PATIENT REGISTRATION

Patient Full Name:_____

Date of Birth:_____/_____/_____ **Full Social Security Number:**_____

Sex: Male_____**Female**_____ **Ethnicity:**_____

Home Phone #:_____ **Cell Phone #:**_____

Email Address:_____

Street Address:_____

_____

Marital Status: S_____**M**_____**W**_____**D**_____

Spouse Name:_____**Phone #:**_____

Referred By:_____

Primary Care Doctor:_____**Phone #:**_____

Reason for Office Visit (type of injury/ illness:_____

_____

Is Patient currently employed? Y_____**N**_____ **Financial Responsibility: Self**_____**Other**_____

Patient's Employer:_____**Occupation:**_____**Phone #:**_____

IN CASE OF EMERGENCY

Name:_____**Phone #:**_____**Relationship:**_____

Address:_____

Authorization for Treatment and Financial Agreement: I do herby consent to medical care encompassing such diagnostic procedures and medical treatment performed on me and ordered by my physician, his assistants, as is necessary in the judgement of my physician. I herby authorize direct payment to physician of all medical insurance benefits (including without limitations Medicare and Medicaid benefits) to which the patient in entitled in consideration of services to be rendered by provider of services to the patient. I understand that I am financially responsible for charges not covered by insurance benefits and guarantee payment for such charges.

Signature:_____**Date:**_____

Patient:_____**Parent of Guardian of Minor:**_____**Authorized Representative:**_____

Past Medical History

Hospitalizations: (Medical/Surgical) Year Any Complications

_____
_____
_____
_____
_____

Allergies:

_____
_____
_____

Medications: (LEAVE BLANK IF YOU HAVE A MEDICATION LIST)

Name the Drug Strength Frequency Taken

_____
_____
_____
_____
_____
_____
_____
_____

Pharmacy Phone Number Address

_____ _____ _____

Family Medical History: Age Now or At Death Cause of Death Any Health Problems, If Alive

Mother_____
Father_____

Social History:

Smoker, Yes_____ No_____ If Yes, how many packs per day_____ for _____ days/wks/mnths/yrs
If No, did you ever smoke and when did you quit? _____

Alcohol, Yes_____ No_____ If Yes, how often? Daily_____1-2 times/wk._____ 1-2 times/month_____ 1-2 times/yr_____

Recreational/Illicit Drugs, Yes_____ No_____

Hearing Impaired, Yes_____ No_____ Hearing Aid, Yes____ No____ Dentures, Yes____ No____

Are you on a special diet (Diabetic, Low-sodium, etc.)? Yes_____ No_____

Ongoing Medical Problems - CHECK WHAT THAT APPLIES			Describe your problem
Lungs, Breathing	Yes_____	No_____	_____
Do you wear contact/glasses?	Yes_____	No_____	_____
when was last exam?	_____		
Heart Problems	Yes_____	No_____	_____
Diabetes	Yes_____	No_____	_____
High blood Pressure	Yes_____	No_____	_____
Bleeding Problems	Yes_____	No_____	_____
Balance Problems (Dizziness)	Yes_____	No_____	_____
Numbness/Tingling	Yes_____	No_____	_____
Anxiety/Depression	Yes_____	No_____	_____
AIDS/HIV	Yes_____	No_____	_____
Cancer	Yes_____	No_____	_____
Arthritis	Yes_____	No_____	_____

FINANCIAL POLICY FOR HORIZON FOOT & ANKLE INSTITUTE, RAYMOND BROCKHOUSE, DPM

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate 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.

MEDICARE: We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However, that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any copayments & co-insurance.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

COPAYMENTS AND DEDUCTIBLES: All co-payments, co-insurance 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 at each visit.

SELF PAY: Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment of these services.

REFERRALS/AUTHORIZATIONS: We are **required** to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of this visit. If you do not have a referral from your primary care physician at the time of a visit, you will be financially responsible for all services received due in full upon completion of the visit. Full credit will be given if a referral is presented to our office within 48 hours of this visit. You will also be given the option to reschedule your appointment.

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonable 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.

PATIENT BILLING: You will be sent up to three notices for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account may be forwarded to collections. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check or VISA/Mastercard. An additional $25.00 will be added to your statement if the check is returned for insufficient funds. In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance.

I have read the above policy regarding my *financial responsibility* to **Horizon Foot & Ankle Institute, Raymond Brickhouse, DPM** for medical services provided. I agree to pay **Horizon Foot & Ankle Institute, Raymond Brickhouse, DPM** any balance unpaid by my insurance carrier for myself of the below named person.

Assignment of Benefits
I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **Horizon Foot & Ankle Institute, Raymond Brickhouse, DPM** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information.

PRINT Patient Name: _____ **Signature:** _____

FINANCIALLY RESPONSIBLE PARTY:

PRINT Name: _____ **Signature:** _____

Relationship to Patient: _____ **Date:** _____

Raymond Brickhouse, DPM

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

Patient Name or Legal Guardian: _____

Signature: _____ **Date:** _____

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date:	Initials:	Reason:

PAD Patient Intake Decision Tree

Answers to the following questions will help determine if you are at risk for Peripheral Arterial Disease (PAD) and if a vascular examination can help better assess your vascular health status.

1	Do you experience any pain in your legs or feet while at rest?	Yes No
2	Do you have uncomfortable aching, fatigue, tingling, cramping or pain in your feet, calves, buttocks, hip or thigh during walking/exercise?	Yes No
3	If yes to Question 2, does the pain go away when you stop walking/ exercising?	Yes No
4	Do your feet get pale, discolored or bluish at any time during the day?	Yes No
5	Do you have an infection, skin wound or ulcer on your leg or foot that is slow to heal over the past 8-12 weeks?	Yes No
6	Are you over the age of 65	Yes No
7	Are you over the age of 50	Yes No
8	Do you have high cholesterol or other blood lipid (fat) problems or require cholesterol medication?	Yes No
9	Do you have high blood pressure or take medication to reduce blood pressure?	Yes No
10	Do you have diabetes?	Yes No
11	Do you have a history of chronic kidney disease?	Yes No
12	Do you currently or have you ever smoked?	Yes No
13	Do you have a history of stroke or mini-stroke (TIA)?	Yes No
14	Do you have a history of heart disease (heart attack, MI)?	Yes No
15	Do you have a history of carotid stenosis, AA (abdominal aortic aneurysm), and/ or stent placement?	Yes No

1 Yes
ABI

2 Yes
ABI

HORIZON
FOOT & ANKLE INSTITUTE

Raymond Brickhouse DPM & Jacob Button DPM

Physician & Surgeon of the Foot & Ankle

6400 Clayton Rd, Ste 412, St. Louis, MO 63117 |Phone: (314) 381-1800 | Fax: (314) 442-7749

MEDICAL RECORDS RELEASE FORM

Patients only fill out the highlighted portions of this document. Our office will fill out the remainder.

PATIENT'S NAME:_____

ADDRESS:_____

DATE OF BIRTH: _____

I HEREBY AUTHORIZE:

FACILITY/ PROVIDER: _____

PHONE: _____ FAX: _____

TO RELEASE MY RECORDS INCLUDING:

_____

_____

_____

_____

VIA FAX/ AND OR MAIL TO HORIZON FOOT AND ANKLE INSTITUTE, 6400 CLAYTON RD, STE 412, SAINT LOUIS, MO 63117

PHONE: (314)381-1800 FAX: (314)442-7749

SIGNATURE: _____ DATE:_____

PRINTED NAME & RELATIONSHIP: _____