EAST TEXAS
Foot & Ankle
CENTERS

PATIENT REGISTRATION

DEMOGRAPHIC INFORMATION

Last Name: _____ First Name: _____MI: ____
Date of Birth: _____ (mm/dd/yyyy) Sex: M F Race: _____
Social Security #: _____ Ethnicity: _____
Address: _____ Address 2: _____
City: _____ State: _____ Zip: _____
Marital Status: Single ____ Married ____ Partner ____ Divorced ____ Widow ___
Pregnant ____ (Check if applicable) Nursing: ____ (Check if applicable)

CONTACT INFORMATION

Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email: _____

EMERGENCY CONTACT INFORMATION

Contact First Name: _____ Contact Last Name: _____
Contact Home Phone: _____ Contact Cell Phone: _____
Relationship to Patient: _____
Contact Address: _____

_____

PRIMARY CARE PHYSICIAN

Physician Name: _____ Practice Name: _____
Address: _____ City: _____ State: _____ Zip:_____
Last Date of Service with Primary Care Physician: _____

PHARMACY INFORMATION

Pharmacy Name: _____ Phone: _____
Pharmacy Location: _____

INSURANCE INFORMATION

Primary Ins. Name: _____ Secondary Ins. Name: _____

6603 Oak Hill Blvd.
Tyler, Texas 75703
(903) 939-3668 Office
(903) 939-0661

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CURRENT MEDICAL HISTORY

Reason for Visit with Us: _____

_____

Date of Injury: _____ Is this injury work related? Y or N

Pain Scale (Circle) 0 1 2 3 4 5 6 7 8 9 10 (worst) Location of Pain: _____

Is today the first time you have been seen for this injury? Y or N

MEDICATIONS: _____

_____

_____

ALLERGIES

_____

PREVIOUS PROCEDURES OR SURGERIES (WITHIN THE LAST 10 YEARS)

_____

_____

PAST MEDICAL HISTORY

No Known Problems ____ Cancer ____ Anxiety ____Diabetic ___ Gout ____
HIV ____ Hepatitis ____ Dementia ____ Alzheimer's ____ Asthma ____ Arthritis
____ COPD ____ CHF ____ Fibromyalgia ____ GERD ____ Liver Disease ____
MRSA infection ____ Osteoporosis ____ Kidney ____ High Cholesterol ____
Hypertension ____ Neuropathy ____ RSD/CRPS Reflex ____ Stroke ____
Swelling Legs/Feet ____ Thyroid Disorders _____ Other _____

FAMILY HISTORY

Mother _____Father_____
Daughter _____ Son _____
Brother _____Sister _____

SOCIAL HISTORY

Do you smoke? Y or N Do you use tobacco? Y or N Do you drink Alcohol? Y or N
Recreational Drug Use? Y or N

OCCUPATION: _____

JOB REQUIRES: Climbing ____ Lifting 10+ lbs. ____ Sitting ____ Standing ____
Traveling _____ Walking _____

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LIVE WITH: Spouse _____ Children ____ Roommate _____ Self _____ Other __

East Texas Foot and Ankle Centers Policies and Procedures

1. Appointments: To allow for greater access of care, our team of physicians is available by appointment during posted business hours.
2. Emergency/after hours: During a medical emergency, patients should call 911 or proceed to nearest emergency room.
3. Messages: Phone messages received before 3PPM are usually returned daily. Emails are returned less frequently.
4. Payment: ETFAC accepts CASH, CREDIT CARD (EXCLUDES CARE CREDIT), OR CASH.
5. Insurance Claims: ETFAC files claims electronically for the patient's primary contracted plan and accepts payments via the patient's assignment ETFAC only files secondary claims for Medicare patients' non-Medicare patients may request itemized statements to file to multiple carriers.
6. Insurance Network: ETFAC only files claim to carriers whom we have a contractual relationship with.
7. Referrals: ETFAC may refer patient's to other providers, facilities, and labs. ETFAC is not responsible for these entities. The patient should contact these non-ETFAV providers, facilities or labs directly regarding any billing questions. The policy holders are responsible for all insurance authorizations or managed care referrals necessary for payment to ETFAC. Compliance with provide4rs, facilities and other treatments impact patient outcomes.
8. Missed appointments: A $50 NO SHOW fee will be charged to the patient's account if appointments are broken or canceled less than 24 hours without notice.
9. Patient balance statement: ETFAC will send a reminder or balance statement to the patient when the benefits have been misrepresented by the carrier. Each statement will be assessed a $10 rebilling fee for each month that it is reissued.
10. Refund: ETFAC issues patient refunds by check within 30 days of a completed investigation of the potential overpayment as long as other outstanding accounts have been resolved.
11. Returns: ETFAC does not accept returns unless product has a manufacturer defect.
12. Medical Records: The cost for copied medical records and completion of disability forms will be charged to the patient and collected prior to replicating. The fees for these services are regulated by HIPAA and Texas health and safety code.

ATTEST

I do hereby attest that this information is true, accurate, and complete to the best of my knowledge. I understand that any falsification, omission, or concealment of any material fact may subject me to all fees for services and/or other liability. I also understand that I am to notify East Texas Foot and Ankle Centers, PA immediately of any changes to the above information.

The undersigned certifies also, that he/she has read and understandings the foregoing 1-12 statements, and is either the patient, or is duly authorized by the patient to execute the above and accepts its terms.

_____	_____	_____	_____
Print Name of Patient or Legal Rep.	**Signature**	**Relationship**	**Date**

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AUTHORIZATION FROM PATIENT OR LEGAL REPRESENTATIVE

1. CONSENT TO TREAT: the undersigned consents to any initial or follow up evaluations, examinations, x-rays, laboratory procedures, other tests, medications, medical treatment, surgery, physical therapy, home instructions, orthotics, other durable medical equipment, photographing and or videotaping and or other services rendered to the patient by ETFAC and its providers. The undersign agrees that it is their responsibility to contact and or schedule with ETFAC for any follow up visits, other services, prescriptions, and items ordered for the patient. The undersigned also understands that ETFAC's providers exercise their care with reasonable skill and diligence, but make no guarantee as to the results or cure that will attained.

2. ASSIGNMENT OF BENEFITS: I hereby irrevocably assign, transfer and convey to ETFAC and any practitioner providing care and treatment to me/my child, any and all benefits and all interest and rights (including causes of action, the right to enforce payment and the right to appeal an adverse benefit determination) to which I am entitled under an employee benefit plan sponsored by my employer, all insurance policies, benefits, any third party reimbursement, or prepaid health care plan for services rendered or products I received from ETFAC.

3. MEDICARE ASSIGNMENT: I certify that the information given by me in applying for payment under XVIII of the social security act is correct and agree to complete the Medicare screening form annually. I authorize the release of information concerning me to the Social Security Administration or its intermediaries as well as any information needed for filing a Medicare claim; I request that payment and authorized benefits be made on my behalf. I assign benefits payable to ETFAC.

4. AUTHORIZATION TO RELEASE INFORMATION: I consent and authorize ETFAC and its agents to release my health information and the payment treatment and healthcare operations

5. Designation of Authorized Representative I designate and appoint ETFAC (and it's agents) as my authorized representative and authorize it to act on my behalf to 1. Request and receive a copy of the summary plan description, 2. Pursue a benefit claim, 3. Appeal and adverse benefit determination, and or 4. File a legal equitable action to recover benefits from my employee benefit plan, insurance policy, and my third-party reimbursement to or prepaid health care plan. I with respect to an initial determination of the claim for health benefits relating to treatment and health care services received by me/my child at ETFAC, any request for documents relating to this claim and appeal of an adverse determination of the claim.

6. Financial agreement: I hereby promise that premiums for my insurance are kept current. Furthermore, I agree to pay for all products received or services rendered to me/my child to the extent I am legally responsible for such payment, copayments, deductibles, coinsurances, otc over the counter items and NCS non covered services and any other amounts that apply at the time of service or at the pre-operative appointment. Should the insurance misrepresent their coverage or delay payment of a claim greater than 45 days, as the designated responsible party, I am responsible for all of the monies owed to ETFAC. I also understand that the insurance policy is a contract between me and the insurance company; therefore, the policy holder should contact the insurance carrier first when there are questions regarding explanation of benefits.

The undersigned certifies that he/she has read and understands the foregoing statements 1-6 and is either the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms. This document shall remain in force until a written revocation by me Is delivered to ETFAC.

_____ _____ _____ _____

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