

AUSTIN ORTHOPEDIC SPECIALISTS SAN MARCOS ORTHOPEDICS

Dr. Mark McDonnell, DPM | Dr. Aseem Saini, 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 _____

**AUSTIN ORTHOPEDIC SPECIALISTS & SAN MARCOS ORTHOPEDICS
MEDICAL HISTORY REPORT**

Dr. Mark McDonnell, DPM | Dr. Aseem Saini, DPM

Name: _____

B/P _____ PULSE _____ HT _____ WT _____

Age: _____

Marital Status:

- Married Single
 Separated Widow

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

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?

What surgeries have you had in the past?

| <u>Procedure</u> | <u>Year</u> |
|------------------|-------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

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

| <u>Medication</u> | <u>Dose</u> | <u>Frequency</u> |
|-------------------|-------------|------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

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
& SAN MARCOS ORTHOPEDICS
PATIENT HIPAA CONSENT FORM
Dr. Mark McDonnell, DPM | Dr. Aseem Saini, 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 appointment reminders via text? | 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 name & phone 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 | Dr. Aseem Saini, 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