
**Elizabeth Fernandez, DPM**
1576 Lomaland Drive
El Paso, TX 79935
(915) 995-1650

Name of Patient _____ Social Security# _____

SEX: M F DOB_____ Age _____

Marital Status: (S M D W Separated) Number of Children _____

Home Phone _____ Cell _____ Work Phone _____

Home Address: _____ City _____ State _____ Zip _____

Email Address: _____

**Employer** _____

Occupation _____

Work Address _____ City _____ State _____ Zip _____

**Responsible Party** _____

Home Address _____ Cell _____

Relationship to Patient _____ DOB _____ Occupation _____

**WHO MAY WE THANK FOR REFERRING YOU TO US?**

_____

Emergency Contact _____ Relationship to Patient _____

Emergency Contact Phone Number _____

## INFORMATION

**Welcome to our office! This information is important for our medical records and your health. Please fill in the information as completely and accurately as possible.**

**CHIEF COMPLAINT :** Please describe your main foot and/or ankle problem or areas that need attention . ( Specify Left/Right Foot )

_____

Have you seen another specialist or physician regarding this condition? YES **NO**

If yes, Name the Specialist of Physician _____

Do you wear custom insoles, orthotics, or braces ? **YES NO**

What is your height ? _____ What is your weight? _____

What is your shoe size? _____ Shoe width? **Narrow Medium Wide**

Family Physician or Internist _____ Last Visit _____

Specialty Physician TYPE _____ NAME _____

Specialty Physician TYPE _____ NAME _____

**Pharmacy Name** _____ **Address** _____

## MEDICATIONS

PLEASE LIST THE NAMES AND DOSAGES OF **ALL** MEDICATIONS (PRESCRIPTION AND OVER THE COUNTER) THAT YOU ARE CURRENTLY TAKING:

_____

_____

_____

_____

## MEDICAL HISTORY

Have you ever had any serious illness or medical condition? YES NO

If yes, please explain _____

**Please SPECIFY if you have had or are currently dealing with any of the following conditions**

Diabetes (type?) _____
Lungs _____
Asthma _____
Blood Clots _____
Heart _____
Liver _____
Stroke _____
Kidneys _____
Thyroid (type?) _____
Stomach _____
Ulcer _____

Phlebitis _____
Arthritis _____
Cancer (type?) _____
T.B. _____
Murmur _____
Hypertension _____
Bladder _____
AIDS/HIV _____
Skin_____
Anemia _____
Gout _____

Psychological _____
Epilepsy _____
Circulation _____
ADHD _____
RA _____
Psoriasis _____
Depression _____
Crohn's /IBS _____
Fibromyalgia _____
Cholesterol _____

**Are you currently pregnant or breastfeeding? YES NO**

## ALLERGIES

Are you allergic or sensitive to any of the following? Explain, Reaction.

**IF NO KNOWN DRUG ALLERGIES, PLEASE INITIAL _____**

Penicillin _____
Morphine _____
Tape _____
Sulfa _____
Novocaine _____
Latex _____
Aspirin _____

Codeine _____
Iodine _____
Neosporin _____
Betadine _____
"Mycins" _____
If others (please list) _____

**Do you have allergic reactions or sensitivity to metals, jewelry, or nickel? YES NO**

## SURGERIES

Please list all surgeries/procedures that you have had. Please include when, where, and what surgical procedures.

**IF YOU HAVE NEVER HAD ANY PROCEDURE DONE, PLEASE INITIAL _____**

Surgery/Procedure _____ When _____ City/State _____

Surgery/Procedure _____ When _____ City/State _____

Surgery/Procedure _____ When _____ City/State _____

Have you even had a reaction or complication from a procedure or surgery? YES NO

If yes, please explain _____

## TRAUMATIC HISTORY

Have you ever had any SERIOUS injuries, accidents, or broken bones? If so, please list when, your treatment and outcome.

_____

_____

_____

_____

## HOSPITALIZATIONS

Have you ever been hospitalized for any reason? If so. please list when, where and for what reason.

_____

_____

_____

## FAMILY MEDICAL HISTORY

Does your family have history of any of the following. Please specify:

Diabetes (type) _____ RA _____

Cancer (where) _____ Psoriasis _____

Heart Disease _____ Gout _____

Hypertension _____ Arthritis _____

Foot Problems _____ Charcot Marie Tooth _____

Cholestorol _____

## SOCIAL HISTORY

Caffeine Intake? YES NO How Many Cups Per Day? _____

Do you smoke? YES NO

If yes, how many packs per day ____ How many years _____

Previously smoke YES NO

If yes, how many packs per day ____ How many years _____

Smokeless tobacco? YES NO

If yes, how many times per day _____

Do you drink Alcohol? YES NO

If yes. how often do you drink? _____

Do you use recreational/ illicit drugs? YES NO

If yes, please describe what type _____

Do you exercise? YES NO

If yes, please describe _____

# OFFICE POLICIES

We are dedicated to providing the best possible care and service to you. An essential element of your care and treatment is understanding your financial responsibilities. If you have any questions about the policies, please discuss them with our office manager and/or front office staff.

**Health Insurance** We are contracted with most insurance plans to accept assignment of benefits. Our office will file your visit with the insurance company and will only collect your co-pay, deductible and or co-insurance when it applies. Please note: Our contract with the insurance carrier requires us to collect your co-pay at each visit, If you have insurance coverage with a plan that we do not have a prior agreement with, the charge for your care and treatment are due at the time of service. In the event your health plan determines a service to be "non-covered", you will be responsible for the complete charge. Payment is due upon receipt of statement from this office.

**Referrals** it is your responsibility to obtain a valid referral from your primary care physician when required by your insurance company.

**Disability, Insurance Forms, Medical Records, and copies of X-Rays** There is a $25.00 per form charge to fill out disability and insurance forms. Please mail, or leave them at the front desk along with your payment. Forms will not be completed until payment is received. Please allow at least 3-5 working days for processing. We will call you once we have completed your request. There is a $25.00 fee for copying X-Ray CD and $25.00 fee for medical records request.

**Medication Refills** Refills for medication prescribed by your doctor must be obtained by calling your pharmacy to request the refill. Please do not call the office, as this will only result in additional phone calls for you. Refills are not approved after normal business hours, weekends, or holidays, so please call in your refill request in time for the pharmacy to contact our office.

**Cancellation Policy** our office will make every attempt to confirm your schedule appointment, but it is your responsibility to cancel or reschedule when necessary. Our office reserves the right to charge a $25.00 fee for failure to inform our office of appointment cancellation 24 hour to the appointment.

I have read and understand the office policies, and I agree to be bound by their terms. I also understand and agree that such terms may be amended from time to time by the practice.

_____ _____

Signature Date

## EVALUATION OF TREATMENT

I consent to evaluation and treatment by Premier Foot and Ankle Specialist of Texas with Dr. Elizabeth Fernandez DPM. I understand that Premier Foot and Ankle Specialist of Texas with Dr. Elizabeth Fernandez DPM, may refer me to other doctors, vendors or facilities that nay be in our out of my insurance network. I understand that Premier Foot and Ankle Specialist of Texas with Dr. Elizabeth Fernandez DPM. , cannot know with certainty which doctors, and facilities are in or out of network with my insurance. I understand that use if in or out if network referrals are my choice and responsibility. Furthermore, I affirm that Premier Foot and Ankle Specialist of Texas with Dr. Elizabeth Fernandez DPM. , has not forced me to use any certain facility, doctors, or vendors regardless of insurance network status.

_____ _____

Signature Date

## PATIENTS WITH INSURANCE COVERAGE

I AUTHORIZE THE RELESE OF ANY MEDICAL INFORMATION AND REQUEST THAT BENEFITS BE PAID DIRECTLY TO PREMIER FOOT AND ANKLE SPECIALIST OF TEXAS WITH DR ELIZABETH FERNANDEZ FOR SERVICES RENDERED. I UNDERSTAND THAT PREMIER FOOT AND ANKLE SPECIALIST OF TEXAS WITH DR ELIZABETH FERNANDEZ IS FILING MY CLAIM AS A COURTESY AND THAT THIS DOES NOT RELIEVE ME OF FINANCIAL RESPONSIBILITY OF NON-COVERED SERVICES OR SUPPLIES.

_____ _____

Signature Date

## FINANCIAL POLICY

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE SERVICES THAT I RECEIVE. PAYMENT IS EXPECTED AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. I UNDERSTAND THAT THERE WILL BE A $30.00 NSF FEE FOR ANY RETURNED CHECKS

_____ _____

Signature Date

## HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

I understand that HIPAA protects my medical records and confidentiality. It also restricts medical practices from sharing medical information regarding me and my care un many situations (often including sharing information with my family /friends). I hereby give my consent to share information regarding my medical care by Premier Foot and Ankle Specialist of Texas with Dr. Elizabeth Fernandez DPM to the following individuals and/or organizations
* (please list any and all people that you give us permission to give information on your care, your test/lab results, and/or condition) : *

Name _____ Relationship of Patient _____

_____ _____
Signature Date

## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I ACKNOWLEDGE THAT THE NOTICE PRIVACY PRACTICES WAS AVAILABLE AND THAT I HAVE READ (OR HAD THE OPPORTUNITY TO READ IF I CHOOSE) AND UNDERSTAND THE NOTICE.

_____
Print Patient Name

_____ _____
Signature Date

# EXCLUSIVE FORUM SELECTION AND CHOICE OF LAW AGREEMENT

By Signing this form (the "Agreement"), I, as the patient or representative of the patient, agree to all the following on behalf of the patient and all the of the patient's heirs and beneficiaries:

- I agree that all health care rendered (or not rendered) to the patient by Premier Foot and Ankle Specialist of Texas with Dr. Elizabeth Fernandez DPM (including all employees, contractors and representatives) shall be governed exclusively by Texas Law, and not by the law of any other state or foreign nation. In no event shall the law of any other state or any foreign nation apply to the health care rendered (or not rendered).
- I agree that any dispute, lawsuit, cause of action, or other claim that relates in any way to the health care rendered ( or not rendered) to the patient shall be brought only in Texas court in the country or district in which all or substantially all of the health care services were rendered (or should have been rendered).
- I agree not to file in the courts of any others state any dispute, lawsuit, cause of action, or other claim that relates to health care rendered (or not rendered).
- I understand that this Agreement applies to all claims arising out of or relating to the health care rendered (or not rendered) to the patients by Premier Foot and Ankle Specialist of Texas with Dr. Elizabeth Fernandez DPM including all its employees, contractors and representatives, whether the claim is brought by me or by someone else.
- I understand that the choice of law and forum selection provisions of the Agreement are mandatory, not permissive.

_____
Print Patient Name

SIGNATURE : _____ DATE : _____

## Please read and sign this form. This form will help us receive insurance payment for your visit/ services and allow us to communicate with insurance companies:

I assign the right to payment for medical benefits directly to Premier Foot and Ankle Specialist of Texas with Dr. Elizabeth Fernandez DPM in consideration for medical services and supplies provided to me pursuant to my heath insurance plan. In the event that my health insurance plan refuses to pay for medically reasonable and necessary services provided, I also assign all my ERISA* rights to Premier Foot and Ankle Specialist of Texas with Dr. Elizabeth Fernandez DPM for a full and fair review of any and all denied claims, including any penalties that may be assessed against the insurance company for claims-processing violations. This ERISA assignment is in consideration for the unpaid services provided, in consideration for my insurance plan's reduced fee schedule, and in consideration for the continued willingness of Premier Foot and Ankle Specialist of Texas with Dr. Elizabeth Fernandez DPM to see patients, including me, on an insurance assignment basis. I understand that if my treating doctor prevails in any payment dispute, I may be liable for any applicable co-payment for contested services.

I consent to release medical information to Premier Foot and Ankle Specialist of Texas with Dr. Elizabeth Fernandez DPM. I consent to Premier Foot and Ankle Specialist of Texas with Dr. Elizabeth Fernandez DPM releasing medical information to other health care providers for the purpose of treatment when necessary for my care. I consent to Premier Foot and Ankle Specialist of Texas with Dr. Elizabeth Fernandez DPM and sending all necessary medical information to my insurance plan.

*ERISA is an acronym for the Employee Retirement Income Security Act, which includes federal laws requiring insurance companies to process submitted insurance claims and appealed (denied) insurance claims according to ERISA regulations. The failure to process submitted insurance claims and appealed (denied) insurance claims according to ERISA regulations may result in fines charged to the insurance company un amounts of up to $110 a day for infraction.

_____

Print Patient Name

_____ _____

Signature Date

# DISCLOSURES

In compliance with Section 102.006 of Texas Occupations Code in connection with my informed consent and personal choice of doctors and facilities solely based on the quality and safety of care, reputation of 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 of facility solely in the interest of my healthcare quality and safety. As a result of my informed consent and personal choice of doctors and facilities. (A) his/her affiliation, if any, with the doctor or facility for whom the patients is referred and (B) that he/she will may receive, directly or indirectly, remuneration of referring upon my such request and exercising my rights of freedom of choice for the provider(s) and/or facility under the in-network coverage as provided by my health plan, in compliance with all applicable federal and state laws, Medicare, ERISA, PPACA, and Section 102.003 of the Texas Occupations Code. The Texas Medical Board's disciplinary guidelines consider a licensee's failure to disclose an ownership interest in health care facilities to which the licensee is referring his/her patients to be unprofessional conduct, but it does not provide specific guidance on how the physicians should make such disclosures. 22 Tex. Admin Code 190.8(2)(H). The Texas Medical Association has also expressed sensitivity to the potential conflicts of interest inherent in such arrangements and has encouraged physicians to disclose ownership interest in health care facilities to their patients. (A) physician my own or operate a healthcare facility(i.e., pharmacy, surgical facility, etc.) if there are no resulting explanation of patients. Furthermore, any remuneration or return on investment should be based on the physician's percentage of capital investment and not on utilization, or the volume or value of referrals of patients to a particular facility. It is not unethical for a physician to recover his/her investment in such a facility and earn a reasonable rate of return (See Texas Medical Association , Board of Councilors Current Opinions, "Health Facility Ownership, incentive Payments, and Conflicts of Interest" Fall 2012). The Texas Medical Association has recommended that the following guidelines be followed by physicians who have ownership interest in health care facilities. The Physician has an affirmative ethical obligation to disclose his/her ownership of a health facility to his patients, prior to admission of utilization. Upon request a physician should give the patient a list of alternative facilities, if such are available, and inform the patient that they have the options to use one of the alternative facilities.

The following list of doctors' current investment/ownership or consulting agreements in health-related facilities of companies.Premier Foot and Ankle Specialist of Texas with Dr. Elizabeth Fernandez DPM no disclosures I certify that I was informed of the doctors' investment/ownership and/or consulting agreement in health-related facilities mentioned above. I was informed of the effective alternative resource and facilities available at the time of my decision making and my option to choose an alternative resource/facility (including in and out of network facilities). I certify that I have read and fully understand this Disclosure and may make copies of this form should I chose to do so.

_____

Print Patient Name

_____ _____

Signature Date

# HEALTH INSURANCE RELEASE AUTHORIZATION FORM

Patient Name _____ DOB _____

Premier Foot and Ankle Specialist of Texas with Dr. Elizabeth Fernandez DPM is committed to serving our patients with professionalism and care we also expect the same commitment from our patient. This includes being on time for your appointment and calling 24 hour prior to appointment for any cancellations. It also includes presenting your identification card and insurance cards at EVERY appointment as well as making your copay or deductible payments at the time of your office visit.

Your responsibility is to provide us with accurate and complete information concerning your current address and phone number. As a courtesy Premier Foot and Ankle Specialist of Texas with Dr. Elizabeth Fernandez DPM will bill your primary as well as your secondary insurance.

For services outside of our clinic, like radiology, laboratory, surgery centers, physical therapy, hospitals, and rehabilitation centers, it is your responsibility to know which facility you are required to use. If you aren't sure, please contact your insurance member service center.

FOR ALL INSURANCE PATIENTS: I authorize payment to be made on my behalf to Premier Foot and Ankle Specialist of Texas with Dr. Elizabeth Fernandez for any services provided to me by my providers. I authorize my provider to release to the Health Care Financing Administration and its agents information needed to determine my benefits.

I understand that my signature requests payment to be made to be made to pay my claim. My signature also authorizes the release of medical information necessary to pay my claim. My signature also authorizes the release of benefits payable and medical information necessary to pay any secondary insurance payer.

PATIENTS PRIMARY INSURANCE NAME AND SUBSCRIBER ID:

_____

PATIENTS SECONDARY INSURANCE NAME AND SUBSCRIBER ID:

_____

Signature of Patient OR Guardian _____ Date _____

**PATIENT FINANCIAL RESPONSIBILITY CONTRACT**

Please read the description of your responsibilities and initial each section

This is a legally binding contract between Premier Foot and Ankle Specialist of Texas with Dr. Elizabeth Fernandez DPM and you. The words I, me , my, you and you're all refer to the patient.

_____ I agree to be financially responsible for payment of Premier Foot and Ankle Specialist of Texas with Dr. Elizabeth Fernandez DPM. Cash and all major credit cards are acceptable forms of payment for these services.

_____ Current insurance cards must be presented at every office visit. Premier Foot and Ankle Specialist of Texas with Dr. Elizabeth Fernandez DPM is not responsible for filing your insurance claim, but as a courtesy we will do so. I agree to pay the remaining balance after my insurance has paid on my claim immediately upon receipt of a statement.

_____ I agree to give Premier Foot and Ankle Specialist of Texas with Dr. Elizabeth Fernandez DPM and my complete and accurate insurance information for primary and secondary insurance benefits including referral documents from other providers, if needed. I understand that if I fail to give complete and accurate information about my insurance benefits this may result in a denial of my claim or delay in payment. I agree to pay Premier Foot and Ankle Specialist of Texas with Dr. Elizabeth Fernandez DPM the balance on my account after my insurance claim has been processed.

_____ I agree that if my insurance benefit requires me to provide a referral and if the referral is not in place before my appointment, that I will pay in advance and estimate of charges for my office visit or reschedule my appointment.

_____ I understand that I will be responsible for any missed appointment or any cancelled appointments in which a 24-hour notice was not given. There will be a fee of $30.00 for any missed office visits and $50.00 for any missed office procedures.

_____ I understand that all services provided to me by Premier Foot and Ankle Specialist of Texas with Dr. Elizabeth Fernandez DPM are considered medically necessary, if I fail to have a procedure performed or do not comply with my provider's instructions it may be against medical advice and may void my insurance benefits. Should this occur, I agree to pay the balance remaining on my account after my insurance has been processed.

_____ I understand that my insurance may or may not agree to the usual, customary, or reasonable charges for my local area. I understand that my benefits may not cover all services or might deny payment for services that have been approved in advance. I agree to pay the balance remaining on my account after insurance has been processed.

_____ If I have a high deductible policy or do not currently have insurance benefits, I agree to pay an estimate of charges for my office visit in advance and understand that other charges may apply.

_____ Premier Foot and Ankle Specialist of Texas with Dr. Elizabeth Fernandez DPM has contract with my insurance company. Premier Foot and Ankle Specialist of Texas with Dr. Elizabeth Fernandez DPM will receive payments from my insurance company for covered services provided by my insurance benefits. I agree to pay co-payments or deductibles at the time of service, I understand that my appointment may rescheduled.

_____ I agree to pay any balance remaining on my account for any reason upon receipt of a statement and I understand that when requested I must give Premier Foot and Ankle Specialist of Texas with Dr. Elizabeth Fernandez DPM my current accurate address and other contact information. I understand that if I fail to pay the balance on my account this may result in Premier Foot and Ankle Specialist of Texas with Dr. Elizabeth Fernandez DPM pursuing any collection means possible.

_____ If my account becomes delinquent, it may be forwarded to an outside collection agency without notice. If this happens, I will be responsible for all cost of collection, including but not limited to interest, re billing fees, court costs, attorney fees and collection agency costs. Any delinquencies may be reported to the credit bureau. This does not close your account and you are still responsible for account balance.

## ASSIGNMENT OF BENEFITS

I hereby authorize direct payment of medical benefits, including medical benefits to which U an entitled to Premier Foot and Ankle Specialist of Texas with Dr. Elizabeth Fernandez DPM. This is a DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS. This authorization will remain in effect until cancelled by me in writing. A copy of this authorization is a valid as the original document.

I authorize the release of any medical information necessary to obtain payment and I understand that I am financially responsible for all charges, late fees, interest, attorney fees, and collection charges considered patient responsibility by my insurance company. I understand that if I am not insured I am responsible for the charges of all services provided to me . I authorize Premier Foot and Ankle Specialist of Texas with Dr. Elizabeth Fernandez DPM to deposit checks received on my account when out in my name.

I HAVE READ AND I UNDERSTAND PREMIER FOOT AND ANKLE SPECIALIST OF TEXAS WITH DR. ELIZABETH FERNANDEZ DPM FINANCIAL POLICIES AND I ACCEPT RESPONSIBILITY FOR THE PAYMENT OF ANY FEES ASSOCIATED WITH MY CARE.

Signature of Patient or Guardian _____ Date _____

Signature of Medical Assistant _____ Date _____