Roger J. Beal, D.P.M.
Diplomate, American Board of Podiatric Surgery
Methodist Plaza Building, Suite 122
4499 Medical Drive
San Antonio, Texas 78229-3851
Office: (210) 614-3623

PATIENT REGISTRATION

Welcome to our office. We are committed to providing you the very best and comprehensive foot care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent.

PLEASE FILL IN ALL THE BLANKS. PUT N/A IF THE QUESTION DOES NOT APPLY TO YOU.

Patient name:	Date of Birth	Sex	Age	Marital Status (Married, Single, Divorced, Widowed)
Parent, If Patient Is A Minor:	Parent's Date Of Birth	Sex	Age	PARENTS Marital Status (M, S, D, W)
Patient's Social Security Number:		Drivers License No. or State ID:		
Home Address		City	State	Zip
Mailing Address (If Different): (For Sending Statements)		City	State	Zip
Home Phone:	Work Phone:	Cell Phone:		
Occupation:		Employer:		
Employers Address:	City	State	Zip	Phone
Spouse Name And Address (If Different)		Employer Name:	Address:	Phone:

INSURANCE INFORMATION:

PRIMARY INSURANCE	Telephone		
Claim Address	City	State	Zip
Insured Name and Address (If Different From Above)		Insured Date Of Birth & Social Security Number (If Different)	
Insurance ID Number:	Insurance Group Number:		
SECOND INSURANCE:	Telephone:		
Claim Address	City	State	Zip
Insured Name and Address (If Different From Above):		Insured Date Of Birth & Social Security Number (If Different)	
Insurance ID Number:	Insurance Group Number:		

AUTHORIZATION OF PAYMENT:
I hereby authorize the provider of services to release information concerning my examination and/or treatment for insurance purposes and to receive direct payment for services rendered.

Signed_____**Date**_____

(Patient or Patient's Parent Or Guardian If Minor)

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MEDICAL HISTORY I

NAME_____AGE_____TODAY'S DATE_____

DESCRIBE YOUR FOOT/FEET PROBLEM(S):_____

_____

HOW LONG HAS THIS BEEN BOTHERING YOU? _____

ANY PAST PROBLEMS OF YOUR FEET OR ANKLES: _____

_____

SHOE SIZE_____CURRENT WEIGHT_____HEIGHT_____

MEDICATION ALLERGIES: ***CHECK HERE IF YOU HAVE NO KNOWN ALLERGIES*** ____
(Please Circle Any That Apply)

Adhesive Tape Aspirin Codeine Demerol Iodine Penicillin Latex

Sulfa Local Anesthetics Other Antibiotics_____

Other medications not listed:_____

GENERAL HEALTH INFORMATION

Please Check Yes Or No To Indicate If You Have Had or Have Any Of The Following:

	Y	N		Y	N		Y	N		Y	N
AIDS/ HIV			DEPRESSION			HIGH BLOOD PRESSURE			LUNG DISEASE		
ANEMIA			DIABETES			JAUNDICE			RHEUMATIC		
ANGINA			DIALYSIS			KIDNEY PROBLEMS			SINUS PROBLEMS		
ARTHRITIS			EAR PROBLEMS			LIVER DISEASE			SKIN CANCER		
ARTIFICIAL HEART VALVES			EPILEPSY			LOW BLOOD PRESSURE			STROKE		
ARTIFICIAL JOINTS			EYE PROBLEMS			NERVOUS DISORDERS			THYROID		
ASTHMA			FAINTING			NEUROPATHY			TUBERCULOSIS		
BACK PROBLEMS			GLAUCOMA			OSTEOPOROSIS			ULCERS		
BLEEDING PROBLEM			GOUT			PHLEBITIS			VARICOSE VEINS		
CANCER			HEART ATTACK			PNEUMONIA			VENERAL DISEASE		
CATARACTS			HEART DISEASE			PROSTATE PROBLEMS			OTHER:		
DRUG USE			PAST HEART SURGERY			PSORIASIS					
DIARRHEA			HEMOPHILIA			PSYCHIATRIC CARE					
CIRCULATION PROBLEMS			HEPATITIS			RADIATION TREATMENTS					

RECENT SURGERIES (PLEASE LIST TYPE AND YEAR PERFORMED)

PLEASE EITHER BRING A LIST OF CURRENT MEDICATION OR FILL OUT BELOW: PLEASE INCLUDE DOSAGES).

_____ _____ _____ _____

_____ _____ _____ _____

PRIMARY DOCTOR:_____**DATE LAST SEEN**_____

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MEDICAL HISTORY II

SMOKING HISTORY: [ ] NEVER SMOKED [ ] PAST SMOKER [ ] SMOKER - # PACKS PER DAY_____

ALCOHOL USE: [ ] NONE [ ] YES – HOW MANY PER DAY? _____

REVIEW OF BODY SYSTEMS	PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING
EYES:	[ ] NO PROBLEM [ ] BLURRED VISION [ ] BLINDNESS
MUSCLES/BONES:	[ ] NO PROBLEM [ ] WEAKNESS [ ] NUMBNESS [ ] STIFFNESS [ ] SWELLING [ ] PAIN [ ] FOOT OR LEG CRAMPS
SKIN:	[ ] NO PROBLEM [ ] RASHES [ ] DRY SKIN [ ] ITCHING
LUNGS:	[ ] NO PROBLEM [ ] SHORTNESS OF BREATH [ ] WHEEZING [ ] COUGH
HEART:	[ ] NO PROBLEM [ ] CHEST PAIN [ ] SWELLING ANKLES/FEET
NERVES:	[ ] NO PROBLEM [ ] HEADACHES [ ] DIZZINESS [ ] NUMB/TINGLING [ ] SEIZURES
GENERAL:	[ ] NO PROBLEM [ ] WEIGHT GAIN/LOSS [ ] FEVER [ ] GENERAL FATIGUE
INTESTINAL:	[ ] NO PROBLEM [ ] NAUSEA [ ] VOMITING [ ] JAUNDICE [ ] HEARTBURN
URINARY:	[ ] NO PROBLEM [ ] FREQUENT [ ] BURNING [ ] DISCHARGE [ ] BLOOD IN URINE
BLOOD:	[ ] NO PROBLEM [ ] PROLONGED BLEEDING [ ] EXCESS BRUISING [ ] THINNERS

COMMENTS:_____

_____

_____

CONSENT: I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN **DATE**

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other Purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your Protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

Your have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications form us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have you physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or after April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Print Name:_____ **Signature**_____ **Date**_____

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VISIT FEE POLICIES

- Payment is due at the time of service. (co-pay's, deductible, co-insurance, non-covered items or services) Amounts that are collected are based from benefits received by the insurance company at the time of all visits. NO EXCEPTIONS. Only the staff will be able to inform you of what is due, not the Physician.
- ALL D.M.E. (durable medical equipment) products that are dispensed to the patient are non-returnable and non-refundable. Check with the front office staff, not Physician, to see what your specific plan may cover.
- In the event the payment we require cannot be made by the patient, at the time of service, there are two options. 1) You may leave post dated checks that may be extended for 30 days. 2) You may have automatic deductions made from a credit or debit card. The second option will allow you to extend your payments over 60 days.
- There is a $3.00 monthly maintenance charge for any account balance that carries over.
- Checks that have been returned due to NSF (non-sufficient funds) will have a $30.00 fee assessed. Check amount and fee must be paid within five business days. The check will be forwarded to the District Attorney's Office, Check Section if not paid. (This same fee applies to chargeback's on debit or credit cards.)
- If a credit or debit card is declined after making arrangements, a $20.00 fee will be added to the balance for every attempt to collect on the prior arrangement made.
- If your account has a credit, due to overpayment, a check will be mailed to the address we have on file for you.
- If you require FMLA paperwork to be filled out for your employer, the fee is $35.00. We will contact you when the paperwork is completed.
- If you request medical records copies, the fee is $35.00. If you require x-ray copies, the fee is $25.00.
- We do not fax or mail excuses for school or work. Please request one before leaving.
- If you or an immediate family member has a collection account; the entire amount is due prior to the patient being treated by Physician.
- Appointments that are missed or cancelled without a 24 HOUR notice will receive a $35.00 fee towards their account.
- For prescription refills; please contact your pharmacy FIRST. The pharmacy will contact our office if necessary.
- We no longer accept American Express credit cards.

Thank you and please sign below. Your signature acknowledges that you have read and understand the above.

_____ _____ _____

Patient OR Guardian Signature Printed Name of Patient Date

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CHECKLIST FOR YOUR OFFICE VISIT

1. **INSURANCE CARD AND PICTURE ID**

2. **MEDICATION LIST**

3. **EXISTING OR OLD ARCH SUPPORTS (ORTHOTICS) – IF FOOT PAIN IS YOUR PROBLEM**

4. **IF NO INSURANCE:**

   FIRST OFFICE VISIT IS $95.00

   ANY TREATMENT OR IMAGING COSTS ARE EXTRA (XRAY,ULTRASOUND, ETC.) WILL BE DISCUSSED AT YOUR VISIT