AUSTIN ORTHOPEDIC SPECIALISTS

Dr. Mark McDonnell, DPM

PATIENT INFORMATION

Patient Name (Last, First, Middle)	Social Security # or Driver License #	Sex ○ M or ○ F	Marital Status
Email Address			
Address	Phone #	Age	Date of Birth
City-State-Zip	Cell #	Occupation	

Family Physician	Referred By	If patient is a student, Name of School
In Case of Emergency Notify	Relationship	Phone #

PHARMACY INFORMATION

Pharmacy Name	Address	City	Phone #

INSURANCE INFORMATION

Primary Insurance Policy Holder	Relationship	Social Security #	Phone #
Date of Birth	Address	City-State-Zip	
Employer Name	Address	Phone #	

Secondary Insurance Policy Holder	Relationship	Social Security #	Phone #
Date of Birth	Address	City-State-Zip	
Employer Name	Address	Phone #	

In the event this claim is denied by my insurance company I understand that I am responsible for all charges incurred as a result of this visit. I hereby authorize the above physician to release information to my employer and insurance carrier. I hereby authorize payment directly to the above provider of the surgical and medical benefits if any, otherwise payable to me for his services, but not to exceed the reasonable and customary charges for all those services. I understand that this authorization does not release me from my personal responsibility for payment of all charges.

Signed (Patient or Insured) (Parent signature required for minors)

Signature _____ Date _____

Rev 04/11

AUSTIN ORTHOPEDIC SPECIALISTS
MEDICAL HISTORY REPORT
Dr. Mark McDonnell, DPM

Name: _____

Age: _____ Marital Status:

◯Married ◯Single

◯Separated ◯Widow

Referring Doctor: _____

Reason for today's visit: _____

_____

Which side of the body? ☐Left ☐Right

Was this Problem a result of an injury? ◯ Yes ◯ No

Date of injury: _____

Was injury work related? ◯ Yes ◯ No

Was injury due to an auto accident? ◯ Yes ◯ No

IF YOU ANSWERED YES TO A RED QUESTION, PLEASE SPEAK TO FRONT DESK BEFORE CONTINUING

How did the injury occur? _____

_____

If not an injury. Date of Onset? _____

◯ Gradual ◯ Sudden

Does anything make it better?

_____

_____

Does anything make it worse?

_____

_____

What else can you tell us about the problem?

_____

_____

_____

B/P_____ PULSE_____ HT_____WT_____

Medical Problems: (examples: high Blood pressure, diabetes, asthma, etc.)

_____

_____

What surgeries have you had in the past?

Procedure	Year
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list all medications that you take, including prescription, non-prescription, and vitamins/supplements:

Medication	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you allergic to any medications? ◯ Yes ◯ No

If yes, please list the medicine and type of reaction:

_____

_____

Do you drink? ◯ Yes ◯ No

How often? Rarely ◯, Occasionally ◯, Socially ◯, Daily ◯

Do you currently smoke cigarettes? ◯ Yes ◯ No

If yes, how much and how many years? _____/_____

AUSTIN ORTHOPEDIC SPECIALISTS
PATIENT HIPAA CONSENT FORM
Dr. Mark McDonnell, DPM

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

*Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
*Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Can we call you at home? ◯Yes ◯No

Can we leave a message on your voice mail/answering machine? ◯Yes ◯No

Can we call you at work? ◯Yes ◯No

Can we send you appointment reminders via text message? ◯Yes ◯No

I authorize your office to disclose the specific information below, only for the purposes and parties described below. I may revoke this authorization in writing by contacting your office: (Please list the <u>name & phone</u> number of anyone (Spouse, Parent, Child, etc.) you would allow us to share your medical information with. This includes any information regarding treatment, account balance, appointment date and time, etc.)

_____

_____

_____

Patient Name: _____

Signature: _____ Date: _____

FINANCIAL POLICY

Dr. Mark McDonnell, DPM

This is an agreement between San Marcos Orthopedics and the Patient/Debtor named on this form. **By signing this agreement, you are agreeing to pay for all services that are received.**

Payment options if you have insurance:

You can choose to pay your deductible, coinsurance, and/or copayments by CASH, CHECK, or CREDIT CARD. Any copayments must be collected before seeing the physician.

Our facility **will not** bill services to a third party payer. If you are filing an automobile accident claim or any other claim that involves a third party, this will be considered a SELF PAY account. Third party payers will have to pay you directly for all treatment.

Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in no payment from the insurance company.

Credit History: We have the option to report your account status to any credit reporting agency such as a credit bureau if your account has become delinquent.

Returned checks: There is a **$25 fee** for any checks returned by the bank.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to an attorney, you agree to pay all attorneys' fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Hays County, Texas.

FMLA/Short Term Disability paperwork: There is a $40 charge that has to be paid prior to the paperwork being filled out. Please keep in mind all forms will be completed after your first post-operative appointment. If a revision is needed after it has been sent, we will make the first revision at no charge. After that, you will be charged an additional $40.

No Show Policy: Effective January 1, 2023 any patient who fails to show or cancels/reschedules an appointment with less than **24 hours notice** will be considered a No Show and charged a **$25.00 fee.** This "no-show fee" is not reimbursable by your insurance company. You will be billed directly for it and is due at the time of the patient's next office visit.

Late arrivals: If you are more than **15 minutes late** without prior notice, the appointment will be rescheduled.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Transferring of Records: Some covered entities may charge a retrieval/processing fee for copies of medical records. (Tex. Health & Safety Code § 241.154) We do not charge a fee for doctor to doctor record transfers. There is a fee for records for personal use or record transfers to other organizations..

Workers Compensation: We require approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Effective Date: Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

_____ _____

Signature Date