covered services and supplies. I also authorize the physicians to release any information required to process my claims. **(_________INITIAL)**

***As a courtesy, our office will verify your benefits prior to your appointment. This is not a guarantee of benefits or coverage. It will be your responsibility to follow up with your insurance company directly if your claim is processed differently then you expected. You will be financially responsible for all charges.* (_______INITIAL)**

Durable Medical Equipment/supply policy: Because of the inability to consistently get reimbursed for supplies (walking boots, surgical shoes, ankle braces etc.) we will **NOT** file claims for any durable medical supplies with your insurance company. You have the option to purchase these items from other sources (other distributors or local DME distributors.) If you DO receive durable medical equipment at the time of treatment, you will be expected to pay for them in **FULL**. You may file your own claim, **HOWEVER**, we **DO NOT ACCEPT ASSIGNMENT** at any time for these items, and you will **NOT** be refunded the difference between your payment and the insurance reimbursement. **(_________INITIAL)**

Acknowledgement of Receipt of Notice of Privacy Practices: Attached to this clipboard is a laminated *office* copy of **The Notice of Privacy Practices.** If you choose to have a copy provided to you, please request from our front office staff. Otherwise, this is to acknowledge that you were provided a copy or have read the attached (or had the opportunity to read if you chose) and understood the Notice. By signing below, I acknowledge that I have read and understood the above statements.

______________________________________ ______________

Printed Patient Name Date

______________________________ ______________________________________

Printed Parent or Authorized Representative Signature of Patient or Parent/Authorized Representative

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PATIENT AUTHORIZATION FOR CONTACT & DISCLOSURE OF PHI

I (we) the undersigned patient and/or responsible party hereby authorize this office, its agents/employees to release and disclose all or part of the patients' medical records to any entity, which is, or may be liable for all or part of the provider charges.

I (we) authorize the release and disclosure or any and all medical records to any other entity including by not limited to primary care physicians, referring physicians, hospitals or other health care providers which may be of assistance in the opinion of this office, in providing for the treatment of patient.

I (we) authorize the release of my x-rays, labs and medical results to be left on my voicemail if I am unavailable.
☐Yes ☐No

I (we) the undersigned patient and/or responsible party hereby authorize this office to release medical, billing and appointment information to the following family members in lieu of myself:

	Name	Relationship	Date	Initial
1.				
2.				
3.				
4.				

☐ I <u>DO NOT</u> WISH TO GRANT AUTHORIZATION OF ANY OF MY INFORMATION TO ANY FAMILY MEMBERS/PERSONAL REPRESENTATIVES.

Expiration or termination of authorization – This authorization will remain in effect until terminated by patient's personal representative, or another individual of legal entity authorized to do so by court order or law.

Right to revoke or terminate – As stated in our Notice of Privacy practices, you have the right to revoke or terminate authorization by submitting a written request to our Privacy Manager.

I understand that I may review the disclosed information by contacting Louetta Foot and Ankle Specialists.

____

Patient name (print) Signature of Patient or Parent/Guardian Date

PRESCRIPTIVE PRACTICES NOTICE

You are receiving this letter as notification of our prescriptive practices and compliance monitoring program regarding Schedule II medications.

The Drug Enforcement Administration (DEA) published a final rule of scheduling hydrocodone combination products from Schedule III to Schedule II on August 22, 2014. This rule will go into effect *October 6, 2014*. This ruling greatly restricts the ability of providers to prescribe hydrocodone products (Lortab, Norco, and Vicodin). This ruling will change our ability to prescribe hydrocodone products and provide refills. We have no control over many of the changes our practice is required to make that may unfortunately affect your postoperative care.

The DEA also strongly recommends the institution of a drug compliance program to ensure adequate protection of our patient's health and decrease drug related mortality.

The following changes will be put into effect in our practice due to the increased restrictions that accompany this schedule change:

- Schedule II medications (Norco, Vicodin, Lortab, Percocet) prescriptions must be written on an official prescription form. This means that we will no longer be able to call in prescriptions for this medication. The prescription must be physically picked up from our office.

- **We cannot legally provide phone refills on hydrocodone/oxycodone prescriptions.** Patients will be prescribed an adequate supply according to a schedule that will last until their next appointment. No refills will be given between appointments. If a refill is needed an appointment must be made Monday through Friday.

- **No "last minute" appointments for refills will be made on Fridays, no exceptions will be made.**

- If your prescription is lost or stolen, we will be unable to provide you with another prescription until your next scheduled appointment.

- You should expect that narcotic based medications will not be given any longer than six weeks after your last surgery. We will continue to try and treat your pain with non-narcotic modalities after six weeks. If you believe you will require hydrocodone/oxycodone beyond six weeks, it is advised that you establish care with a chronic pain or primary care physician as soon as possible and notify our clinic that another physician will be assuming care of your pain.

- You may be required to submit a toxicology screening during appointments.

- Oral DNA samples may be required to evaluate patient susceptibility to medications.

- If you have a chronic pain physician, it is advised that you make an appointment as soon as possible, as you will not be able to receive the medication from multiple physicians. We will defer to your chronic pain physician for any postoperative narcotic prescription.

If you have questions or concerns, we will direct you to your local senator or representative.

By signing below, I acknowledge that I have read the notice, and I have had an opportunity to request a copy for my records.

____ ____________________

Signature of Patient or Patient's Authorized Representative Date