Hays Foot & Ankle
SURGICAL ASSOCIATES, PLLC

Kyle | Dripping Springs | Seguin
P: (512) 268-3668 F (512) 268-5785

PATIENT REGISTRATION

Please print clearly so that we can process your information quickly and efficiently.

Name *(First, Mid, Last)*_____

Date of Birth _____ Age _____ Male / Female Marital Status: S M W D

Mailing address_____

_____Email _____

Phone Number_____Social Security #_____ Referring Physician_____

Primary Care Physician (PCP)_____PCP Phone #_____Date Last Seen by PCP_____

Preferred Pharmacy_____ Pharmacy Address _____

If Student, School Name_____ Full-Time / Part-Time

Responsible Party (If other than the patient)

Name_____Relationship to Patient _____

Address_____

Employer_____ Phone Number _____

Employer Address _____

Emergency Contact_____ Phone Number _____

Primary Insurance Information

Insurance Company_____ Phone Number _____

Address _____

Group _____ID# _____

Insured's Name_____Male / Female Relationship to Patient: Self / Spouse / Dependent

Insured's Address _____ Insured's D.O.B _____

Insured's Employer _____ Phone Number _____

Secondary Insurance Information

Insurance Company_____ Phone Number _____

Address _____

Group _____ ID # _____

Insured's Name_____Male / Female Relationship to Patient: Self / Spouse / Dependent

Insured's Address _____ Insured's D.O.B _____

Insured's Employer _____ Phone Number _____

I hereby assign, transfer, and set over to Hays Foot and Ankle Surgical Associates, PLLC all my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether they are covered by insurance.

Patient Signature _____ **Date**_____

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Our Patient's Bill of Rights

As a patient and physician, ours is more than a relationship, it's a partnership. To ensure this, we have lived by the following principles

- A patient has the right to know what his or her condition is and what trouble it is likely to cause.
- A patient has a right to have the condition explained in real terms, not medical terms.
- A patient has the right to know our qualifications and experiences.
- A patient has the right to consult other doctors without us being insulted or angry that the patient wants another opinion.
- A patient has a right to understand our fees.
- We will spend the patients' money wisely as possible. We will look for and recommend the most cost-effective way of solving our patient's problems.
- We will not recommend surgery unless the patient needs help that only surgery can provide.
- If a patient feels that we have not provided them with our best efforts, please make this known. We cannot guarantee the results of treatment, but we can guarantee you our best efforts to treat you honestly and fairly.
- Considerate, respectful care always and under all circumstances with recognition of your personal dignity.
- Personal and informational privacy, within the law.
- Confidentiality of records and disclosures. Except when required by law, you have the right to approve or refuse the release of records.
- The opportunity to participate in decisions involving your health care, unless contraindicated by concerns about your health.
- Impartial access to treatment regardless of race, color, sex, national origin, religion, handicap or disability.
- Know the identity and professional status of individuals providing service to you.

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OFFICE AND COLLECTION POLICIES

Office Visits: *Office hours:* Monday-Friday: 8:00 am-5:00 pm, closed for lunch 12:00 pm-1:00 pm
We request that you make appointments for all your visits and be aware of the office hours. Our philosophy is to provide you with the highest quality care. Always bring a current list of all your medications with the exact dosages, to each office visit. We know that your time is as valuable as ours and we make every effort to keep our schedule on time. Please notify us in advance if you are unable to keep your appointment. **Appointments not canceled 24 hours in advance of the scheduled appointment time may be subject to a cancellation fee of $25 per office visit.** Extenuating circumstances will be taken into consideration. After three "No Shows" for your scheduled appointments, you will be considered non-compliant and qualify for termination from the practice.
Any outpatient surgeries scheduled that are not canceled 24 hours in advance are subject to a $250 No Show Fee

Telephone Calls: Our staff will be happy to answer your questions about office policy and scheduling. A receptionist, however, does not answer calls before or after hours or during lunch. Medical questions will be referred to one of our experienced medical assistants or one of the doctors. During clinic, a medical assistant is NOT available to speak with but will return messages as soon as possible. Extended phone consultations or after-hours and weekend calls resulting in telephone treatment may be billed a telephone visit from $10.00-$35.00.

After Hours Calls: All routine matters should be handled during regular office hours. If you believe your situation is critical, always go to an emergency room where the physicians there can assist you. Otherwise, call our office before going to the emergency room — many problems can be handled over the telephone.

Refill Request: Please contact your pharmacy for prescription refill requests. Each request may take 24-48 hours to complete. You will be notified if an appointment is required for a medication refill. A standard 90-day follow-up is required for certain prescriptions we choose to monitor. We are NOT a liberal prescribing practice find do intensely monitor the prescriptions that we issue. Please be aware that we will delay a prescription until we feel it is safe and needed.

Privacy and Security: Hays Foot and Ankle Surgical Associates, PLLC, holds all information of the care and treatment of our patients in the strictest confidence. All information in the patient's medical record is maintained with the utmost care and respect to preserve privacy and confidentiality. The practice fully complies with the Federal Government's mandated HIPAA requirements and all guidelines for patient confidentiality and privacy of healthcare and financial information. As a new patient, you will be asked to review and acknowledge receipt of our Notice of HIPAA Privacy Practice that outlines the circumstances for which we can disclose protected health information without authorization. Only the patient can provide the authorization to release records necessary for the practice to disclose protected health information, for instances not related to your ongoing treatment and/or payment of claims. A patient may request to view a copy of their medical records in the office. We also require consent to discuss or release any information to my member of your extended family, spouse, or children.

Self-Pay: ***Payment in full is due at the time of service if you do not have health insurance***, Hays Foot and Ankle Surgical Associates, PLLC, offers a prompt pay discount.

Collection Policy: ***All payments are due at the time of services rendered*****.** Hays Foot and Ankle Surgical Associates, PLLC, has a legal obligation to the insurance companies they are contracted with to collect co-payments. Once a balance reaches 90 days with quality communication and/or payment arrangement, it may qualify to be transferred to a third party for further collections or other actions.

Forms: (FMLA) There will be a fee of $50.00 for any forms needing to be filled out completely by Dr. Henke or Dr. Razmara.

Sunshine ACT Disclosure: In compliance with the Sunshine Act, a provision of the Affordable Care Act, we wish to disclose that our office occasionally receives food and beverages, sample drugs and patient coupons, and promotional material from pharmaceutical vendors and/or manufacturers in conjunction with product education. We do not receive direct financial compensation from any of our vendors.

I have read and understand the office/collection policies of Hays Foot and Ankle Surgical Associates, PLLC

_____	_____	_____
Patient Signature	**Patient Printed Name**	**Date**

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AKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge I have received this office's Notice of Privacy Practices, which explains how any medical information will be used and disclosed.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Name of Patient or Personal Representative Description of Personal Representative's Authority

AUTHORIZATION TO RELEASE ANY INFORMATION TO EXTENDED FAMILY AND/OR SPOUSE AND CHILDREN

Please think about anyone who may be calling in for information or for billing purposes. Without the name appearing on this form, we will NOT be authorized to release ANY information,

I authorize_____to receive private medical information on my behalf e my care and billing details or arrangements.

Authorizing Signature_____ Date: _____

PARENTAL PREAUTHORIZATION FOR MINORS

For families who have established relationships with our practice, it may be convenient to have on file prior authorization for medical care for children when a parent cannot be present for treatment. Please complete the following form if you want to authorize the treatment in advance.

I request and authorize Hays Foot and Ankle Associates, PLLC and its personnel to deliver medical care to my child listed below:

Child Name_____ Date of Birth _____

Please try to contact us regarding the health if care of our child at the following number(s):

Parent Name _____ Phone _____

Parent Name _____ Phone _____

Other _____ Phone _____

Note: If any special parental or custodial relationship exists (such as if the child has one parent only or if legal custody is held by guardians in the absence of both parents). Please explain the situation below along with your signature, printed name, and a contact phone number.

Parent/Guardian Name _____ Date _____

Parent/Guardian Signature _____ Date _____

Relationship to Patient _____

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PATIENT PORTAL AGREEMENT

We are pleased to provide a Patient Portal in partnership with our electronic medical records provider, e-CW for the exclusive use of patients in our practice. The Patient Portal is designed to enhance patient and physician communication. All users must be established by a previous office visit.

We strive to keep all the information in your records correct and complete, if you identify any discrepancy in your records, you agree to notify us immediately. Additionally, by using the Patient Portal, the user agrees to provide factual and correct information. The Patient Portal provides access to the following services: which may or may not be utilized at this time:

- Receive educational materials
- See your visit summary
- View current and past statements
- Send messages to our office staff

The Patient Portal is not intended to provide internet-based diagnostic medical services. The following limitations also apply:

- No internet-based triage and treatment requests. Diagnosis can only be made, and treatment rendered after the patient is SEEN by a medical provider in our office.
- No emergent communication or services. Any emergency conditions should be handled by calling the office directly, going to an urgent care clinic or emergency room, or calling 911 should the emergency be life-threatening.
- No requests for narcotic/controlled medications will be accepted.
- No requests for new prescriptions or refills for conditions for which you are not being treated by our clinic will be accepted.
- It may take 72 hours to receive a response to an email request. If you do not receive a response within 72 hours you should contact the office at **(512) 268-3668.**
- If you lose your password or username, you may request a new one through the web portal or in person at the office by providing valid identification.
- Always remember to log out and close your browser when you are finished accessing password-protected Patient Portal services. This prevents someone else from accessing your personal information, YOU SHOULD NEVER USE A PUBLIC COMPUTER TO ACCESS THE PATIENT PORTAL.

The Patient Portal is provided in partnership with e-CW, our EHR software vendor and provider. That data is HIPAA compliant with high-level encryption that exceeds the HIPAA standards. While we believe that the IT infrastructure and data are safe and secure, it does not guarantee unforeseen adverse events cannot occur. To the extent possible, our office has undergone rigorous IT implementation and security standards exceeding industry recommendations.

Please read our HIPAA policy for information on how private health information is used in our office, All patients have signed a HIPAA agreement form. If you do not recall having signed a HIPAA agreement or need to reacquaint yourself with the HIPAA policy.

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PATIENT PORTAL ACKNOWLEDGEMENT

To opt out of Patient Portal please continue and fill out the next page

Patient Acknowledgement and Agreement: I acknowledge that I have read and fully understand this form of consent. I have been given the risks and benefits of the Patient Portal and agree that I understand the risks associated with online communications between the practice and myself, and consent to the conditions outlined herein. I acknowledge that using the Patient Portal is entirely voluntary and will not impact the quality of care I receive should I decide against using the Patient Portal. In addition, I agree to adhere to the policies set forth herein, as well as any other instructions or guidelines that Hays Foot and Ankle Surgical Associates may impose for online communications. I have been allowed to ask questions related to this agreement and all of my questions have been answered to my satisfaction. I also understand this consent is valid for one year.

Patient/Guardian Signature **Date**

_____ _____

Secure/Private Patient/Guardian Email

_____

If you choose to opt out of our patient portal,
Please read and fill out Opt-Out request

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Information Exchange and Patient Portal Opt-Out Form

Hays Foot and Ankle Surgical Associates, PLLC participates in a health information exchange (HIE) which is a secure internet-based health record exchange that enables patient information to be shared electronically with physicians and other healthcare professionals/facilities involved in your healthcare. Additionally, we provide a patient portal that allows electronic access to your health information.

The goal of the HIE and patient portal is to help healthcare professionals provide better, more efficient, and coordinated patient care by providing access to a patient's most recent health information. However, you have the right to opt out of both the HIE and the electronic access provided by the patient portal.

OPT-OUT REQUEST

IF YOU CHOOSE TO OPT-OUT:
Please indicate your preferences by checking the appropriate boxes below:

- ☐ **I do not wish to participate in the Health Information Exchange (HIE):** By signing this form, I understand that I am directing Hays Foot and Ankle Surgical Associates, PLLC to opt me out of the electronic sharing of my health information with the HIE.
- ☐ **I do not wish to have electronic access to my health information via the patient portal:** By signing this form, I understand that I am directing Hays Foot and Ankle Surgical Associates, PLLC to disable my electronic access to the patient portal.

Patient Information

Patient Printed Name: _____

Patient's Date of Birth: _____ Todays Date: _____

Signature: _____

Patient Signature (or Legal Representative Signature):

_____

Mailing Address:
HHS Office of the Ombudsman
P. O. BOX 13247, Austin, TX 78711-3247

Compliance/HIPAA Privacy Officer Contact:
Phone: 1 (877) 787-8999
Fax: 1 (888) 780-8099
Online question or complaint form: https://hhsportal.hhs.state.tx.us/heartwebextr/hhscOmd

This form ensures that patients have the option to opt out of both the health information exchange and the electronic access provided by the patient portal, in compliance with information blocking regulations.

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PATIENT MEDICAL HISTORY

(*Bold/Italic for office use only*)

Patient Name: _____ Date: _____

Height _____'_____" Weight _____lbs

If 65 or older, history of pneumonia vaccine? [ ] YES ***(4040F)*** [ ] NO ***(4040F/8P)***

If 50 or older, current or previous flu vaccine? [ ] YES ***(G8482)*** [ ] NO ***(G8484)***

Fall History: ***(1101F)***

Do you have a history of falls?	NO	YES
If a returning patient, have you fallen since your last visit?	NO	YES
Two or more in the past year?	NO	YES
Fall with an injury in the past year?	NO	YES

PAST MEDICAL HISTORY

Please check (✓) if you have ever had any of the following problems.

- o No Past Medical Problems

Osteoarthritis

(1106F) pt needs (SF36) form

Arthritis
- o Degenerative
- o Fibromyalgia
- o Lupus
- o Rheumatoid
- o Other:_____

- o Asthma
- o Blood Disorder
- o Anemia
- o Clotting Disorder
- o Leukemia

Cancer
- o Bladder
- o Breast
- o Cervical
- o Colon
- o Lung
- o Myeloma
- o Prostate
- o Skin
- o Other:_____

Osteoporosis:

Anxiety/Depression

Circulation Problems
- o Phlebitis
- o Varicose Veins
- o Peripheral Vascular Disease
- o Stroke

Diabetes
- o Insulin Dependent
- o Adult Onset
- o Well Controlled
- o Not Well Controlled

Ear/Eye Trouble
- o Blurred Vision
- o Cataracts/Glaucoma

Elevated Cholesterol

Gout

Heart Trouble
- o Atrial Fibrillation
- o Coronary Artery Disease
- o Irregular Heartbeat
- o Mitral Valve Prolapse
- o Tachycardia

Herniated Disc

- o High Blood Pressure
- o HIV Positive
- o Intestine Problems
- o Acid Reflux
- o Crohn's Disease
- o Irritable Bowel
- o Stomach Ulcers
- o Kidney Disease
  - o Dialysis
  - o Transplant
- o Liver Disease
  - o Hepatitis
  - o Fatty Liver
  - o Transplant
- o Peripheral Neuropathy
- o Prolonged Bleeding
- o Rheumatic Fever
- o Seizure Disorder
- o Thyroid Disorder
- o Tuberculosis

Other:_____

Have you had a central dual-energy x-ray, also known as a DX to check for Osteoporosis?	NO ***(G8400)***	YES ***(G8399)***
Have you been Diagnosed with Osteoporosis in last 12 months?	NO	YES
IF YES, Are you currently taking medication to treat your Osteoporosis?	NO ***(4005F/8P)***	YES ***(4005F)***
Have you had or do you have a fracture?	NO	YES
IF YES, Have you received RX medication to treat Osteoporosis?	NO ***(G8635)***	YES ***(G8633)***
Have you had Dexa scan to check bone mineral density test?	NO ***(309SF/8P)***	YES ***(3095F)***

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FAMILY HISTORY

Please check (✓) if you have had any of the following in your family history and enter a relationship to the patient. Applies to siblings, parents, and grandparents. (Enter Relationship on space provided. Example: Father)

- o No Family Medical Problems
- o Diabetes _____
- o Cancer _____
- o Foot Problems _____
- o Heart Disease _____
- o High Blood Pressure _____
- o Stroke _____
- o Obesity _____ Other _____

MEDICATIONS

Please list ALL medications (including non-prescription) and vitamins that you are taking.

[ ]None [ ] List Attached

Name of Medication	Dose Strength	How often taken? (EX: 2x Per Day)	Name of Medication	Dose Strength	How often taken? (EX: 2x Per Day)

ALLERGIES/INTOLERANCES

Are there medications to which you have had an allergic reaction/unpleasant side-effects? [ ] Yes [ ] No Known Allergies

Name of Medication	Reaction

Please check (✓) if you have an allergic reaction to any of the following:

- o Latex
- o Local Anesthesia
- o Codeine
- o Iodine
- o Penicillin
- o Sulfa
- o Other: _____

PAST SURGICAL HISTORY

Please check (✓) if you have ever had any of the following procedures and include the year the procedure took place.

- o No Prior Surgeries
- o Tonsils
- o Appendix
- o Spleen
- o Liver
- o Gall Bladder
- o Pancreas
- o Hernia
- o Hemorrhoids
- o Brain
- o Bariatric Surgery
- o Heart Angioplasty
- o Heart Bypass
- o Coronary Artery Stent
- o Heart Valve
- o Pacemaker
- o Leg – Angioplasty/Bypass
- o Organ Transplant
- o Mastectomy
- o Pelvis Laparoscopy
- o Bladder Suspension
- o C-Section
- o Tubal Ligation
- o Prostate Surgery
- o Vasectomy
- o Ovaries/Hysterectomy
- o Bone and Joint
- o Neck
- o Back
- o Shoulder
- o Elbow
- o Hand
- o Hip/Replacement
- o Knee/Replacement
- o Ankle
- o Foot
- o Amputation
- o Other: _____

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SOCIAL HISTORY

Please check (✓) all that apply.

- o No Current Alcohol Use
- o Social Alcohol Use
- o Prior History of Alcohol of Abuse
- o Alcohol Consumption 1-3 Times Per Week
- O Alcohol Consumption 4+ Times Per Week
- O No Current Tobacco Use
- O Prior History of Tobacco Use
- O Occasional Tobacco Use
- O Current Tobacco Use *(4004F)*
- O No Current Drug Use
- O Current Drug Use
- O Prior History of Drug Abuse
- O Prior History of IV DrugAbuse
- O Other: _____

REVIEW OF SYSTEMS

Please check (✓) if you are currently experiencing any of the following.

- o No Current Medical Problems

Constitutional
- o Fever/Chills
- o Recent Illness
- o Weight Loss

Cardiovascular
- o Chest Pain
- o Shortness of Breath
- o Palpitations
- o Cold Feet
- o Leg Cramps

Gastrointestinal
- o Heartburn
- o Bloody Stool

Dermatological
- o Rash
- o Redness
- o Itching

Lymphatic/Hematologic
- o Swelling in Lower Extremities
- o Easy Bruising
- o Poor Wound Healing

Musculoskeletal
- o Low Back Pain
- o Hip Pain
- o Knee Pain
- o Foot/Ankle Pain
- o Pain at its worst 1-10:_____

Nervous System
- o Extremity Weakness
- o Extremity Burning
- o Extremity Numbness
- o Extremity Tingling

Endocrine
- o Frequent Urination
- o Excessive Thirst
- o Dramatic Weight Change

Female Reproductive
- o Breast Feeding
- o Currently Pregnant

Patient Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____