LONE STAR FOOT & ANKLE SURGICAL ASSOCIATES

Office (830) 800 – 8478
Fax (512) 268 – 5785

PATIENT INFORMTION

Please print clearly so that we can process your information quicky and effectively.

Name (*First, Mid, Last*): _____

Date of Birth: _____ Age: _____ Gender: _____ Marital Status: S M W D

Mailing address: _____

Email: _____

Cell Number: _____ Home Number: _____ Social Security: _____

Primary Care Doctor (PCP): _____ Date last seen by PCP:_____

Primary Care Phone Number: _____ Referring Doctor: _____

Preferred Pharmacy: _____ Pharmacy Number: _____

Preferred Pharmacy Address: _____

If Student, School Name: _____ Full-Time / Part-Time

RESPONSIBLE PARTY (*if other than patient*)

Name: _____ Relationship to patient: _____

Address: _____

Employer: _____ Employer Number: _____

Employer Address: _____

Emergency Contact: _____ Phone Number: _____

PRIMARY INSURANCE INFORMATION *(must fill out all, if insurance cards are **not** provided)*

Insurance Company: _____ ID Number: _____

Group Number: _____ Payer ID: _____ Phone Number:_____

Claims Address: _____

Insured's Name: _____ Date of Birth: _____

Relationship to patient: _____ Insured's Employer: _____

SECONDARY INSURANCE INFORMATION *(must fill out all, if insurance cards are **not** provided)*

Insurance Company: _____ ID Number: _____

Group Number: _____ Payer ID: _____ Phone Number:_____

Claims Address: _____

Insured's Name: _____ Date of Birth: _____

Relationship to patient: _____ Insured's Employer: _____

Knowing your insurance coverage, benefits, and obligations is your responsibility. If the insurance company or other payer requests information about the member or patient, you are responsible for providing that information to them immediately upon request to prevent delay or denial of your claim. If you do not provide the insurance company with the information they request, and your claim is denied or rejected, you will be responsible for the entire claim balance. ***I hereby assign, transfer, and set over to Lonestar Foot and Ankle Surgical Associates, PLLC all my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization will remain valid until I revoke it by written notice.***

I understand that I am financially responsible for all charges whether they are covered by insurance.

Patient Signature: _____ Date: _____

LONE STAR
FOOT & ANKLE
SURGICAL ASSOCIATES

Office (830) 800 – 8478
Fax (512) 268 – 5785

OUR PATIENT'S BILL OF RIGHTS

As a patient and physician, ours is more than a relationship, it's a partnership.
To ensure this, we have lived by the following principles

- A patient has the right to know what his or her condition is and what trouble it is likely to cause.
- A patient has a right to have the condition explained in real terms, not medical terms.
- A patient has the right to know our qualifications and experiences.
- A patient has the right to consult other doctors without us being insulted or angry that the patient wants another opinion.
- A patient has a right to understand our fees.
- We will spend the patients' money wisely as possible. We will look for and recommend the most cost-effective way of solving our patient's problems.
- We will not recommend surgery unless the patient needs help that only surgery can provide.
- If a patient feels that we have not provided them with our best efforts, please make this known. We cannot guarantee the results of treatment, but we can guarantee you our best efforts to treat you honestly and fairly.
- If a patient has financial problems, our office is committed to making arrangements so proper, necessary care is always provided.
- Considerate, respectful care at all times and under all circumstances with recognition of your personal dignity.
- Personal and informational privacy, within the law.
- Confidentiality of records and disclosures. Except when required by law, you have the right to approve or refuse the release of records.
- The opportunity to participate in decisions involving your health care, unless contraindicated by concerns about your health.
- Impartial access to treatment regardless of race, color, sex, national origin, religion, handicap or disability.
- Know the identity and professional status of individuals providing service to you.

LONE STAR FOOT & ANKLE SURGICAL ASSOCIATES

Office (830) 800 – 8478
Fax (512) 268 – 5785

OFFICE AND COLLECTION POLICIES

Office hours: Mondays & Wednesdays: 8:00 AM – 5:00 PM, closed for lunch 12:00 PM – 1:00 PM.
We request that you make appointments for all your visits and be aware of the office hours. Our philosophy is to provide you with the highest quality care. Always bring a current list of all your medications with the exact dosages, to each office visit. We know that your time is as valuable as ours and we make every effort to keep our schedule on time. Please notify us in advance if you are unable to keep your appointment. **Appointments not canceled 24 hours in advance of the scheduled appointment time may be subject to a cancellation fee of $50 per office visit.** Extenuating circumstances will be taken into consideration. After three *No Shows* for your scheduled appointments, you will be considered non-compliant and qualify for termination from the practice. **Any outpatient surgeries scheduled that are not canceled 24 hours in advance are subject to a $250 No Show Fee**

Telephone Calls: Our staff will be happy to answer your questions about office policy and scheduling. A receptionist, however, does not answer calls before or after hours or during lunch. Medical questions will be referred to one of our experienced medical assistants or one of the doctors. During clinic, a medical assistant is NOT available to speak with but will return messages as soon as possible. Extended phone consultations or after-hours and weekend calls resulting in telephone treatment may be billed a telephone visit from $10.00-$35.00.

After Hours Calls: All routine matters should be handled during regular office hours. If you believe your situation is critical, always go to an emergency room where the physicians there can assist you. Otherwise, call our office before going to the emergency room — many problems can be handled over the telephone.

Refill Request: Please contact your pharmacy for prescription refill requests. Each request may take 24-48 hours to complete. You will be notified if an appointment is required for a medication refill. A standard 90-day follow-up is required for certain prescriptions we choose to monitor. We are NOT a liberal prescribing practice we do intensely monitor the prescriptions that we issue. Please be aware that we will delay a prescription until we feel it is safe and needed.

Privacy and Security: Lonestar Foot and Ankle Surgical Associates, PLLC, holds all information of the care and treatment of our patients in the strictest confidence. All information in the patient's medical record is maintained with the utmost care and respect to preserve privacy and confidentiality. The practice fully complies with the Federal Government's mandated HIPAA requirements and all guidelines for patient confidentiality and privacy of healthcare and financial information. As a new patient, you will be asked to review and acknowledge receipt of our Notice of HIPAA Privacy Practice that outlines the circumstances for which we can disclose protected health information without authorization. Only the patient can provide the authorization to release records necessary for the practice to disclose protected health information, for instances not related to your ongoing treatment and/or payment of claims. A patient may request a copy of their medical records in the office. We also require consent to discuss or release any information to my member of your extended family, spouse, or children.

Self-Pay: *Payment in full is* due *at the time of service if you do not have health insurance*, Lonestar Foot and Ankle Surgical Associates, PLLC, offers a prompt pay discount.

Collection Policy: *All payments are due at the time of services rendered*. Lonestar Foot and Ankle Surgical Associates, PLLC, has a legal obligation to the insurance companies they are contracted with to collect co-payments. Once a balance reaches 90 days with quality communication and/or payment arrangement, it may qualify to be transferred to a third party for further collections or other actions.

Forms: (FMLA) There will be a fee of $50.00 for any forms needing to be filled out completely by Dr. Henke or Dr. Razmara.

Sunshine ACT Disclosure: In compliance with the Sunshine Act, a provision of the Affordable Care Act, we wish to disclose that our office occasionally receives food and beverages, sample drugs and patient coupons, and promotional material from pharmaceutical vendors and/or manufacturers in conjunction with product education. We do not receive direct financial compensation from any of our vendors.

I have read and understand the office/collection policies of Lonestar Foot and Ankle Surgical Associates, PLLC

Patient Printed Name: _____ Date:_____
Patient or Guardian Signature: _____

LONE STAR FOOT & ANKLE SURGICAL ASSOCIATES

Office (830) 800 – 8478
Fax (512) 268 – 5785

AKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge I have received the office's Notice or Privacy Practices, which explains how any medical information will be used and disclosed. *This can be found on our website haysrfootdoctor.com/patient-forms-and-resources*

_____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative Date

AUTORIZATION TO RELASE ANY INFORMATION TO EXTENDED FAMILY AND/OR SPOUSE AND CHILDREN

Please think about anyone who may be calling in for information or for billing purposes. Without the name of the appearance on this form, we will **NOT** be authorized to release any information.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I, _____, authorize the above listed to receive medical information on my behalf of any medical care and/or billing details.

_____

Signature Date

PARENTAL PREAUTHORIZATION FOR MINORS

For families who have established relationships with our practice, it may be convenient to have prior authorization for medical care for children when a parent cannot be present for treatment. Please complete the following form if you want to authorize the treatment in advance.

I request and authorize Lonestar Foot and Ankle Surgical Associates, PLLC and its personnel to deliver medical care to my child listed below:

Child Name: _____ Date of Birth: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Please try and contact us regarding the health care of our child at the following number(s):

Parent Name: _____ Phone:_____

Parent Name: _____ Phone: _____

ALL MINORS UNDER THE AGE OF 18 MUST BE ACCOMPANIED BY AN AUTHORIZED ADULT

LONE STAR FOOT & ANKLE SURGICAL ASSOCIATES

Office (830) 800 – 8478
Fax (512) 268 – 5785

MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

Height: _____ft _____in Weight: _____ lbs Todays date: _____

MEDICATIONS

Please list <u>all</u> medications (including non-prescription) and supplements

☐ None ☐ List attached **If you need more space, please use the back of this pape**

Name of medication	Dose Strength	How often: (ex: 2x a day)	Name of medication	Dose Strength	How often: (ex: 2x a day)

PAST MEDICAL HISTORY

- ○ No Past Medical History
- ○ Arthritis
- ○ Degenerative
- ○ Fibromyalgia
- ○ Lupus
- ○ Rheumatoid
- ○ Osteoarthritis
- ○ Other:_____
- ○ Asthma
- ○ Blood disorder
- ○ Anemia
- ○ Clotting disorder
- ○ Leukemia
- ○ Cancer
- ○ Bladder
- ○ Breast
- ○ Cervical
- ○ Colon
- ○ Lung
- ○ Myeloma
- ○ Prostate
- ○ Skin
- ○ Other: _____
- ○ Anxiety
- ○ Depression
- ○ Circulation problems
- ○ Phlebitis
- ○ Varicose veins
- ○ Peripheral Vascular Disease
- ○ Stroke _____
- ○ Diabetes Type I
- ○ Diabetes Type II – A1C _____
- ○ Insulin dependent
- ○ Adult onset
- ○ Well controlled
- ○ Not well controlled
- ○ Ear / Eye trouble
- ○ Blurred vision
- ○ Cataracts
- ○ Glaucoma
- ○ Elevated cholesterol
- ○ Gout
- ○ Heart trouble
- ○ Atrial Fibrillation
- ○ Coronary Artery Disease
- ○ Irregular heartbeat
- ○ Mitral Valve Prolapse
- ○ Tachycardia
- ○ Herniated disc
- ○ HIV positive
- ○ Intestine Problems
- ○ Acid reflex
- ○ Crohn's Disease
- ○ Irritable bowel
- ○ Stomach ulcers
- ○ Kidney disease
- ○ Dialysis
- ○ Transplant
- ○ Liver disease
- ○ Hepatitis
- ○ Fatty liver
- ○ Transplant
- ○ Peripheral neuropathy
- ○ Prolonged bleeding
- ○ Rheumatic fever
- ○ Seizure disorder
- ○ Thyroid disorder
- ○ Tuberculosis
- ○ Other

Please list any other medical history

_____

_____

_____

LONE STAR FOOT & ANKLE SURGICAL ASSOCIATES

Office (830) 800 – 8478
Fax (512) 268 – 5785

ALLERGIES AND INTOLLERANCE

Please check (✓) if you have an allergic reaction to any of the following:

- ○ Latex
- ○ Local Anesthesia
- ○ Codeine
- ○ Iodine
- ○ Penicillin
- ○ Sulfa

Are there any medications to which you have had an allergic reaction/unpleasant side effect?

☐ Yes ☐ No Known Allergies

Name of Medication	Reaction

PAST SURGICAL HISTORY

Please check (✓) if you have had any of the following procedures and include the year it took place.

- ○ No prior surgeries
- ○ Tonsils
- ○ Appendix
- ○ Spleen
- ○ Liver
- ○ Gall bladder
- ○ Pancreas
- ○ Hernia
- ○ Hemorrhoids
- ○ Brain
- ○ Bariatric surgery
- ○ Heart angioplasty
- ○ Heart bypass
- ○ Coronary artery stent
- ○ Heart valve
- ○ Pacemaker
- ○ Leg – Angioplasty/bypass
- ○ Organ transplant

_____

- ○ Mastectomy
- ○ Pelvis laparoscopy
- ○ Bladder suspension
- ○ C-section
- ○ Tubal ligation
- ○ Prostate surgery
- ○ Vasectomy
- ○ Ovaries/Hysterectomy
- ○ Bone and Joint

_____

- ○ Neck
- ○ Back
- ○ Shoulder
- ○ Elbow
- ○ Hand
- ○ Hip/Replacement
- ○ Knee/Replacement
- ○ Ankle
- ○ Foot
- ○ Amputation
- ○ Other:

_____
_____
_____
_____

HOSPITALIZATIONS

Have you had any hospitalizations in the past year? ☐ Yes ☐ No

If yes, please provide the reason and date of hospitalization:

Date: _____ Reason:_____

Date: _____ Reason: _____

Date: _____ Reason: _____

LONE STAR FOOT & ANKLE SURGICAL ASSOCIATES

Office (830) 800 – 8478
Fax (512) 268 – 5785

FAMILY HISTORY

Please check (✓) if you have any of the following in your family history

☐ No Family Medical Problems ☐ Adopted ☐ Unknown

	Mother	Father	Sibling(s)	Aunt/Uncle	Grandparent (Maternal/Paternal)	Other
Diabetes						
Hypertension						
Heart Disease						
Mental Illness						
Cancer						
Stroke						
Obesity						
Foot Problems						

SOCIAL HISTORY

Please check (✓) all that apply

Tobacco Use	Alcohol Use	Drug Use
○ Nonsmoker ○ Former smoker Start: _____ Stop: _____ ○ Current smoker Start: _____ How often: ○ Social/Occasional _____ cigarettes per week/month _____ pack per week/month ○ Light _____ cigarettes per week/day _____ pack per week/day ○ Heavy _____ cigarettes per day/week _____ pack per day/week ○ Other: _____ How often: _____	○ No current alcohol use ○ Social alcohol use ○ Monthly or less ○ 2 – 4 times a month ○ 2 – 3 times a week ○ Daily or almost daily ○ Decline to specify How many drink(s) on a typical day ○ 1 – 2 drinks ○ 3 – 4 drinks ○ 5 – 6 drinks ○ 7 or more How often do you have 6+ drinks ○ Never ○ Monthly ○ Weekly	○ No current drug use ○ Prior history of drug use ○ Prior history of IV drug use ○ Current drug use _____ Do you smoke marijuana ○ No current marijuana use ○ Prior history of marijuana use ○ Current marijuana use Other drug use _____ _____ _____

LONE STAR FOOT & ANKLE SURGICAL ASSOCIATES

Office (830) 800 – 8478
Fax (512) 268 – 5785

REVIEW OF SYSTEMS

Please check (✓) if you are currently experiencing any of the following:

☐ No Current Medical Problems

Constitutional
- ○ Fever / chills
- ○ Recent illness
- ○ Weight loss

Cardiovascular
- ○ Chest pain
- ○ Shortness of breath
- ○ Palpitations
- ○ Cold feet
- ○ Leg cramps

Gastrointestinal
- ○ Heart burn
- ○ Bloody stool

Dermatological
- ○ Rash
- ○ Redness
- ○ Itching

Lymphatic/Hematologic
- ○ Swelling in lower extremities
- ○ Easy bruising
- ○ Poor wound healing

Musculoskeletal
- ○ Low back pain
- ○ Hip pain
- ○ Knee pain
- ○ Foot/ankle pain

Pain at its worst on a scale of 1-10:

Nervous System
- ○ Extremity weakness
- ○ Extremity burning
- ○ Extremity numbness
- ○ Extremity tingling

Endocrine
- ○ Frequent urination
- ○ Excessive thirst
- ○ Dramatic weight change

Female reproductive
- ○ Breast feeding
- ○ Currently pregnant

PREVENTATIVE CARE AND WELLNESS

VACCINATIONS / SCREENINGS

☐ Yes	☐ No	Influenza	Date of last vaccine? _____
☐ Yes	☐ No	Pneumococcal	Date of last vaccine? _____
☐ Yes	☐ No	Mammogram	Date of last screening? _____
☐ Yes	☐ No	Colorectal cancer screening	Date of last screening? _____
☐ Yes	☐ No	Diabetic screening	Date of last screening? _____
		If diabetic, what was your last hgA1C?	hgA1C _____

☐ 5.5 – 5.9 ☐ 6.0 – 6.9 ☐ 7.0 – 7.9 ☐ 8.0 – 8.9 ☐ 9.0 – 9.9 ☐ 10 or above

FALLS RISK ASSESSMENT *(65 years and older)*
- ○ No falls in the past year
- ○ One fall without injury in the past year
- ○ Two or more falls without injury in the past year
- ○ One fall with injury the past year
- ○ Two or more falls with injury in the past year

OSTEOPOROSIS SCREENING *(65 years and older)*

Have you had a central dual-energy, X-ray, also known as a DX to check for osteoporosis?	☐ Yes	☐ No
Have you been diagnosed with osteoporosis in the last 12 months?	☐ Yes	☐ No
If yes, are you currently taking medication to treat your Osteoporosis?	☐ Yes	☐ No
Have you had or do you have a fracture?	☐ Yes	☐ No
If yes, have you received a prescription to treat osteoporosis?	☐ Yes	☐ No
Have you had a Dexa scan to check bone mineral density?	☐ Yes	☐ No

Patient signature: _____ Date: _____

LONE STAR
FOOT & ANKLE
SURGICAL ASSOCIATES

Office (830) 800 – 8478
Fax (512) 268 – 5785

PATIENT PORTAL AGREEMENT

We are pleased to provide a Patient Portal in partnership with our electronic medical records provider, e-CW for the exclusive use of patients in our practice. The Patient Portal is designed to enhance patient and physician communication. All users must be established by a previous office visit.

We strive to keep all the information in your records correct and complete, if you identify any discrepancy in your records, you agree to notify us immediately. Additionally, by using the Patient Portal, the user agrees to provide factual and correct information. The Patient Portal provides access to the following services: which may or may not be utilized at this time:

- Request prescription refills
- Receive educational material
- View current and past statements
- See your visit summary
- Send messages to our office staff
- Receive health maintenance reminders

The Patient Portal is **not** intended to provide internet-based diagnostic medical services. The following limitations also apply:

- There are no internet-based triage and treatment requests. Diagnosis and treatment can only be rendered after the patient is seen by a medical provider in our office.
- There is no emergent communication or services. Any emergency conditions should be handled by calling the office directly, going to an urgent care clinic or emergency room, or calling 911 if the emergency is life-threatening.
- No requests for narcotic/controlled medications will be accepted.
- No requests for new prescriptions or refills for conditions for which our clinic is not treating you will be accepted.
- It may take 72 hours to receive a response to an email request. If you do not receive a response within 72 hours you should contact the office at (512) 268-3668.
- If you lose your password or username, you may request a new one through the web portal or in person at the office by providing valid identification.
- Always remember to log out and close your browser when you are finished accessing password-protected Patient Portal services. This prevents someone else from accessing your personal information, YOU SHOULD NEVER USE A PUBLIC COMPUTER TO ACCESS THE PATIENT PORTAL.

The Patient Portal is provided in partnership with e-CW, our EHR software vendor and provider. That data is HIPAA compliant with high-level encryption that exceeds the HIPAA standards. While we believe that the IT infrastructure and data are safe and secure, it does not guarantee unforeseen adverse events cannot occur. To the extent possible, our office has undergone rigorous IT implementation and security standards exceeding industry recommendations.

LONE STAR FOOT & ANKLE SURGICAL ASSOCIATES

Office (830) 800 – 8478
Fax (512) 268 – 5785

Please read our HIPAA policy for information on how private health information is used in our office, All patients have signed a HIPAA agreement form. If you do not recall having signed a HIPAA agreement or need to reacquaint yourself with the HIPAA policy, we will be happy to provide you with a copy.

Once you have signed the Patient Portal Agreement and have provided our office with a legitimate email address that is secure, you will be given our system-generated unique user identification and password. The site may be accessed by going to http://www.LonestarFootDoctor. com

Patient Acknowledgement and Agreement: I acknowledge that I have read and fully understand this consent form. I have been given the risks and benefits of the Patient Portal and agree that I understand the risks associated with online communications between the practice and myself, and consent to the conditions outlined herein. I acknowledge that using the Patient Portal is entirely voluntary and will not impact the quality of care I receive should I decide against using the Patient Portal. In addition, I agree to adhere to the policies set forth herein, as well as any other instructions or guidelines that Lonestar Foot and Ankle Surgical Associates may impose for online communications. I have been allowed to ask questions related to this agreement and all of my questions have been answered to my satisfaction. I also understand this consent is valid for one year.

Patient/Guardian Email: _____
Patient/Guardian signature: _____ Date: _____

HEALTH INFORMATION EXCHANGE AND PATIENT PORTAL OPT-OUT

Lonestar Foot and Ankle Surgical Associates, PLLC participates in a health information exchange (HIE) which is a secure internet-based health record exchange that enables patient information to be shared electronically with physicians and other healthcare professionals/facilities involved in your healthcare. Additionally, we provide a patient portal that allows electronic access to your health information.

The goal of the HIE and patient portal is to help healthcare professionals provide better, more efficient and coordinated patient care by providing access to a patient's most recent health information. However, you have the right to opt out of both the HIE and the electronic access provided by the patient portal.

OPT-OUT REQUEST

Please indicate your preferences by checking the appropriate boxes below:

☐ **I do not want to participate in the Health Information Exchange (HIE):** By signing this form, I understand that I am directing Lonestar Foot and Ankle Surgical Associates, PLLC to opt me out of the electronic sharing of my health information with the HIE.

☐ **I do not want to have electronic access to my health information via the patient portal:** By signing this form, I understand that I am directing Lonestar Foot and Ankle Surgical Associates, PLLC to disable my electronic access to the patient portal.

Patient signature: _____ Date: _____

**** This opt-out request applies only to our practice. To officially opt out of HIE, you must complete and mail the appropriate opt-out form, available upon request. ****