Amarillo Foot Specialists

New Patient Information

Patient Name_____ Date_____

First Middle initial Last

Address:_____ City:_____ St_____ Zip_____

Cell phone number _____ Alternative phone _____

SS#_____ Date of Birth_____ □ Male □ Female

Employer:_____ Occupation:_____

Work:#_____ Email address: _____

Marital Status □ Single □ Married □ Divorced □ Separated □ Widowed

Spouse/Parent Name_____ Phone_____ Date of Birth_____

Spouse/Parent Employer _____ Spouse/Parent SS#_____

Family Doctor's Name _____ Phone _____

In case of an emergency we need a contact that is not living in your home:

Name:_____ Relationship_____
Phone_____

Who referred you to our office? _____

Insurance information: Please provide your insurance card and referral if required. Thank you

INSURANCE:

Primary Insurance ID# _____ Group # _____

Subscriber name:_____ Subscriber Date of Birth: _____

Subscriber SS#_____

Secondary Insurance ID# _____ Group # _____

Subscriber name:_____ Subscriber Date of Birth: _____

Subscriber SS#_____

Wyatt Clinic: _____ Liability: _____

Medicare #: _____ Supplement Policy: _____

We require a photo Id to protect you from identity theft. Please be prepared to pay any copay or deductible which may apply to your visit. If your insurance should deny payment for lack of required referral or any other criteria that you, the insured, are responsible for we will expect payment from you for services. Please contact your insurance company with any questions which you may have regarding your coverage.

PATIENT INTAKE FORM

Amarillo Foot Specialists

Patient Name_____

Date of Birth_____

Podiatric History

Foot problem you are having today:_____

Have you injured your feet in the past?_____ When? _____

How?_____

Who referred you to our clinic?_____

Pharmacy Name & Address _____Pharmacy Phone_____

Medical History

Allergies to Medications: No known Allergies □

If yes, Please List:_____

Family History of Cancer if YES,who?:_____

Family History of Diabeties, if YES, who?:_____

Family History of Heart Disease, if YES, who?:_____

Alcohol Usage: Never Occasional Weekly Daily (circle one)

Tobacco Usage: Yes or No How many years? _____

Please circle all that apply:

AIDS/HIV	Diabetes	Liver Disease
Allergies to Anesthetics	Insulin/ Pill / Diet	Low Blood Pressure
Anemia	Ear Problems	Neuropathy
Arthritis	Epilepsy	Psychiatric Care
Artificial Heart Valve	Eye Problems	Radiation Treatment
Artificial Joints	Fainting	Respiratory Disease
Asthma	Foot or Leg Cramps	Rheumatic Fever
Back Problems	Gout	Shortness of Breath
Bleeding Disorders	Headaches	Sinus Problems
Cancer	Heart Disease	Stroke
Chemical Dependency	Hepatitis	Swelling of Ankles, Feet
Chest Pain	□A □B or □C	Tuberculosis
Chronic Diarrhea	High Blood Pressure	Ulcers
Circulatory Problems	Kidney Problems	Weight loss, unexplained

List Major Hospitalizations/Surgeries & Dates:

_____

_____

Please list current Medications:

_____

_____

If you have a list of medications please give to receptionist.

Signature_____

Date_____

Thank you for choosing Amarillo Foot Specialists as your foot care provider.

We are committed to provide you with quality and affordable health care.

Consent To Treatment: I hereby voluntarily consent to medical treatment, diagnostic procedures and examinations by Brandon K Holloway, DPM or Travis D Holloway, DPM, their assistants and employees. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risk of injury or even death. I acknowledge that no guarantee is or will be made to me as a result of examination or as a result of treatment by Dr. Holloway.

I authorize Dr. Holloway to release medical information to insurance companies and their representatives for the purpose of filing claims for payment or reimbursement relating to the medical treatment rendered by Dr. Holloway, I transfer and assign to Dr. Holloway all my right, title, and interest in any payment due for medical treatment and/or services under any policy of insurance including major medical and I authorize my insurance carrier(s) to pay directly to Dr. Holloway all benefits due from my insurance carrier. In consideration of medical treatment rendered by Dr. Holloway, I transfer and assign all my right, title, and interest in and to any claim or cause of action against any person or entity on account of personal injuries making the medical treatment necessary. Provided, however this assignment shall not exceed the necessary and reasonable charges of Dr. Holloway for medical treatment provided for my benefit. I certify that the information given in applying for benefits under the Social Security Act is correct and that I authorize any holder of medical or other information about me to release to the Social Security Administration or it's intermediaries or carriers any information needed for this or any related Medicare or Medicaid claim. I request the payment of authorized benefits be made on my behalf. I assign the Medicare and/or Medicaid benefits payable for physician serviced to Dr. Holloway and authorize Dr. Holloway to submit claim to Medicare and/or Medicaid for payment.

The undersigned agrees, whether signing as a patient or an agent, that in consideration of medical services and/or medical treatment rendered to the patient, he individually obligates himself to pay reasonable and necessary charges of Dr. Holloway for the medical treatment rendered.

_____ _____

Patient Signature / Legal Guardian or Authorized person to Consent for Patient — Date

_____ _____

Witness — Date

Acknowledgement of Receipt of Privacy Notice

Dr. Holloway is committed to protecting your privacy and ensuring that your health information is used and disclosed properly. Please acknowledge that you have read or received the Privacy Notice. We have posted this notice in our lobby and may provide you with a notice upon request. Please list caregivers or family members you would like us to share your healthcare information with.

1._____ 2._____

Patient Signature:_____

Financial Policy for Amarillo Foot Specialists

Amarillo Foot Specialists believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

1. **PAYMENT is expected at the time of your visit**. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company.

2. **INSURANCE:** We are participating providers with several insurance plans. We will file all of these insurance claims as a courtesy. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company requires a referral for you to see a specialists it is your responsibility to get this from your PCP before your scheduled appointment. Failure to obtain a referral will result in the rescheduling of your appointment.

If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. Due to the many different insurance products out there, our staff can not guarantee your eligibility and coverage. Be sure to check with you insurer's member benefits department about services and physicians before your appointment. Many web sites have erroneous information and are not a guarantee of coverage. You are responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim rejects for the lack of one.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

3. **RETURNED CHECKS** will incur a $30.00 service charge.

4. **ACCOUNTING PRINCIPALS** Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

5. FORMS FEES: Completing insurance forms, copying medical records, etc... Requires office staff time and time away from patient care for our doctors. We require pre-payment for completing forms, copying medical records, notarizing, or for extra written communication by the doctor. Copying fees for Medical Records is $25 for the first twenty (20) pages and $0.50 per page in excess of twenty. Amarillo Foot Specialists will have 15 business days in which to copy records before making them available for patient to pick up, and these 15 days will commence after payment for copying has been received and after patient has signed this form authorizing records' release.

6. **CANCELLATIONS OR MISSED APPOINTMENTS**: If you do not cancel your appointment at least 24 hours before, or if you no-show, we will assess you a $25 missed appointment fee.

7. **ASSIGNMENT OF INSURANCE BENEFITS**: I hereby assign, transfer, and set over directly Amarillo Foot Specialists sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said clinic. I authorize Amarillo Foot Specialists to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Amarillo Foot Specialists. I authorize Amarillo Foot Specialists to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

8. SELF PAY PATIENTS & MEDICAID PATIENTS: Amarillo Foot Specialists does not make payment arrangements or extend credit. All services are expected to be paid in full at the time of service. **Amarillo Foot Specialists is not contracted with MEDICAID, THEREFORE, IF YOU HAVE MEDICAID YOU ARE RESPONSIBLE FOR YOUR BILL AS WE WILL NOT BILL MEDICIAD.**

9. COLLECTION FEES: It is our office policy that all past due accounts be sent two statements. If payment is not made on the account, a single phone call will be made to try and resolve the account balance. If no resolution can be made, the account will be sent to the collection agency, or attorney, and possible discharge from the practice.

In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs.

10. **DIVORCED PARENTS of PATIENTS**: By signing below, the adult who signs a minor child into our practice on the day of service accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who signs in that day. Parents are responsible between themselves to communicate with each other about the treatment.

11. BILLING OFFICE: If you have questions in regard to any of your billing statements, our accounts receivable staff at (806) 322-3338

I have read and understand the Amarillo Foot Specialists financial policy and agree to be bound by its terms.

_____ _____

Signature of Patient/Legal Guardian (Guarantor if applicable) Date

_____ _____

Printed Name of Patient/Legal Guardian Date