DR. ROBERT E. NEVILLE & ASSOCIATES, P.A
MEDICAL AND SURGICAL SPECIALIST OF THE FOOT AND ANKLE

PATIENT INFORMATION (please print clearly with full detail)

Date:____/____/____ Whom may we thank for your referral?_____

Patient's last name:_____ Patient's first name:_____ MI___ Age:___

DOB:_____ Male__ Female__ Social Security #_____ Marital Status: S__M__D__W__

Address_____ City_____ State_____ Zip_____

Home#:◯_____ Cell #:◯_____ Email _____
Please Check box for Primary

Ethnicity and Race: ◯ American Indian or Alaska Native ◯Asian ◯Black or African American
◯ Native Hawaiian or Other Pacific Island ◯White ◯Other Race◯Decline to Specify

Patient's Employer_____Occupation_____

Emergency Contact Name_____ Number_____

RESPONSIBLE PARTY INFORMATION

Last Name_____ First Name_____ DOB_____ Age_____

Address_____ City_____ State_____ Zip_____

Male___ Female____ Home Phone_____ Work Phone_____

Social Security #_____ Employer_____

INSURANCE INFORMATION

Insurance Company_____ Insurance Phone #_____

Subscriber/Medicare ID#_____ Group #_____PPO__POS__EPO__HMO___

Subscriber's Last name_____ First Name_____ DOB_____
Employer_____ Phone Number_____

Secondary Insurance: Company_____ Subscriber ID#_____

ASSIGNMENT AND RELEASE

My Signature below authorizes the doctor to release my medical information necessary to process my insurance claims. I authorize that any benefits due me be paid directly to my physicians. I understand payment is expected at time of service. I acknowledge that I was provided/offered a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I choose) and understand the Notice.

Responsible Person's Signature_____
Date_____

MEDICAL HISTORY

Patient Name:_____

It is a pleasure to welcome you to our office! In order to best serve your podiatric medical/surgical needs, please take a moment to complete this medical history form.

Are you in good health?_____
Are you now or have you been under a Physician's care during the past year?_____
If so, for what medical problem?_____
Pharmacy Name and Location_____
Pharmacy Phone Number_____
Do you have a family physician? No If Yes; Last time seen_____

Physician's Name_____ Phone Number_____

Are you being treated by any specialty physicians? Yes No

Physician's Name_____ Phone Number_____

Are you currently taking any medications? Yes No If so, please list medication dosage

Name of Medication	Dosage/Strength	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

Daily vitamins_____ Daily Aspirin_____

Do you have any allergies or have you ever had a negative reaction to Penicillin, Sulfa, Codeine, Aspirin, Iodine, Novocain, metals, shellfish, adhesive tape, local anesthetics, pollen, mold, dust, materials, foot, topical contactants, animals, soap, clothing, jewelry, cosmetics or anything else?_____
_____
_____

Please circle if you have ever been treated for any of the following conditions: **Heart disease, Gout, High Blood Pressure, Diabetes, Blood Clot, Rheumatic Fever, TB, Cancer, Thyroid, Ulcers, Hepatitis, Asthma, Epilepsy, Stroke, Anemia, Phlebitis, Arthritis, AIDS, Depression, Bronchitis, Anxiety, Heart Murmur, Syphilis, Gonorrhea, Sickle Cell, Broken Bones, Prolonged bleeding, Bowel, Bladder, Kidney, Liver or Lung Problems, or any other medical concern?**_____
_____

Have you ever been hospitalized for an illness, injury or have you ever had any surgery? If so please list:
_____
_____

Do you have a family history of any of the following health disorders? **Heart Disease, Diabetes, High Blood Pressure, Cancer, Sickle Cell Anemia, Other:**_____
_____
_____

Patient's Name: _____

Do you smoke? ◯Never ◯Current ◯Former If yes, how much?_____ How long?_____
Do you drink the following beverages?

Coffee:	Frequently	Occasionally	Never

Soda: Frequently Occasionally Never
Alcohol: Frequently Occasionally Never

Do you take birth control pills?_____ How long?_____
Are you now or is there a possibility that you are pregnant?_____
Are you breast feeding?_____

Do you take any recreational drugs?_____

Have you ever been treated for or diagnosed with AIDS or HIV carrier?_____

Do you heal well?_____
Do you tend to bruise or scar easily?_____

Are you currently involved in a sport or exercise program on a regular basis?_____

What kind of shoes do you wear the most?_____
What is your shoe size?_____ Width?_____

What is your weight?_____Height?_____

Were you ever treated with foot disorders as a child?_____
Were you ever treated with foot disorders as an adult?_____

Do you wear custom insoles (prescription orthotics)?_____

What is the foot or ankle problem that brought you to our office? Please be specific.

_____
_____
_____
_____

How long have you had this problem?_____

What makes it better?_____

What makes it worse?_____

Thank you for taking the time to answer these questions. Your answers will enable us to give you the kind of care that is best for your foot health needs. If you have any other medical concerns not listed above, please list them below or discuss them with the doctor.

_____

Review of Systems: Please check all that apply

Patient Name: _____

General

- ☐ General good health
- ☐ Fever Chills
- ☐ Loss of appetite
- ☐ Headache
- ☐ Dizziness

Ears, Eyes, Nose, Throat

- ☐ Vision problems/glasses
- ☐ Hearing problems/hearing aids
- ☐ Nasal Congestion
- ☐ Dental difficulies/dentures
- ☐ Neck stiffness/pain

Hematologic

- ☐ Ease of bleeding
- ☐ Ease of bruising
- ☐ Anemia

Allergic/Immunologic

- ☐ Reactions to drugs or foods
- ☐ Seasonal Allergies

Skin

- ☐ Scaling/dryness
- ☐ itching/rashes
- ☐ Open wounds
- ☐ Nail changes
- ☐ Scar easily
- ☐ Psoriasis
- ☐ Dermatitis

Endocrine

- ☐ Heat or cold intolerance
- ☐ Sweating
- ☐ Thirst
- ☐ Change in appetite
- ☐ Unusal Fatigue
- ☐ Weight Loss
- ☐ Weight gain

Genitourinary

- ☐ Painful Urination
- ☐ Frequent urination/incontinence
- ☐ Kidney Disease/Hemidialysis
- ☐ Sexually transmitted disease

Respiratory

- ☐ Shortness of breath
- ☐ COPD
- ☐ Painfull Breathing
- ☐ Asthma
- ☐ Cough
- ☐ Fever or night sweats
- ☐ Sleep apnea

Gastrointestinal

- ☐ Indigestion
- ☐ Ulcers
- ☐ Diarrhea
- ☐ Constipation
- ☐ GI bleeding
- ☐ Heart Burn
- ☐ Vomiting
- ☐ Liver Disease

Psychiatric

- ☐ Anxiety
- ☐ Depression
- ☐ Addiction
- ☐ Psychiatric care

Musculoskeletal

- ☐ Joint/muscle stiffness
- ☐ Back pain
- ☐ Redness of joints
- ☐ Swelling of joints
- ☐ Trauma
- ☐ Gout
- ☐ Arthritis
- ☐ Muscle/joint pain
- ☐ Muscle weakness
- ☐ Muscle cramps
- ☐ Limitation in motion

Cardio Vascular

- ☐ Chest pain/Heart attck
- ☐ Hisotry of CHF
- ☐ History of heart surgery
- ☐ Palpations/fainting
- ☐ Cold feet
- ☐ Night cramps
- ☐ Intermittent Claudication
- ☐ Peripheral Edema

Neurological

- ☐ Shooting or burning pain
- ☐ Seizures
- ☐ Unsteady gait
- ☐ Tremors
- ☐ Dizziness
- ☐ Fainting
- ☐ Tingling in extremities
- ☐ Numbness in extremities
- ☐ Weakness
- ☐ Paralysis

Please check all that apply

Past Medical History

- ☐ Thyroid disorder
- ☐ Osteopenia
- ☐ AIDS/HIV
- ☐ Hepatitis
- ☐ Heart Disease
- ☐ Alzheimer's
- ☐ Blood clots/DVT
- ☐ Cancer
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Sickle Cell Disease
- ☐ Gout
- ☐ Rheumatic fever
- ☐ TB
- ☐ Ulcers
- ☐ Stroke
- ☐ Heart Murmer

Past Family Medical History

- ☐ Cancer
- ☐ Diabetes
- ☐ Gout
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Rheumatoid Arthritis
- ☐ Stroke
- ☐ Thyroid Disease

Mark "A" for alive and "D' for deceased

- ☐ Mother
- ☐ Father

If deceased please explain cause of death and age:

_____

_____

_____

_____

_____

CREDIT CARD POLICY

DR. ROBERT E NEVILLE & ASSOCIATES, P.A.
MEDICAL AND SURGICAL SPECIALIST OF THE FOOT AND ANKLE

As of January 1, 2016 we now require a credit or debit card on file with our office if we will be billing insurance for you. If you do not have insurance, then payment in full is due at the time of service.

As you may have experienced when you check into a hotel or rent a car, the first thing you are asked for is a credit card which is swiped and later used to pay your bill. Due to the changes occurring in healthcare, most medical practices are implementing a similar policy.

Our office requires that a valid credit or debit card is provided at the time of service to be kept on file in a secure, encrypted system. In the event that a balance remains after you have been notified of the outstanding balance via (2) statements sent to the address provided, payment of this balance in full will be charged to the credit/debit card. If your account should ever be turned over to a collection agency, a $25.00 fee will be added to your account. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

If you have any questions about this policy, please do not hesitate to ask.

Frequently Asked Questions:

Why the change?

Many changes are occurring in healthcare as of January 1st, 2014 due to the implementation of the Affordable Care Act. In order to continue providing care and to keep medical costs as low as possible, we need to ensure that we have a guarantee of payment on file in our office. You will find that over the next year or so most medical practices will require full payment up front or credit/debit card on file for payment of patient balances.

But I always pay my bills, why me?
We have to be fair and apply the policy to all patients. We have great patient and we know that most of you pay your balances.

How will I know how much you are going to charge me?
You will receive two invoices before we charge your credit card. We will charge you for the balances on the invoices sent to you. We determine this balance by looking at the Explanation of Benefits (EOB) that your insurance sends us that showing what the patient responsibility is.

I'm nervous about leaving my credit card.
We store your credit card information on a secure gateway that is completely compliant as required by law – just like a hotel or rental car agency does. We access your information only on this to process a payment. If you absolutely do not want your credit card on file, then you can choose to pay the entire billed amount at the time of service. If your insurance then pays, we will send you a refund.

What if I need to dispute my bill?
We will always work with you to understand if there has been a mistake, and we will refund you if we have made a billing error.

What if I don't have insurance?
If you do not have insurance, payment in full is due at the time of service. In this case we do not need to have a credit card on file.

I have read and understand the above information regarding the credit card on file policy:

Signature: _____ Date: _____

Printed Name: _____

OFFICE AND FINANCIAL POLICIES

DR. ROBERT E NEVILLE & ASSOCIATES, P.A.
MEDICAL AND SURGICAL SPECIALIST OF THE FOOT AND ANKLE

Welcome and thank you for choosing Dr. Robert E. Neville & Associates for your foot health concerns. We are committed to providing you with the highest quality medical care in an efficient, timely, and effective manner. We hope that providing you with our policies in advance, we can prevent any misunderstanding or frustration at the time of your visit.

Insurance: It is your responsibility to confirm with your insurance company that the physician is currently under contract with your plan. If your plan requires that you have a referral prior to seeing a specialist, please contact your primary physician so that you have the referral in hand prior to your appointment. We do not accept a faxed referral-if we do not have a referral at your appointment time, we will need to reschedule your visit, unless you choose to be seen without using your insurance benefits and pay for your visit in full. If your insurance should happen to change, we require that you notify our office 24 hours prior to your appointment time.

It is your responsibility to know the benefit coverage for specialist visits. We will gladly file your insurance claim on your behalf. We allow 45 days from the date the claim is filed for the insurance company to pay. If your carrier does NOT pay within this time, you could be responsible for the entire balance. We will not become involved in disputes between you and your insurance company regarding coverage and/or policy benefit criteria (ie: deductibles, non-covered services, co-insurance, coordination of benefits, pre-existing conditions or reasonable and customary changes, etc) other than to supply factual information when necessary. You are responsible for deductibles, co-insurance, non-covered services and any other charges insurance may not cover. You will be sent statements on a monthly basis regarding any monies owed.

Non-Covered Services: An "Insurance Waiver" may be required to acknowledge understanding of your responsibility for non-covered services.

Check-In: Please arrive to your appointment at least 15 minutes prior to your scheduled time to complete all required paperwork. Please bring your current insurance card with you to EACH VISIT as well as your valid identification card. On follow-up visits, you will be asked to verify demographic/insurance information as well as complete any necessary paperwork so that our records remain up-to-date. Any outstanding balances will be due at check-in in order to see your provider. If payment toward your outstanding balance cannot occur at that time, your appointment will need to be rescheduled and/or cancelled.

Credit Card Policy: Please provide a valid credit card upon check-in. We will input your credit card information into our secure and encrypted credit card service provider. (Transaction Express)

Check-Out: **Please be prepared to pay for your current visit**. Payment of co-pays, deductibles, supplies or any non-covered services will be required at the time of service. Estimated patient responsibilities for surgical procedures and office care will be determined by insurance benefit coverage verification and collected at the time of service. Paying at the time of service does not mean you will not get a bill, fees are estimated. We only accept the following: Cash, Check, Debit Card, MasterCard, Visa, Discover, and American Express.

Late Arrivals: If you arrive more than 15 minutes past your scheduled appointment time, you will be rescheduled so that other patients are not inconvenienced.

No Shows and Late Cancellations: We require a 24-hour notice if you must cancel your appointment. If you cancel the same day as your appointment, you will be considered a NO SHOW for that visit. A **$25.00 charge** is charged to your account for each **NO SHOW**. You will be expected to pay that charge and any others that may occur at the time of your next visit.

Minors: The parent(s) or guardian(s) accompanying a minor are responsible for providing current insurance information for the minor and/or payment in full for services provided. Unaccompanied minors must have a written authorization for medical treatment signed by the parent or guardian before treatment can be released.

I have read, understand and agree to the above office and financial policies. I hereby attest that I have given and agree to provide current demographic and insurance information and authorize release of information necessary for insurance filing and precertification by signing this statement.

Patient Name: _____ Responsible Person's Signature: _____ Date: _____

Witness: _____ Date: _____

For Staff Member Use only: _____ Date: _____
Card Provided: ○ Yes ○ No

AUTHORIZATION FOR TREATMENT AND RELEASE OF MEDICAL INFORMATION

DR. ROBERT E NEVILLE & ASSOCIATES, P.A.
MEDICAL AND SURGICAL SPECIALIST OF THE FOOT AND ANKLE

AUTHORIZATION FOR TREATMENT

I, the undersigned, hereby authorize Dr. Robert E. Neville and Associates, PA to render treatment and/or therapy to myself that he deems medically necessary in order to treat the condition and/or conditions I have required from himself or his staff.

Signature of Patient or Guardian: _____ Date: _____

Relationship of Guardian to Minor Child: _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Dr. Robert E Neville & Associates, PA all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature of Patient/Guardian: _____ Date: _____

Relationship of Guardian to Minor Child: _____

For Staff Member Use Only:
1. _____ date: ____

PATIENT CONSENT FORM

DR. ROBERT E NEVILLE & ASSOCIATES, P.A.
MEDICAL AND SURGICAL SPECIALIST OF THE FOOT AND ANKLE

Disclosures of Physician Ownership

Please be informed that Dr. Robert E. Neville and physicians in Neville Foot and Ankle Centers have direct and indirect financial ownership relations, and may receive remuneration directly or indirectly from the entities of: Neville Foot and Ankle Centers, Dr. Robert E Neville & Associates, PA, PinPointe Laser System, Vasomed Sensilase, Metasurg Medical Devices, Memorial Hermann Surgery Center Woodlands Parkway, Assurance Consolidated Pharmacy, Vision Park Premier Imaging Center, Tronown Thomas Life ChekDrug, Eugene Lansangan PT, Texas Neurodiagnostic Associates Inc, Village RX Group LLC, Next Health-Select Pharma LLC Hallux Podiatric Pathology Laboratory, Marlinz Pharma, Pharma Select-Select Pharma, PND Neurodiagnostics, and Sleep Tight Diagnostic Laboratory. Decisions regarding the admissions, recommendations, referrals, or any other form of arrangement for utilization by patients of your physician of specific services or facilities are made with regard to the best interest of each individual patient. You have the right to choose the provider of your health services. You will not be treated differently by your physician if you choose to obtain other health care services. If you have any questions concerning this notice, please feel free to ask your physician.

By signing below, I certify that I have read and understand this policy.

Patient/Guardian Signature: _____ Date: _____

Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient's Rights section describing your rights under the law. You have the right to review our notice before signing the Consent. The terms of our notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The practice has a Notice of Privacy Practices and the patient has the opportunity to review the Notice
- The practice reserves the right to change the Notice of Privacy Policies
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease

Occasionally it is necessary to call our patients to remind them of an appointment, discuss medical test results, or even to return a patient's call. Often we are greeted by an answering machine- please authorize the type of message you would like us to leave on the phone numbers provided by you on the patient demographic forms or verbally to our staff members (check all that apply):

_____ Ok to leave message on machine with detailed message, including normal lab results or benign pathology results

_____ Ok to leave message with call back number only

_____ Ok to leave message with family member (Please specify name of individual: _____)

_____ Other/Note: _____

HIPAA requires health care providers to protect the privacy of your health information. However, if you would like your provider to be able to share your health information with a family member(s) or friend(s) please state his/her name below. We will not be able to share any information with any individual not listed below.

I wish to give the following individual(s) permission to obtain information regarding my health (please list names in box):

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Patient Name: _____ Responsible Person's Signature: _____ Date: _____

Witness: _____ Date: _____ For Staff Member Use Only:

1. _____ date: _____