



New Patient Information

PATIENT INFORMATION

Name: _____
(Last) (First) (Middle) (Suffix)

Sex: Male Female Date of Birth: _____ Social Security Number: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

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

E-Mail Address: _____

Marital Status: Single Married Separated Divorced Widow/Widower

Employed: Yes No Occupation: _____

Employer's Name and Address: _____

BILLING INFORMATION

Person Responsible for paying bill: Self Parent Spouse Other: _____

Name (if different from above): _____ Date of Birth: _____
(Last) (First) (Middle)

Address (if different from above): _____

Social Security Number: _____ Best Contact Number: _____

Employer's Name and Address: _____

Please bring your driver license and insurance cards to your appointment

EMERGENCY CONTACT

Person to Contact in Case of Emergency:

Name: _____ Date of Birth: _____ Phone Number: _____

Address: _____ Relationship: _____

PRACTICE INFORMATION

Primary Care Physician: _____

How did you hear about us? (please circle one) Advertising Primary Care Physician Specialist Physician
Word of Mouth Patient in Practice Hospital Insurance Company

Preferred Pharmacy: _____

RACE AND ETHNICITY

Race: White African American American Indian European Other: _____

Ethnicity: Central American Cuban Dominican Hispanic or Latino/Spanish Latin American/Latin, Latino Mexican
Not Hispanic or Latino Puerto Rican South American Spaniard



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FINANCIAL POLICY

We strongly feel all patients deserve the very best medical care that we can provide. Everyone benefits when financial arrangements are agreed upon. We have prepared this material to acquaint you with our policy. Our professional services are rendered to you, not the insurance company. Payment for treatment is your responsibility.

FINANCIAL/INSURANCE AGREEMENTS:

Please initial:

_____ In the event I have no insurance coverage, I understand that I am responsible for payment of services rendered to me or my dependents at the time of service. I understand if I fail to pay amounts owed: the clinic has the right to secure an outside collection agency and/ or attorney to collect the unpaid debt and to report the unpaid debt to a credit- reporting agency. I further understand that I will be responsible for any additional charges or fees necessitated by securing the collection agency or attorney, including reasonable attorney's fees. I hereby authorize the release of any information necessary to process insurance claims and request payment of benefits to be made for services rendered to my dependents or to me. I understand I am responsible **at the time of service** for paying any required co-payment and deductible.

**I have read and understand the payment policy of this office and agree to abide by the said policy.
I understand a \$30.00 charge will be assessed on all returned checks.**

Patient / Parent / Guardian

Relationship to Patient

Date

HIPAA

Due to the Health Portability and Accountability Act (HIPAA) of 1996, the following information must be filled out by each patient annually.

Your rights are posted in the waiting rooms at each Lonestar Foot & Ankle Group clinic. Copies of the rights are also available at the receptionist desk if you would like to keep this information for your records.

I authorize Lonestar Foot & Ankle Group to release any of my medical or insurance information necessary to process my medical claims and coordinate/manage my healthcare.

With whom may we discuss information about your care, treatment or diagnosis?

_____ Relationship: _____

I acknowledge the HIPAA Patient Rights and Privacy forms. I have read and understand my rights.

Signature (Patient or Patient if Minor)

Printed Name

Date

ELECTRONIC MEDICAL RECORDS HISTORY

Lonestar Foot & Ankle Group utilizes an Electronic Medical Records (EMR) System in our office.

- We now have the ability to check your prescription eligibility and download your pharmacy history into our system.
- We also have the added ability to fax mail order prescriptions, review prescription benefits, and drug formulary all while you are in our office.

By signing below, you are granting Lonestar Foot & Ankle Group permission to obtain this information on your behalf. I, the patient/parent of a minor, give my consent to Lonestar Foot & Ankle Group to obtain my pharmacy benefits.

Signature

Printed Name

Date



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General Patient Information

Thank you for choosing Lonestar Foot & Ankle Group as your healthcare provider. We are committed to providing you with quality, affordable healthcare. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this. Please review and ask us any questions you may have.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment and/or deductible at each visit.

3. Non-covered services. Please be aware that some or all of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit and a signature is required from you prior to services being rendered.

4. Proof of insurance. All patients must complete our patient information forms before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you or your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments. The staff at Lonestar Foot & Ankle Group understands that certain circumstances require rescheduling of an appointment. However, three or more "no shows" may result in a patient being discharged from the provider. A "no show" is defined as when a patient misses an appointment and has not called prior to the appointment time to reschedule, or is more than 15 minutes late. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. A charge of

\$25.00 may be billed directly to you. Please help us serve you better by keeping your regularly scheduled appointment.

* Medicare recipients are exempt from the missed appointment charge.

* If you are a Medicaid recipient your health care plan will be notified of any and all missed appointments

* If 3 or more appointments are missed you may be placed on a work in only list or even discharged from our practice.

9. Date/Time of Appointment. Patients will be called back according to their scheduled appointment time by healthcare provider. Every effort is made to assure that patients are seen as close to their scheduled appointment time as possible. Patients whose symptoms are severe, infectious, or change dramatically while waiting may be taken to a patient room as soon as possible for their appointment. We appreciate your understanding at all times.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

Please visit our website at: www.lonestarfootandankle.com