LOUETTA FOOT AND ANKLE SPECIALISTS, P.A.

Brad Bachmann, D.P.M Amy Walsh, D.P.M Vorice Batts, 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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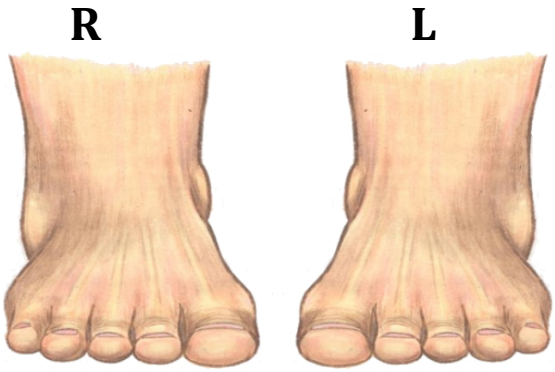
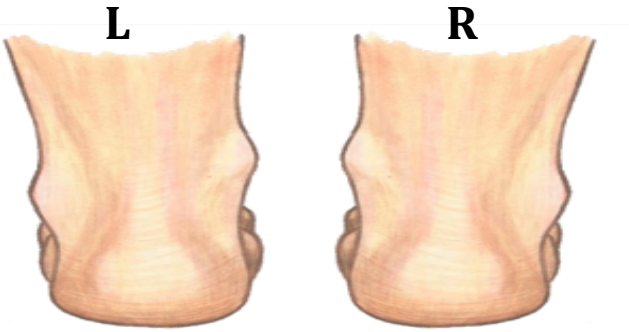
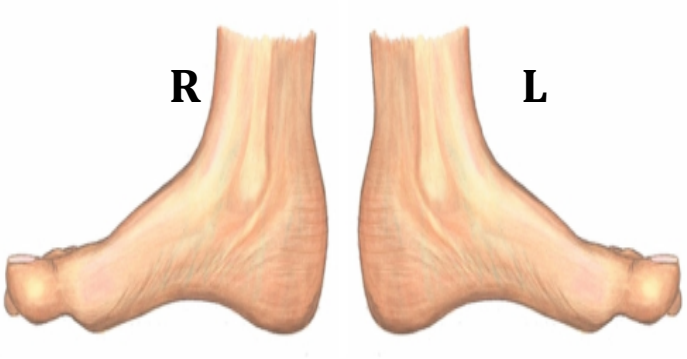
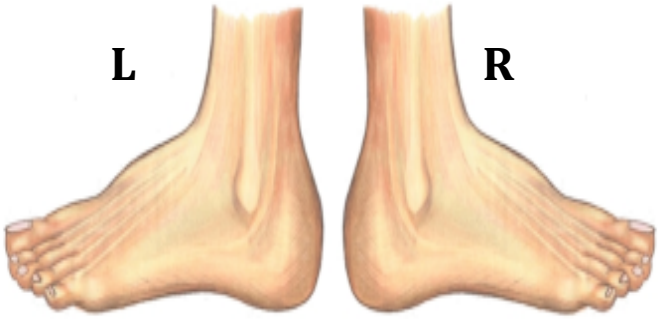
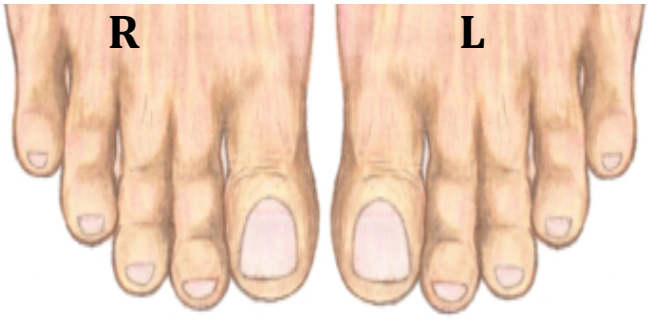
(Please place an X on the areas where you are having pain or would like to be examined)

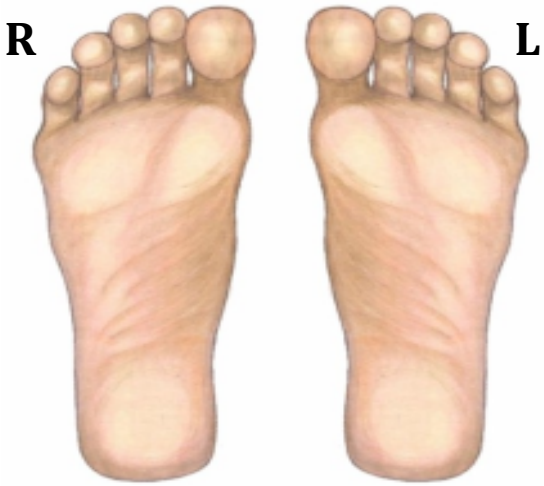












Are you or do you think you are pregnant? ☐ n/a ☐ No ☐ **Yes…. If yes, how many weeks? _____**

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 ~

Payment methods: If paying with a credit card, there will be a 2.913% service charge applied to all purchases. For your convenience, customers may avoid this extra fee by paying with cash or check**. (_____INITIAL)**

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**. 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

LOUETTA FOOT AND ANKLE SPECIALISTS, P.A.

NOTICE OF PRIVACY PRACTICES

(Please keep for your records)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect (04/14/03) and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of the Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

TREATMENT: We may use or disclose your health information to a physician, other healthcare provider or laboratory providing treatment to you.

PAYMENT: We may use and disclose your health information to obtain payment for services we provide to you. This may include contact with your health insurance plans for determination of eligibility, benefits, hospital admission and stay.

HEALTHCARE OPERATIONS: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include, but are not limited to, quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, and certification, licensing or credentialing activities. We may share your protected health information with third party business associates that perform various activities.

YOUR AUTHORIZATION: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

TO YOUR FAMILY AND FRIENDS: We must disclose your health information to you, as described in the Patient's Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

PERSONS INVOLVED IN CARE: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

MARKETING HEALTH-RELATED SERVICES: We may use your health information for marketing communications to contact you with information about treatment alternatives that may be the interest of you. We may disclose your protected health information to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further such information by telling us using the contact information listed at the end of this Notice.

RESEARCH; DEATH; ORGAN DONATION: We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

PUBLIC HEALTH AND SAFETY: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health and safety, or the health or safety of others, to a government agency authorized to oversee the health care system or programs or its contractors, and to public health authorities for public health purposes.

HEALTH OVERSIGHT: We may disclose protected health information to a health oversight agency including government agencies, benefit programs, regulatory programs and civil rights laws for activities authorized by law, such as audits, investigators, inspections.

FOOD AND DRUG ADMINISTRATION: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

CRIMINAL ACTIVITY: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, or if necessary for law enforcement authorities to identify or apprehend an individual.

REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law.

ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

NATIONAL SECURITY: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

ACCESS: You have the right to look at or get copies of your health information, with limited expectations. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month-period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

RESTRICTION: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional requests, but if we do, we will abide by our agreement (except in an emergency).

ALTERNATIVE COMMUNICATION: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means of location you request.

AMENDMENT: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

ELECTRONIC NOTICE: If you receive this Notice on our Website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Dr. Brad Bachmann

Address: 8681 Louetta Rd., Ste. 150 Spring, TX 77379 Telephone: 281-370-0648 Fax: 281-251-3350

Address: 455 School St. Suite 12 Tomball, TX 77375 Telephone: 281-351-5599