North Texas Podiatric Medicine & Surgery Assoc. / Dr. Leon R. Brill, DPM, FACFAS, CWS, PA

PATIENT INFORMATION

Name: _____
(Last) (First) (Middle)

Address: _____
(Apt.) (City/State) (Zip)

Home Phone: _____ **E-Mail Address:** _____

Cell Phone: _____ **Preferred Contact: Email** _____ **Home**_____ **Cell**_____

Single ____ Married ____ Divorced ____ Widowed _____ Other _____ **Date of Birth:** _____ **Age:**

Primary Language: _____ **Sex: M F Height:**

Race: Caucasian _____American Indian or Alaska Native _____ **Social Security:** _____
Native Hawaiian/Other Pacific Islander_____ Asian _____
Hispanic or Latino _____ Black or African American _____ **Work Phone:** _____ **ext.:**
Other _____

Ethnicity: Hispanic or Latino _____Not Hispanic or Latino _____ **Employer / Occupation:**_____

Reason for Visit: _____ **Primary Care Physician:** _____

_____ **Primary Care Phone:** _____

Do You Have Diabetes?: Yes No **Referred By:** _____

PRIMARY INSURANCE INFORMATION

Insurance: _____ **ID No:** _____ **Group #:** _____
(ID number and Group number shown on insurance card)

Policy Holder: _____ **Social Security:** _____
(Patient, Spouse or Parent Name)

Date of Birth: _____ **Employer:** _____

SECONDARY INSURANCE INFORMATION

Insurance: _____ **ID No.:** _____ **Group #:** _____
(ID number and Group number shown on insurance card)

Policy Holder: _____ **Social Security:** _____
(Patient, Spouse or Parent Name)

Date of Birth: _____ **Employer:** _____

IN CASE OF EMERGENCY, PLEASE CONTACT

_____ _____ _____
(Name) (Relationship) (Telephone)

_____ _____ _____
(Name) (Relationship) (Telephone)

Consent to Treatment: I recognize that I need medical services. I consent to care by Dr. Leon R. Brill, DPM. I understand that the practice of medicine is not an exact science that any treatment and/ or prescribed medication may involve risk and side effects. I understand that I that any treatment and / or prescribed medication may involve risk and side effects. I understand that I will be informed about the availability of alternate modes of treatment or procedures and their benefits and risks, including no treatment at all, except in emergencies.

I attest that the information stated on this questionnaire is true to the best of my knowledge and duly authorize its release as needed for insurance filing purposes.

AUTHORIZATION TO PAY PHYSICIAN: I hereby authorize payment directly to the indicated physician any surgical and/or medical benefits otherwise payable to me. I understand that I am financially responsible to the physician for charges not covered by my policy.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the release of my medical information to my current medical insurance company if requested, in order to expedite payment of any and all claims. I understand any other release of medical information for any other reason will require a dated and signed "Release of Medical Information" form.

(Patient Signature) (Date)

Please bring your insurance card(s) and driver license ID with you to the front desk we will need to photo copy them. We will need to also take your *picture for our medical record system. Thank you.*

Pharmacy Information

Please list the name and phone number of the pharmacy you would like your prescriptions sent to:

Medical History Form

Past Medical History: Please circle any of the following conditions that pertain to you. Past & On-Going

Diabetes Mellitus Type I or II	Stomach ulcer	Asthma
High Blood Pressure	Gallbladder disease	Tuberculosis
Heart Attack	Colon disease	Gout
Anxiety / Depression	Lupus / Autoimmune disease	Rheumatoid Arthritis
Vascular Disease - PAD	Thyroid disease	Osteoarthritis
Cancer - Type _____	Kidney disease	Angina
Stroke	Anemia	Bleeding disorder
Seizure disorder	Spinal abnormalities	HIV
Multiple Sclerosis	Sleep Apnea	Hepatitis -Type _____
Coronary Artery disease	Hyperlipidemia / High Cholesterol	Fibromyalgia

Major Surgeries: _____ Check if no history of such conditions

1. _____ When: _____
2. _____ When:_____
3. _____ When: _____
4. _____ When: _____
5. _____ When: _____

Please list any other serious or chronic illnesses. _____ Check if no history of such conditions

1. _____ When: _____
2. _____ When:_____
3. _____ When: _____
4. _____ When: _____
5. _____ When: _____

Smoking History (check and fill in the blanks if indicated):

_____ Never smoked

_____ Currently Smoking Age started:_____ How many cigarettes per day? _____

_____ Quit Smoking Age Started:_____ Age Stopped:_____

Alcohol Intake (please check one) _____No _____Yes _____ Occasionally

Number of drinks per day: _____ **OR** number of drinks per week: _____

Recreational drugs (please check one) _____No _____Yes

If yes which type?_____ How much?_____

How often? _____ Age Stopped?_____

DATE: _____

(FILL IN TODAY'S DATE)

PATIENT'S NAME: _____

(PLEASE FILL IN YOUR NAME)

Are you allergic to any drugs ? No **Yes** **If yes, please list them and what reaction you had:**

_____

_____

Please list **ALL** medications you are currently taking and the **dosage** :

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

8) _____

9) _____

10) _____

11) _____

12) _____

13) _____

14) _____

15) _____

16) _____

17) _____

18) _____

19) _____

20) _____

NORTH TEXAS PODIATRIC MEDICINE AND SURGERY ASSOCIATES
NOTICE OF PRIVACY ACT

This notice describes how medical information about may be used and disclosed and how you can get access to this information. Please review it carefully.

PROTECTING YOUR PRIVACY: Protecting your privacy and your medical information is at the core of our business. We recognize our obligation to keep your information secure and confidential whether on on paper or on the computer at North Texas Podiatric Medicine and Surgery Associates (hereinafter referred to as "the Practice"), privacy is one of our highest priorities.

KEEPING YOUR INFORMATION: Keeping the medical and health information we have about you secure is one of out most important responsibilities. We value your trust and will handle your information with care. Our employees access information about you only when necessary to provide treatment, verify insurance eligibility, obtain insurance authorization, process claims and otherwise meet your needs. We may also access information about you when considering a request from you or when exercising our rights under the law or any agreement with you. We safeguard information during all business practices according to established security standards and procedures, and we continually assess new technology for protecting information. Our employees are trained to understand and comply with these information principles.

WORKING TO MEET YOUR NEEDS THROUGH INFORMATION: In the course of doing business, we collect and use various types of information, like your name, address and insurance information. We use this information to provide service to you, to process your insurance claims and to bring you health information that might interest you.

KEEPING INFORMATION ACCURATE: Keeping your health information accurate and up to date is very important. If you believe the health information we have about you is incomplete, inaccurate or not current, please write or call us at the telephone number or address listed below. We take appropriate action to correct any inaccurate information as quickly as possible through a standard set of practices and procedures.

HOW AND WHY INFORMATION IS SHARED – We limit who receives information and what type of information is shared.

- *Sharing information within the Practice.* We share information within our company to deliver you the health care services and the related information and educations programs specified in your plan.

- *Sharing information with companies that work for us.* To help us offer you our services, we may share information with companies that work for us, such as insurance claim processing and mailing companies and companies that deliver health education and information directly to you. These companies act on our behalf and are obligated contractually to keep the information we provide them confidential.

- *Other.* Patient-specific personally identifiable data is released only when required to provide a service for you and only to those with a need to know, or with your consent. Data is released on the condition that the person receiving the data will not release it further, unless you give your permission to do so.

If we receive a subpoena or similar legal process demanding release of any information about you, we will do so only in the presence of a signed authorization from you or someone appointed to give such authorization for you. Except as required by law or as described above, we do not share information with other parties, including government agencies.

The Practice does not share any customer information with third-party marketers who offer their products and services to our patients.

Count on our commitment to your privacy: You can count on us to keep you informed about how we protect your privacy and limit the sharing of information you provide to us, whether it is at our office, over the phone or by computer.

NORTH TEXAS PODIATRIC MEDICINE AND SURGERY ASSOCIATES
5481 Blair Road, Dallas, TX 75231 214-369-7400 214-369-7408

Please sign below to acknowledge receipt of this notice.

Sign: _____ Date: _____

North Texas Podiatric Medicine and Surgery Associates
Leon R. Brill, DPM, FACFAS, CWS, PA
5481 Blair Road, Dallas, TX 75231

PATIENT FINANCIAL RESPONSIBILITY

Your Insurance Benefits are a contract between yourself, your employer and the insurance company. We are not a part of that contract and will not be involved with any disputes regarding benefits. **It is your responsibility as the Insured to *know what your benefits are.*** We have made every effort to verify your medical benefits prior to your visit in order to collect the correct payment from you, and we must rely on the information provided to us by your insurance company. Any disagreements you might have with the information we have received, must be addressed by you with your insurance company. We will expect payment for services according to the information we received at the time the services are performed.

If you are a member of an insurance company with whom we participate, you will be expected to pay any co-payment, co-insurance and/or deductible that is dictated by your insurance plan at the time services are rendered. The remainder of your bill will be sent to your health plan for direct payment to our office. Any additional balance indicated by your insurance company that is your responsibility will be billed directly to you and payment in full is required. If you have not received confirmation of payment in the form of an Explanation of Benefits from your insurance company within 45 days, it is your responsibility to contact them to see what the status is.
If you are not insured and/or not a member of an insurance company with whom we participate, you will be expected to provide payment in full for our services at the time they are rendered unless previous arrangements have been made with our office.
If your health plan denies a procedure/service for any reason and determines the procedure/service is to be paid by the member, our office cannot be responsible for the charges. It is your responsibility as a patient to know exclusions and regulations of your plan and to pay the denied amounts in full. This includes, but is not limited to tests done in the office and tests sent to the contracted lab.
It is your responsibility to notify our front desk of the name of your Primary Care Physician and the last date seen, prior to your visit for Routine Care. It is also your responsibility to know what hospitals are in network with your insurance plan.

- **Your** health plan may refuse payment of a claim for some of the following reasons:
    - This is a pre-existing illness, which is not covered by your plan.
    - You have not met your full calendar year deductible.
    - The type of medical service required is not covered by your plan.
    - You have other insurance which must be filed first.

- **Additional Charges**
    - **Medical Records/X-rays** transfer requests require a fee of $25.00 and 7–10 days to process.
    - **Medical Leave/Disability** paperwork requires a $25.00 fee and 7–10 days to process.
    - **Late Fees** in the amount of $10.00 will be assessed on past due balances once the balance is turned over to you by your insurance company, on a monthly basis
    - **No Shows** for an appointment without 24 hour advance notification will incur a $25.00 fee. Also, not showing for an appointment 3 times, without 24 hour notification, could result in your being discharged from the practice.

Our primary mission is to provide you with quality, cost effective medical care. Together, we are trying to adapt to the changing way health care is financed and delivered. We value you as a patient and our first priority is to provide you with the best possible care.

I have read and understand my obligations, and I acknowledge that I am fully responsible for payment of any services not covered or approved by my insurance carrier.

ACCEPTED AND AGREED

_____ _____

Patient Signature Date

Permission to Communicate with Family & Friends Form / Voicemail

So that we may serve you better, you have the option of providing us with a list of family and friends with whom we may discuss your health information. You are not required to provide a list or to sign this form. By signing this form I give consent to this Dr. Leon R. Brill, DPM to discuss health information with the people listed below who assist with my care. If I do not want certain information discussed, I have listed it below. I understand that sensitive information, like HIV and pregnancy test results, mental health or substance abuse will not be shared unless I fill out the "Authorization to disclose Health or Billing information" form 900010.

Do not discuss information about _____

Release information to:

Name	Phone Number	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

❑	I give Dr. Leon R. Brill, DPM permission to leave Normal Lab/Test results on my answering machine/Voicemail.
❑	I **DO NOT** give Dr. Leon R. Brill, DPM permission to leave any Lab/Test results on my answering machine/Voice Mail.
❑	I give Dr. Leon R. Brill, DPM permission to leave my Appointments/Other on my answering machine/Voice mail.

_____

Patient/Patient Representative Signature Patient Name Date

_____

Date of Birth