It is important that you fill out ***ALL INFORMATION*** to the best of your knowledge.

PATIENT INFORMATION

Today's Date: _____

Name: _____ Sex: ☐ Male ☐ Female
First Middle Last

Date of Birth: _____ Social Security Number: _____
* This must be provided for verification *

Race: ☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander
☐ White

Ethnicity: ☐ Hispanic or Latino
☐ Not Hispanic or Latino

Marital Status: ☐ Single ☐ Widowed
☐ Married ☐ Divorced

Address 1: _____ (No PO Box)Zip Code: _____
Home: _____ Work: _____ Cell: _____
Preferred Contact: ☐ Home ☐ Work ☐ Cell

Email Address: _____ (For sending records via Patient Portal)

How did you hear of us? ☐ Radio ☐ Facebook ☐ Friend ☐ TV ☐ Google ☐ Insurance Company
☐ Event: _____
☐ Doctor/Office: _____ ☐ Other: _____

Emergency Contact: _____ Phone: (___)_____ Relationship: _____
Are we allowed to talk to someone about your medical/financial are? Y N if Yes, name one person
_____ relationship _____ cell: _____,
Please give them access to your patient portal. Also, please fill out Release form included in this packet.

Employer Status: ☐ Employed ☐ Unemployed ☐ FT Student ☐ PT Student ☐ Retired ☐ Child ☐ Other
Employer Name: _____ Employer Phone: _____
Employer Address: _____ Employer Zip Code: _____

Pharmacy Name: _____ Zip Code: _____ Phone: _____

PHYSICIAN(s) **Date Last Seen:** _____

Organization Name: _____
PCP Name: _____ Phone: _____ Address: _____

GUARANTOR INFORMATION

*Please complete if the patient is not the responsible party. *

Name: _____ Sex: ☐ Male ☐ Female
Last First Middle
Date of Birth: _____ Social Security Number: _____
This must be provided for verification
Address 1: _____ (No PO Box)Zip Code:
_____
Home: (___)_____ Work: (___)_____ Cell: (___)_____

☐ I feel safe at home ☐ I feel safe with the person who I am here with today
☐ I understand I can talk to any staff member here, at any time, if I do not feel safe
(NHTH) at 1-888-373-7888

INSURANCE INFORMATION

It is very important you provide us with correct information so we can bill insurance.

Primary: _____ **Effective Date** _____ **ID#:** _____

Specialist Copay: $_____ **Deductible $** _____ **Is this HMO?** □ Yes □ No

Is a referral/authorization required? □ Yes □ No **What is the referral/authorization #** _____

Secondary: _____ **Effective Date** _____ **ID#:** _____

Specialist Copay: $_____ **Deductible $** _____ **Is this HMO?** □ Yes □ No

Is a referral/authorization required? □ Yes □ No **What is the referral/authorization #** _____

Tertiary: _____ **Effective Date** _____ **ID#:** _____

I certify that the above insurance information is accurate and truthful. If the information I have provided is incorrect or not completed, I understand that Highlands Foot & Ankle, LLC can transfer any charges to self-pay and I will be responsible for full payment. I agree to provide my insurance cards to Highlands Foot & Ankle, LLC for verification. I agree to pay the specialist copay set by my insurance company, as well as the deductible amount or any amounts that my insurance company has left me responsible for. If my insurance policy has expired Highlands Foot & Ankle, LLC will release all charges to self-pay & I understand that I will be responsible for them. I understand it is my responsibility to get/make sure all referrals and or authorizations have been granted by my insurance company before being seen, otherwise I can become responsible for all charges.

Due to the Affordable Care Act, you may be responsible for a portion of your deductible if it has not already been met.

I understand and agree to the terms and conditions stated above.

_____	_____	_____
Print Name	Signature	Date

2524 Washington Avenue, Waco, Texas 76710
(P) 254.300.7703 (F) 254.300.7709
www.HighlandsFoot.com

PERSONAL MEDICAL HISTORY

Reason for today's visit: _____

Is this a work-related injury? □ Yes □ No Date of Injury _____ Where did it occur? _____

Is this a sports related injury? □ Yes □ No Date of Injury _____ What were you doing? _____

Weight: _____ Height: _____ Shoe Size: _____ □ Regular □ Narrow □ Wide

Allergies (Please check and state your reaction) □ **No known Allergies**

□ Ace Inhibitor: _____ □ Amoxicillin: _____ □ Animal Hair: _____ □ Antihistamines: _____

□ Cephalosporins: _____ □ Bee Sting: _____ □ Codeine: _____ □ Aspirin: _____

□ Egg/Poultry: _____ □ Fish Products: _____ □ Gluten: _____ □ Flu Vaccines: _____

□ Lactose: _____ □ Latex: _____ □ Levodopa: _____ □ Macrolides: _____

□ Milk Products: _____ □ Mumpsvax: _____ □ Niacin: _____ □ Novocain: _____

□ NSAIDS: _____ □ Olive Oil: _____ □ Peanuts: _____ □ Penicillin: _____

□ Pollen: _____ □ Quinolones: _____ □ Salicylates: _____ □ Shellfish: _____

□ St John's Warts: _____ □ Sulfa: _____ □ Tetanus: _____ □ Tetracyclines: _____

□ Vitamin C: _____ □ Melon: _____ □ Tape: _____ □ Iodine: _____

□ Valium: _____ □ Local Anesthesia: _____ □ Tricyclic Compounds: _____

□ Other: _____

Personal History (check all that apply) ☐ I have NOT had the COVID-19 Vax ☐ I HAVE had the COCID-19 vax

As of today, I have had the COVID-19 Vax (please circle) **Pfizer:** 1 2 booster, **Mederna**: 1 2 booster, **J&J:** 1 booster

□ Diabetes Type 1	□ Diabetes Type 2	□ High B/P	□ Low B/P	□ Seizures	□ Head Trauma
□ Pacemaker	□ Osteoporosis	□ Asthma	□ Gout	□ Stroke	□ Heart Trouble
□ Sickle Cell Anemia	□ Aids/HIV	□ Hepatitis	□ Arthritis	□ Anemia	□ Skin Disorders
□ Sleep Disorders	□ Liver Disease	□ Cancer	□ Ulcers	□ Hernias'	□ Slow Healer
□ Blood Disorders	□ Birth Defects	□ Phlebitis	□ Epilepsy	□ Blood Clots	□ Eye Disorders
□ Rheumatic Fever	□ High Cholesterol	□ Flu Shot	□ H1N1 Shot	□ Blood Transfusion. Year? _____	
□ Muscle Weakness	□ Chronic Dermatitis	□ Migraines	□ Constant burning or electrical pain		

Please list all other medical problems not stated above: _____

_____

Please check all that you have previously been treated for.

□ Lower Back Pain	□ Broken foot/ankle	□ Bunions	□ Rash	□ Hammertoes'
□ Ankle Injuries	□ Plantar Warts	□ Arch Pain	□ Heel Pain	□ Plantar Fascia
□ Inherited Disease	□ Ingrown Nails	□ Neuroma	□ Calluses	□ In-toeing

Please explain any boxes you checked above: _____

_____

Are you currently pregnant? □ Yes □ No If so, what trimester? _____

Are you experiencing pain in calves? □ Yes □ No If so, does the pain occur at rest or while walking? _____

Are you experiencing numbness to any areas? □ Yes □ No If so, where? _____

Have you ever been in a car accident? □ Yes □ No If so, what year and were you hospitalized? _____

Please list all recent diagnostic tests: _____

Please list all surgeries and dates: _____

_____

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FAMILY MEDICAL HISTORY

Member	Age		**Medical Condition**: Please check all that apply and circle any cause of death.
Mother		□ Living □ Deceased	□ Diabetes □ High B/P □ Low B/P □ Cancer □ Heart Problems □ Arthritis □ Bunions □ Stroke □ Tumors □ Birth Defects □ Tuberculosis □ Osteoporosis Please list any medical problems not stated above: _____ _____
Father		□ Living □ Deceased	□ Diabetes □ High B/P □ Low B/P □ Cancer □ Heart Problems □ Arthritis □ Bunions □ Stroke □ Tumors □ Birth Defects □ Tuberculosis □ Osteoporosis Please list any medical problems not stated above: _____ _____
Sister		□ Living □ Deceased	□ Diabetes □ High B/P □ Low B/P □ Cancer □ Heart Problems □ Arthritis □ Bunions □ Stroke □ Tumors □ Birth Defects □ Tuberculosis □ Osteoporosis Please list any medical problems not stated above: _____ _____
Brother		□ Living □ Deceased	□ Diabetes □ High B/P □ Low B/P □ Cancer □ Heart Problems □ Arthritis □ Bunions □ Stroke □ Tumors □ Birth Defects □ Tuberculosis □ Osteoporosis Please list any medical problems not stated above: _____ _____
		□ Living □ Deceased	□ Diabetes □ High B/P □ Low B/P □ Cancer □ Heart Problems □ Arthritis □ Bunions □ Stroke □ Tumors □ Birth Defects □ Tuberculosis □ Osteoporosis Please list any medical problems not stated above: _____ _____

SOCIAL HISTORY

Tobacco Use: □ Never □ Quit on (date) _____ □ Current Smoker. Packs/day? _____ Years used? _____
Type of tobacco, if used: □ Chew □ Cigar □ Cigarettes □ Pipe □ Smokeless
Exposure to second-hand smoke? □ Yes □ No

Do you drink any of the following? □ Coffee □ Tea □ Caffeine If so, how many cups per day? _____
Do you drink alcohol? □ Yes □ No If so, how often? _____

Do you use street drugs? □ Yes □ No If so, what kind and how often? _____
Prescription abuse? □ Yes □ No

Diet Type: □ Balanced □ No Special Diet □ Vegetarian □ Vegan □ Other: _____
Do you exercise? □ Yes □ No If yes, how often and what type? _____

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INSURANCE & SELF PAY SECTION

All co-pays, deductibles, co-insurances and self-pays are due at the time services are rendered. I understand that it is my responsibility to provide Highlands Foot & Ankle, LLC with the correct and accurate insurance information. If I have an HMO insurance, I will be responsible for payment in full if I did not get a referral for each visit and it is my responsibility to get that from my PCP, it is **NOT** the responsibility of Highlands Foot & Ankle, LLC. If for any reason I am seen by any of the doctors at Highlands Foot & Ankle, LLC, I take full responsibility for not reading this disclaimer nor understanding that they are not liable for this error. I agree to provide my driver's license, insurance cards, referrals, social security number at all visits for proof of my identity. I allow Highlands Foot & Ankle, LLC to place a picture of me on their EMR system for identification purposes whether or not I have insurance. I understand that I am responsible for payment in full at time services are rendered, whether or not I have insurance. If I leave without making a payment, Highlands Foot & Ankle, LLC will send me a statement, after 3 statements & non-payment, Highlands Foot & Ankle, LLC can send me to collections/file judgment without notice. If I am approved for a payment plan, I understand that I must fulfill this obligation. This must be signed to see the doctor.

AUTHORIZATION AND PAYMENT POLICY

I, the undersigned, certify that I (or my dependent, under the age of 18), have insurance with the above name(d) company(s), and assign directly to Highlands Foot & Ankle, LLC, Dr. David Sappington, or any other doctor associated with this company- all insurance benefits and agree to reimburse if insurance pays me, the insured, for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctors to release all information necessary to secure the payments of benefits. I understand that I am responsible for any and all deductibles, co-pays, and out of pocket expenses. If I do not pay- I am subject to being placed in collections, I understand that further action, such as a judgment, can be placed on me and will pay all fees associated with collection and judgment status if payment is not received. I authorize the use of this signature on all insurance submissions. **RETURN POLICY:** If products are purchased and they have a return policy I will receive and sign the policy, and a copy will be placed in my file, otherwise there is nothing that can be returned. **MEDICARE/MEDICAID AUTHORIZATION** (If applicable): I request that payment of benefits be made on my behalf to the above-named doctors/company for any services by that physician. I authorize any holder of medical information needed to determine these benefits or the benefits payable for related services. I understand my signature request that payment be made and authorized release of medical information to pay the claim. If "other health insurance" is indicated in item 9 on the HCFA-1500 form or elsewhere on other approval claims forms, such as electronically submitted, my signature authorizes release of the information to the insure or agency. In Medicare/Medicaid assigned cases, the physician or supplier agrees to accept the charges/payments/allowed amounts determined by the contract with the insurance company, and the patient is responsible for the amount the insurance company leaves them responsible for, including deductibles, co-pays, co-ins, non-covered services/items, or what the EOB states as patient responsibility. ALL **INSURANCE PAYMENT POLICY**: All co-pays, deductibles, and co-insurances are due at the time services are rendered. If I leave without making a payment, Highlands Foot & Ankle, LLC will send me a statement, after 3 statements & non-payment, Highlands Foot & Ankle, LLC can send me to collections/file Judgement without notice. If I belong to an HMO, I understand that my insurance company requires a referral from my PCP and if not received by my appointment time, I will be fully responsible for payment in full at time services are rendered or I may have to reschedule to another date and time. If for some reason, Highlands Foot & Ankle, LLC does not realize or notice there is no referral on file, & I am seen as a patient for any appointment or any reason, it is still my responsibility for payment in full to the company. If I belong to a PPO, I understand that I have a co-pay, deductible, and co-insurance. I know that it is my responsibility as the patient to get authorization/referral if one is required and if it is not obtained, I am responsible. It is my responsibility to inform a staff member of any new insurance, changes in address, phone numbers, or health and medication changes, whether or not they ask for this information. **SELF PAY POLICY**: I understand that I am responsible for payment in full at time services are rendered. If I leave without making a payment, Highlands Foot & Ankle, LLC will send me a statement, after 3 statements & non-payment, Highlands Foot & Ankle, LLC can send me to collections, or file a judgment against me without notice. If I am approved for a payment plan, I understand that I must fulfill this obligation. **INSURANCE RELEASE/AUTHORIZATION:** I understand that for medical/legal purposes and by the Texas State Law, x-rays and medical records taken/created by this office are the property of Highlands Foot & Ankle, LLC not mine. I also understand that all charges for services are due and payable at the time services are rendered. Highlands Foot & Ankle, LLC accepts cash, checks, debit cards, MasterCard, Visa, and Discover. There can be, up to a $55.00 NFS (fee may change at any time with or without notice) fee for returned checks and must be taken care of in a timely fashion (21 days) or charges may be filled against me. I agree to be responsible for all the above, where it applies to me. This must be signed to see the doctor.

HIPPA

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US. I UNDERSTAND THAT I MAY HAVE A COPY IF I CHOOSE. A covered entity may disclose PHI to certain parties to facilitate treatment, payment, or health care operations without a patient's express written authorization. Any other disclosures of PHI require the covered entity to obtain written authorization from the individual for the disclosure. In any case, when a covered entity discloses any PHI, it must make a reasonable effort to disclose only the minimum necessary information required to achieve its purpose. Highlands Foot & Ankle, LLC has the right to discuss minimal information with family but does not approve to give certain information to employers unless we receive a signed document from the patient of legal age.

I have seen a copy of the "Notice of Privacy Practice Act" & know that this signed copy will be placed in my EMR chart

I have read all above sections and the HIPAA agreement and understand that with my signature I agree to the above terms and conditions. I certify that I have provided truthful and accurate information.

Signature: _____ Date: _____ *This must be signed to see the doctor.*

2524 Washington Avenue, Waco, Texas 76710
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MEDICATION RECORD

Name: _____ Today's Date: _____

Please list all medications you are currently taking. Include all over the counter medications as well.

	Medication Name	Reason for Medication	Start Date	Dosage
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				

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HIPAA Privacy Authorization Form

Effective Date: (today's date) _____

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. Authorization. I authorize Highlands Foot & Ankle, LLC (or health care provider) to use and disclose the protected health information (PHI) described below to the requesting party being related to the Patient by blood (to the best of our knowledge) as their family member (individual seeking the information).

2. Effective Period. This authorization for release of information covers all past, present, and future periods of health care. I can have right to revoke this authorization, in writing, at any time.

3. Extent of Authorization. I authorize the release of my financial & complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

4. Use. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. Termination. This authorization shall be in force and effect until the death of patient, at which time this authorization form expires except for final balance payment as insurance can take several months.

6. Revocation Rights. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. Benefits. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. Disclosure. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

9. Email / Patient Portal. I authorize Highlands Foot & Ankle, LLC to send my information to the family member below via HIPAA-compliant email and attachments or they can have access to my patient portal. If they request this information in other formats Highlands Foot & Ankle, LLC, may charge (to the family member) a reasonable fee, paid in full before receiving the information in a format requested. This can take up to 30 business days.

Patient's Signature (or Power of attorney-must provide notarized proof):

Patients Signature_____ Date: _____

Person to receive information _____ Relationship: _____

Contact information Cell: _____ Email: _____

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HIGHLANDS
FOOT & ANKLE

NO SHOW & LATE SHOW POLICIES

Highlands Foot & Ankle, LLC, is constantly striving to provide the best possible care to our patients. Please review the changes that we have made to our No Show and Late appointment policies to ensure each patient receives quailty and timely care in our office.

Termanology:
"No Show" patient who fails to arrive for a scheduled appointment.
"Same Day Cancellation" patients who cancel an apointment less than 48 hours prior to their scheduled appointment.
"Late Arrival" patient who arrives at the clinic 15 minutes after the expected arrival time. It is the policy of the practice to monitor and manage appointment no-shows and late arrivals and cancellations. Highlands Foot & Ankle, LLC goal is to provide excellent care to each patient in a timely manner. If it is necessary to cancel an appointment, patients are required to call or leave a message at least 48 hours in advance of their appointment time. Notification allows the practice to better utilize appointments for other patients in need of prompt medical care.
"Established Patient" Established Patient: An individual who receives professional services from the physician/NPP or another physician of the same specialty who belongs to the same group practice within the previous 3 years.

"New Patient" someone not previously seen or someone who does not have a current medical record.

Procedures & Appointments
I understand that I am responsible for notifying Highlands Foot & Ankle to shecdule, confirm, cancel or reschedue my appointments or I will be responsible for any charges as they will not be billed to my insurance company.
All established and New Patients:

- 48 hours cancellaction Notice
- $40.00 late cancellation or No Show fee, that will have to be paid, in-full, before a new appointment can be scheduled.
- In addition, the patient may be subject to dismissal from Highlands Foot & Ankle, LLC for non-compliance. This is determined by a physician only, no exceptions, in accordance with Highlands Foot & Ankle, LLC, guidelines

All fees are subject to change without notice All No-Show fee's are the patients responisbility and will not be billed to insurance companies. I have read all sections and understand that with my signature, I certify that I understand the above policy.

Signature _____ (*This must be digned to see the dr.)*

Print Patients Name _____ Date _____