Permian Basin Foot and Ankle
Stride Healthcare
PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name_____ MI ____

Address_____

City_____ State_____ Zip_____

Telephone (___)_____

*E-mail:_____

☐o not have an email Deny to provide email

Primary Physician_____

Phone# _____

Referring Physician_____

Phone#_____

☐Male ☐ Female

☐ Single ☐ Married ☐ Widowed ☐ Divorced

☐American Indian or Alaska Native ☐Asian ☐ White

☐Black or African American ☐ Native Hawaiian

☐Hispanic Latino ☐ Veteran ☐ Other

SSN_____

Date of Birth_____

Occupation _____

Employer _____

Check Preferred Method

☐ Work Phone (___)_____Ext_____

☐ Cell Phone (___)_____

Spouse Information (If Applicable)

Name _____

Telephone _____

***Do you have an advanced directive?**

☐Yes No Do not resuscitate

(A legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity)

INSURANCE INFORMATION

Primary- Ins. Co. Name_____

Policyholder Name_____

☐ Self ☐ Spouse

Policyholders Date of Birth____/____/____

Employer_____

Secondary- Ins. Co. Name_____

Policyholder Name_____

Policyholders Date of Birth____/____/____

☐ Self ☐ Spouse

PHARMACY INFORMATION

Pharmacy Name_____

Phone#: _____Fax#:_____

Address_____

City_____ State_____

Zip_____

EMERGENCY CONTACT (If other than Spouse)

Name_____

Relationship:_____

Telephone (___)_____

Guarantor Information: Complete if different from Patient

Name_____

Address_____

City_____

State_____ Zip_____

Telephone (___)_____

DOB_____

Employer_____

Work Phone (___)_____Ext_____

Permian Basin Foot and Ankle
Stride Healthcare
PATIENT REGISTRATION FORM

Is your treatment today due to:

.....a work related injury ☐ Yes ☐ No Injury Date_____

Do you have written authorization from your employer and comp carrier to be treated ☐ Yes ☐ No

.....a motor vehicle accident ☐ Yes ☐ No Accident Date_____

.....a an accident/ liability case ☐ Yes ☐ No Accident Date_____

I hereby authorize the release of any medical information pertaining to my treatment or information necessary for processing insurance claims and payment of medical benefits to myself or the party who accepts assignments. This authorization will remain valid until revoked by me in writing. I understand that I am legally responsible for all charges whether or not reimbursed by my insurance company.

Signature X_____ **Date**_____

MEDICARE SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made either to me or on my behalf of **Permian Basin Foot and Ankle** for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

PATIENT'S NAME (Please Print)		PROVIDER: Name, Address, and Zip
		Permian Basin Foot and Ankle **Stride HealthCare** **420 E 6th Suite 104 4214 Andrews Hwy. Suite 305** **Odessa TX 79761 Midland, TX 79703**
PATIENT'S SIGNATURE		
PATIENT'S MEDICARE NO.	DATE	

Cancellation and NO-Show Policy

We ask you to be aware of the following:

Missed appointments will result in a $50 fee. (This will be assessed if you do not call and/or do not show up for your scheduled appointment)

Please call 24 hours prior to your appointment to cancel or reschedule. (This will not result in any fee being assessed to your account) Our office will do our best to alert you of your upcoming appointment, so please be sure our office has your correct contact information.

Patient
Signature_____Date_____

History & Medical Information

1. Explain your foot/ankle problem ☐ Right ☐ Left _____

_____

2. When did pain/discomfort begin (date): _____

Describe pain/discomfort: ☐ Burning ☐ Numbness ☐ Sharp ☐ Other _____

3. What makes the pain/discomfort better: _____

4. Have you had a physical trauma? ☐ No ☐ Yes _____

5. Have you had an accident? ☐ No ☐ Yes _____

6. Occupation: _____ **Is your problem work related?** ☐ Yes ☐ No

7. Past Medical History: ☐ Gout ☐ Thyroid Disorders ☐ Osteoarthritis

☐ Anemia ☐ Heart failure ☐ Lung/Respiratory Disorders ☐ Other Arthritis

☐ Bleeding Disorders	☐ Hepatitis	☐ Mitral Valve Prolapse	☐ Rheumatic Fever
☐ Cancer _____	☐ High Cholesterol	☐ Nerve Disorders	☐ Stroke
☐ Diabetes	☐ HIV / AIDS	☐ Neurological Disorders	☐ Kidney Disease
☐ Epilepsy	☐ High Blood Pressure	☐ Prostate Disorders	☐ Other: _____

8. List all medications/herbs/vitamins: ☐ **NONE** _____

_____

9. Allergies: (Describe reaction) ☐ **NONE**

☐ Penicillin _____	☐ Aspirin _____	☐ Narcotic Agent / Codeine _____
☐ Anesthesia _____	☐ Shellfish _____	☐ Sulfa Drugs _____
☐ Nickel / Metal _____	☐ Radiographic Contrast Dye _____	
☐ Other _____		

10. Are you currently pregnant? ☐ No ☐ Yes _____

11. Surgical History: Have you had surgery? ☐ Yes—if yes, describe below ☐ No

Surgery / Date: _____

_____

12. Social History: (Only check what is pertinent to you)

☐ Tobacco Use ☐ Alcohol Use ☐ Exercise habits _____

☐ Caffeine Use ☐ Drug use (recreational, IV)

13. Family History: (List relationship of family member(s) who have had these problems):

☐ Diabetes _____	☐ Heart Disease _____	☐ Kidney Disease _____
☐ Hypertension _____	☐ Stroke _____	☐ Mental Illness _____
☐ Rheumatology _____	☐ Bleeding Disorders _____	☐ Cancer _____

☐ Other family History: _____

14. Height: _____ **Weight:** _____ **Shoe size:** _____ **Flu vaccine** _____ **Pneumonia Vaccine** _____ **A1C results** _____ **Date** _____

NOTICE OF PRIVACY PRACTICES

Joseph C. Morgan, D.P.M. and Associates are committed to protecting the privacy and security of individual identifiable health information and other protected health information of a confidential nature for this medical practice as set forth in the health insurance portability and accountability act. ("HIPPA")

I hereby acknowledge that I have read this "Notice of Privacy Practices."
I agree and give permission for the office to leave voicemail on my phone number on my demographics.

Patient signature: _____ Date: _____

Witness signature: _____ Date: _____

Permian Basin Foot & Ankle

Joseph C. Morgan, DPM, Justin Brown, DPM

420 E. 6th Street Suite 104
Odessa, Texas 79761

4214 Andrews Hwy Suite 305
Midland, Texas 79701

A. Permian Basin Foot & Ankle

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare/Insurance doesn't pay for **any service, materials, or equipment** below, you may have to pay. Medicare/Insurance does not pay for everything, even some care that your healthcare provider has good reason to think you need. It is possible Medicare/Insurance may not pay for the below listed items.

D. Possible Procedure(s)	E. Reason Insurance May Not Pay	F. Estimated Cost
11721 DFC/Routine foot care	If Medicare OR your **Insurance**	$ 95.00
11720 DFC/Routine foot care one foot	does not pay	$ 65.00
11055 Callus removal	For any of the procedures or	$ 50.00
17110 Skin lesion/Wart	products these charges may	$ 60.00
11042 wound debridement	apply.	$ 85.00
L3260 Post Op Shoe		$ 25.00
L4360 Walking boot		$150.00
Diabetic Shoes and inserts		$250.00
Ingrown Toenail procedure		$363.00
Initial Office visit-self pay		$150.00
Established office visit-self pay		$ 95.00

WHAT YOU NEED TO DO NOW:

Read this notice, so you can make an informed decision about your care.

Ask us any questions that you may have after you finish reading.

Choose an option below about whether to receive the **service and equipment** listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

X **OPTION 1. I want the foot care, services, and equipment listed above.**
I want Insurance/Medicare billed for an official decision on payment, which is sent to me on a Summary Notice. If payment is made and Insurance/Medicare does pay, you will refund any payments I made to you, less copays or deductibles.

☐ **OPTION 2. I want the foot care, services, and equipment listed above, but do not bill Insurance/Medicare.**
You may ask to be paid now as I am responsible for payment. **I cannot appeal if Insurance/Medicare is not billed.**

☐ **OPTION 3. I don't want the foot care, services and equipment listed above.**
I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare/Insurance would pay.**

H. Additional Information:

This notice gives our opinion, not an official Insurance decision. If you have other questions on this notice call your insurance or Medicare billing, (1-800-633-4227)

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date: