Coastal Foot and Ankle Associates

HELLO! WELCOME TO OUR OFFICE!
Please print the following information.
This information is important for our records and your health.

DATE: _____

Patient Name: _____ Birthdate: _____ Age: _____

Address: _____ Primary Language: _____

City: _____ State:_____ Zip: _____

Home Phone:_____ Cell Phone: _____

Work Phone:_____ Employed By: _____

Email: _____

Race:_____ Ethnicity:_____

Social Security No:_____ Sex: M F Marital Status: S M D W

Family Physician: _____ Physician Phone: _____

Referred to our office by: _____

Contact in case of emergency: _____ Phone Number: _____

Insured's Name: _____ Relationship: _____

Insured's Employer: _____ Insured's Work #: _____

Insured's SS #: _____ Insured's Birthdate: _____

Primary Insurance: _____ Address: _____

Subscriber ID #: _____ Group #: _____

Secondary Insurance: _____ Address: _____

Subscriber ID #: _____ Group #: _____

**** If over 65 years of age: Do you have a living will or someone who is your decision make? YES_____ NO_____**
If no, why?_____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE
I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to myself or to the party who accepts assignment.

_____
Signature

I HEREBY GIVE MY PERMISSION TO THIS OFFICE TO EXAMINE AND TREAT AS INDICATED
DATE: _____ SIGNATURE: _____

PATIENT NAME: _____DOB_____ **DATE:** _____

***CHIEF COMPLAINT:**

_____

_____

***ANY DRUG ALLERGIES?** **No Known Allergies?** _____

_____ Penicillin	_____ Aspirin	_____ Cortisone
_____ Codeine	_____ Tape	_____ Novocaine
_____ Sulfa Drugs	_____ Any Antibiotic	_____ Other (please list)

_____

***CURRENT MEDICATIONS:** **NONE**: _____

If **YES**, please list: _____

_____

* **PAST MEDICAL HISTORY:** **(Please circle all that apply)**

Diabetes	Sleep Apnea	Tremors	Anemia	Impotency	Kidney Problems
Gout	Halitosis	Seizures	Stroke	Swelling	Heart Problems
HIV	Dermatitis	Anxiety	Vomiting	Shortness of breath	Liver Problems
Hepatitis	Psoriasis	Asthma	Diarrhea	Rheumatic fever	Blood Clots or Phlebitis
Tinnitus	Rash	Paranoia	Blood in Stool	Tuberculosis	Lung Problems
Fatigue	Eczema	Depression	Blood in Urine	Varicose Veins	Difficulty in Healing
Cancer	Tinea Pedis	Epilepsy	Frequent Urine	High Blood Pressure	Diminished Hearing
Bloating	Allergies	Tumors/ Growth	Stomach Ulcer	Difficulty Swallowing	Unexplained Weight Loss

List any other serious condition or illness: _____

If diabetic what is your A1C value?_____

***PREVIOUS SURGERIES:** _____

_____

***FAMILY MEDICAL HISTORY:** □ **NONE**

Hypertension	□Mother	□Father	Heart	□Mother	□Father
Diabetes	□Mother	□Father	Lungs	□Mother	□Father
Kidney	□Mother	□Father	Cancer	□Mother	□Father

If Yes, What type? _____

Have you had your Flu Shot?_____ Have you had your pneumonia shot?_____

***SHOE SIZE:** _____ **HEIGHT:** _____ **WEIGHT:** _____

***SOCIAL HISTORY**: **Smoker? YES or NO** How many packs per day? ____ How many years? _____

Alcohol? YES or NO If **YES**, What? _____How often? _____

For Office Use Only:

Pulse: _____ **BMI:** _____

Blood Pressure: _____ **Temperature:** _____

ACKNOWELDEGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Signature of patient/ Guardian Date

********DO NOT LEAVE BLANK!!!!!!!********

Preferred Pharmacy:_____ Phone:_____

Address:_____

Intersection of: _____&_____

PATIENT CONTACT PREFERENCE:

☐ **PHONE:**

Ok to leave message with:_____

☐ Mail

☐ Email_____

Dr. Mark Moss, DPM
Dr. Hina Hassan, DPM

No Show Policy & Procedure
For Office Visits, Procedures and Outpatient Surgery

Coastal Foot & Ankle Associates imposes the following policy with regard to patients who fail to keep their scheduled office visit appointment, procedure appointment or scheduled outpatient surgery appointment.

- Patients who fail to show for their scheduled **office** appointment or did not notify the office **within 24 hours** of their scheduled appointment time, shall be subject to a **"NO SHOW"** penalty of **$25.00.** In the event of an actual emergency and prior notice could not be given, consideration will be given, and a **one-time exception may be granted.**

- Patients who fail to show for their scheduled **office procedure** appointment or did not notify the office **within 24 hours** of their schedule procedure appointment time, shall be subject to a **"NO SHOW"** penalty of **$75.00.** In the event of an actual emergency and prior notice could not be given, consideration will be given, and a **one-time exception may be granted.**

- Patients who fail to show for their scheduled **outpatient surgery** appointment or did not notify the office within **72 hours** of their scheduled surgery time, shall be subject to a **"NO SHOW"** penalty of **$150.00.** If the surgery is cancelled by a physician as a medical necessity, then the patient is not subject to a no show fee. Also insurance authorization denials exempt the patient of such a fee.

_____ _____

Patient Printed Name Date

_____ _____

Patient or Guardian Signature Date

_____ _____

Witness Signature Date

Disclosure and Authorization Form for:

Patient Referral to Other Non-Participating Physician(s) or Facility

Advocacy for Patient Freedom of Choice for Provider(s)

Patient Name:_____ Physician Name:_____

Diagnosis:_____ Other Physician:_____

For Treatment:_____ Other Entity:_____

Patient Plan In-Network:_____ Location:_____

In order to better serve you with the highest care quality and safety at the most affordable costs, sometimes it is necessary and important to have other or more provider(s) or entities to join our team to complete or continue your medical procedures or treatment in order to ensure the speedy recovery for you. We would like to keep you informed of your choice and our recommendation of these other provider(s) or entities and obtain your informed authorization before our referral and scheduling for your next treatment / procedure(s).

While no provider or entity could be participating in every managed care network, such as the one your health plan has contracted with, these other provider(s) or entities may or may not be in your health plan's network. This Form is used to inform you of your verification that the above named provider(s) or entities are non-participating provider(s) or entities with your health plan. We have verified your insurance coverage for non-participating provider(s) or entities and the recommended treatment/ procedure (s) and obtain pre-certification if applicable for all services as a courtesy to you. Please understand that the insurance verification is not a guarantee of insurance payment according to your health plan. If you have any questions concerning whether you have out of network benefits or your financial obligation under your benefit plan if you see an out of network provider, please call the member services number on your Insurance Identification card.

Compliance & Disclosure under Texas Occupation Code – Section 102.006

In compliance with Section 102.006 of Texas Occupation in connection with my informed consent and personal choice of doctor and facility solely based on the quality and safety of care, reputation and patient satisfaction, and my knowledge in my decision-making in exercising my rights with respect to the in-network or out- of-network coverage and cost sharing, my attending doctor(s) and/or clinic (facility) have disclosed to me at the time of initial contact and at the time of referral with respect to the choice of a doctor or facility solely in the interest of my healthcare quality and safety, as a result of my informed consent and personal choice of doctor(s) and / or facility: (A) his/her affiliation, if any, with the doctor or facility for whom the patient is referred and (B) that he/she will receive , directly or indirectly, remuneration for referring upon my such request and exercising my right of freedom of choice for the provider(s) and facility under the in-network or out-of-network coverage as provided by my health plan, as protected by all applicable federal and state laws, including Medicare, ERISA, PPACA. Doctor or Facility with affiliation and remuneration:

Mark H. Moss D.P.M. Premier Surgical Group Southeast, P.A., Coastal Foot and Ankle Associates, P.A./Premier Surgical Group P.A.: Memorial Hermann Doctors United Surgery Center (5146 Preston, Pasadena, TX 77504), Custom RX/Oak Pharmacy (1535 West Loop South suite 450, Houston Texas 77027), Cantera Testing, LLC. Hina Hassan D.P.M. , Custom RX/Oak Pharmacy (1535 West Loop South suite 450, Houston Texas 77027),Cantera Testing, LLC., Altus Baytown, Memorial Hermann Doctor's United Surgery Center, NIRP National Interventional Radiology Partners.

I certify that the Advocacy for Patient Freedom of Choice for Provider(s) with the above specific disclosure form my provider(s) is in full compliance with Section 102.006 of Texas Occupations Code, in manner otherwise permitted under Section 102.001, in accepting remuneration to advocate, protect, secure or solicit a patient or patronage for a person licensed, certified, or registered by a state health care regulatory agency.

I certify that I was informed of the effective alternative resources reasonable available at the time of my decision-making, and my option to use one of the alternative resources, and that I was assured by my attending physician that I will not be treated differently by the physician and his/her staff if I choose an alternative provider or entity.

I certify that my attending physician(s) has made referrals to the other non-participating providers or entities based only on the needs of my individual healthcare, the medical community standard of care and my informed choice for quality and safety of the care that I will be expecting and receiving, and for provider's professional reputation and patient satisfaction in order to provide me with quality and affordable healthcare that I personally expect under my health plan for out-of-network coverage.

I have read and fully understand this Disclosure and Authorization Form. I hereby authorize this referral to non-participating and out-of-network provider(s) or entities as named above.

_____ _____ _____

Patient Name (print) Signature of Patient Date

McKinney Podiatric Associates, P.A.
MEDICAL & SURGICAL CARE FOR THE FOOT & ANKLE

COASTAL FOOT & ANKLE ASSOCIATES

PATIENT FINANCIAL POLICY

Thank you for choosing us as your facility for foot and ankle care. Our goal is to provide you with the highest quality care at affordable cost. To make our services available to as many patients as possible on an affordable basis, we have adopted the financial collection policy outlined below. We ask you to read the policy carefully and sign prior to any treatment.

- WE MAY ACCEPT ANY ASSIGNABLE INSURANCE WITH APPLICABLE-COVERAGE.
- FULL PAYMENT IS DUE AT TIME OF SERVICE UNLESS ARRANGED OTHERWISE.
- WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD, AND AMERICAN EXPRESS CARD.
- WE OFFER EXTENDED PAYMENT PLAN WITH PRIOR TO CREDIT APPROVAL.
- WE ACCEPT ALL HEALTH SAVINGS ACCOUNT (HSA) PAYMENTS.
- PATIENT REQUESTS FOR COPIES OF RECORDS MAY TAKE 2-4 WEEKS OR LONGER TO RECEIVE AND REQUIRE A CURRENT SIGNED PATIENT MEDICAL RELEASE FORM ON THE DATE REQUESTED. CHARGES OF $25 OR MORE MAY APPLY TO RECORD REQUEST. IN ORDER TO PROTECT YOUR SECURITY, FAXED REQUEST FOR RECORDS ARE *NOT ACCEPTABLE*.
- PLEASE ALLOW A MINIMUM OF 48 HOURS FOR COMPLETION OF ANY FMLA/DISABILITY FORMS AND THERE WILL BE A $25 CHARGE DUE AT THE TIME WE RECEIVE THE FORMS.
- THERE WILL BE A $25 CHARGE ON ALL RETURNED CHECKS.

Regarding Insurance

We may accept assignment of insurance benefits at our discretion if acceptable insurance identification is provided. Acceptable insurance identification is defined as a valid insurance card, policy/plan with applicable coverage, or telephone verification. As a courtesy to our patients, verifiable and assignable insurance will be billed by this surgeon's office. However, you will be personally responsible for your account balance regardless if your insurance will pay for your total balance of your claims, unless you're eligible for discounts under our indigency policy pre-determined before the services are rendered. Your insurance policy/employee benefit plan is a contract between you and your insurance company/employee benefit plan. We are not a party to that contract. In the event we do not accept assignment of benefit we require that you be pre-approved on our extended payment plan by providing a credit card or personal checking account with authorization to charge that amount for the balance due, if your insurance company/employee benefit plan has not paid your full account in full within 45 days or has determined your claims to be your responsibility for the reasons of annual deductible, co-payment, non-covered services and not medically necessary.

We encourage our patients to contact their plans for clarification of benefits prior to service rendered. As our patient, you are responsible for all authorizations/referrals needed to seek treatment. If a patient chooses or is required to bill his/her own insurance, this office will provide an itemized statement and a HCFA- 1500 Form to the patient but will treat the account as self-pay. Patient must inform the office of all insurance changes. In the event the office is not informed in a timely manner, you will be responsible for any charges denied.

Regarding Discount

Due to the Affordable Care Act (ACA), we may offer discounts, reduction of waiver of deductibles, co-insurances and copay to any eligible patient under our Corporate Indigency Policy in accordance with applicable federal and states laws. These discounts are based on medical needs and ability to pay on case-by-case basis and patients may apply for financial indigency discount assistance by asking our staff to determine if you're eligible.

Regarding Surgeon and Facility Charges

We will disclose to every patient our surgeon charges as clearly as practically possible before your medical or surgical procedures. Please feel free to ask our staff if you have any questions about charges and your payment responsibilities. As you may be aware, your insurance company requires your doctors and surgeons to charge and bill the services separately from surgical facilities or hospitals. You shall not be surprised that you will receive separate surgeon, anesthesiologist, diagnostic labs, radiologist, pathologists and others in addition to the surgical facility bills for your surgery. If you have any questions about your surgical facility bills, please direct your questions to that surgical center.

While we don't anticipate any unforeseeable circumstances, we have no control over any such event(s) that may arise, Should you require additional medical or surgical care in any event of the post-surgical complications and reactions, you may incur additional expenses at this facility or outside this facility, such as a hospital.

The charges only include the stated date of service at this facility and do not include any other date of services from us or other providers and facilities.

Surgical procedure will require pre-payment. You will be informed in advance of your financial portion.

Regarding PPO and HMO Network Participation

As you may know, you may have a choice to choose a surgeon or surgical facilities with or without PPO or HMO participation under different insurance coverage and benefit levels. We are dedicated to providing highest quality care to every patient, however we have no power to change your insurance coverage or network limitation. Most health care plans or insurance policies may provide surgical coverage to non-PPO providers and facilities, but at lower percentage of insurance reimbursement. Although it is your responsibility to verify your insurance coverage for non-PPO/HMO providers, we will always disclose to you as to our participation status to your insurance plan. We also provide every patient with financial assistance or discount with high deductibles and coinsurance for our Corporate Indigency Policy in accordance with applicable federal and state laws.

Please understand that we will verify your insurance coverage and obtain pre-certification if applicable for all services as a courtesy to you before your surgery. Please note that all insurance verification is not a guarantee of insurance payment.

Compliance & Disclosure under Texas Occupations Code- Section 102.006

In compliance with Section 102.006 of Texas Occupations Code in connection with informed consent and personal choice of doctors and facility solely based on the quality and safety of care, reputation and patient satisfaction, and my knowledge in my decision-making in exercises my right with respect to the in-network or out-of-network coverage and cost sharing, my attending doctors(s) and/or clinic (facility) have disclosed to me at the time of initial contact and at the time of referral with respect to the choice of doctor or facility solely in the interest of my healthcare quality and safety , as a result of ,y informed consent and personal choice of doctor(s) and/ or facility: (A) his/her affiliation, if any, with the doctor or facility for whom the patient is referred and (B) that he/she will receive, directly or indirectly, remuneration for referring upon such and exercise my rights of freedom of choice for the provider(s) and facility under the in-network or out-of-network coverage as provided by my health plan, in compliance with all applicable federal and state laws, Medicare, ERISA, PPACA and Section 102.006 Texas Occupations Code.

Specifically, Dr. Scott W. McKinney D.P.M. /McKinney Podiatric Associates, P.A. has s financial interest and may receive remunerations from any and all of the following entities: St. Luke's Patient's Medical Center (4600 E. Sam Houston Pkwy S. Pasadena, TX 77505) Altus Baytown Hospital (1626 W Baker Rd. Baytown, Tx77521) Altus Pharmacy (Baytown, TX) Dr. Jorge L. Cuza D.P.M.: St. Luke's Patient's Medical Center (4600 E. Sam Houston Pkwy S. Pasadena, TX 77505) ROC Pharmacy, Triumph Pharmacy Med RX Compounding Pharmacy, Mark H. Moss D.P.M. Premier Surgical Group Southeast, P.A., Coastal Foot and Ankle Associates, P.A./Premier Surgical Group P.A., Custom RX/Altus Pharmacy(1535 West Loop South suite 450, Houston Texas 77027). Memorial Hermann Doctors United Surgery Center Southeast (5146 Preston, Pasadena, Tx 77504) Dr. Edna Reyes-Guerrero D.P.M. CompundOne pharmacy (855-346-7600) Hina Hassan D.P.M, Custom Rx/AltusPharmacy (1535 West Loop South, Suite 450, Houston, Texas 77027. Cantera Testing, LLC., Altus Baytown, Memorial Hermann Doctor's United Surgery Center

Your Responsibility for Cooperation

If we accept your insurance as a payment from your insurance reimbursement, you agree to timely cooperate with your insurance company or health plan in the course of claim processing, such as insurance inquiries, requests for additional information, claims status verification or any inquiries for the purpose of your claim processing. You also agree to notify us immediately of any inquiry or request for additional information and provide us with a copy of any documentation you receive from the insurance company or submitted to insurance company from you.

In an event that you do not receive insurance payment checks for your surgeries/services rendered by this doctor, you agree to submit such insurance reimburse check to our office within five (5) business days after your receipt of insurance checks. In a failure or refusal to forward or send us the insurance reimbursement checks for the medical services from this provider, all of your discount arrangement will be voided, and the total balance is due immediately, as there is no justification for you to keep the insurance payment for our services as you promised to pay for our services. You further agree to compensate us for any legal fees if we have to retain any legal services to collect past dues.

Mutual Agreement

Dr. Mark H. Moss and Coastal Foot and Ankle Associates, P.A. (collectively labeled "Physician") agrees to provide treatment to you ("Patient"). The Physician takes pride in being able to extend a greater degree of privacy than is required by law.

Federal and State privacy laws are complex. Unfortunately, some medical offices try to find loopholes around these laws. For example, physicians are forbidden by law from receiving money for selling lists of patient or medical information to companies to market their products or services directly to patients without authorization. Some medical practices, though, can lawfully circumvent this limitation by having third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Physician agrees not to provide medical information for the purpose of marketing directly to the Patient. Regardless of legal privacy loopholes, Physician will never attempt to leverage its relationship with Patient by seeking Patient's consent for marketing products for others.

We want your feedback. If our office gets it right, tell us. If we could do something better, tell us. We take quality improvement seriously. While there are scores of "rating sites" in cyberspace, many fail to provide useful information. Let's get it done right. We can make recommendations as to which sites follow minimum standards for fairness and balance. Just ask us.

Physician has invested significant financial and marketing resources in developing the practice. Nothing in this Agreement prevents a patient from posting commentary about the Physician—his practice, expertise, and/or treatment—on web pages, blogs, and/or mass correspondence. In consideration for treatment and the above noted patient protection, if Patient prepares such commentary for publication on web pages, blogs, and/or mass correspondence about the Physician, the Patient exclusively assigns all intellectual Property rights, including copyrights, to Physician for any written, pictorial, and/or electronic commentary. This assignment shall be operative and effective at the time of creation (prior to publication) of the commentary.

This Agreement shall be in force and enforceable for a period of five years from Physician's last date of service to Patient. As a matter of office policy, Physician is requiring all patients in its practice to sign the Mutual Agreement so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all Physician-Patient relationship.

Patient and Physicians acknowledge that breech of this Agreement may results in serious, irreparable harm. Patient and Physician agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

We are committed to serving you with highest quality care possible at affordable cost. Our staff is ready to help you at all times!

I have read the Financial Policy and Mutual Agreement. I understand and agree to this Financial Policy and Mutual Agreement.

X_____ _____ _____

Signature of patient/ Responsible party Print Name (Print) Date

X_____ _____ _____

Signature of patient/ Responsible party Print Name (Print) Date