MOORE
Foot & Ankle Specialists

21309 FOSTER ROAD, SUITE 200 SPRING, TX 77388
TEL: 281.444.6300 FAX: 832.375.1247

Today's Date:	PCP Name/Phone:

PATIENT INFORMATION

NAME: LAST, FIRST, MIDDLE NAME (as it appears on insurance card)	Date of Birth: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Address (City, State, Zip):

Social Security no.:	Home/Cell Phone No.	Email:
Occupation:	Employer:	Employer phone no.:

☐ Minor Consent (please check if applicable): I being the parent or guardian of the above listed patient do hereby request and authorize Moore Foot and Ankle Specialists, its affiliates and staff to perform medically necessary services including but not limited to x-rays, administration of medication and anesthetics which are deemed advisable by the physician. Initial/Date: _____

Referral Source: ☐ Website ☐ Search Engine: (Yahoo, Google, Bing): _____ ☐ PCP ☐ Insurance ☐ Returning Patient ☐ Family/Friend:_____ ☐Drive by ☐ Other:_____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST.)

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Name of Insured:	Birth date:	Address (if different):	Home phone no.:

PLEASE INDICATE PRIMARY INSURANCE:

Insurance name/Phone:	Group No.	Policy No.

PLEASE INDICATE SECONDARY INSURANCE:

Insurance name/Phone:	Group No.	Policy No.

WORKMAN'S COMPENSATION INFORMATION

Adjuster Name/Phone:	Date of Injury:	Authorization #:

Type of Injury: (Please describe what happened)

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Contact Phone:

The above information is true to the best of my knowledge. I give permission to Moore Foot and Ankle Specialists and its physicians, affiliates, and medical personnel to provide medical services, including but not limited to x-rays, administration of medications, anesthetics and any treatment recommended by the physician to me/child. I understand that payment is due at the time of service and understand that I as the patient/guardian am financially responsible for any balance, medication, services, or equipment not covered by my insurance. I authorize my insurance benefits to be paid directly to the physician and authorize Moore Foot and Ankle Specialists and/or any of its affiliates to release any information required to process my claims, remit payment or secure payment for the services provided to me. I authorize Moore Foot and Ankle Specialists to disclose my current and previous medical records, consultation and treatment plans, to my referring physician, other healthcare providers, and hospitals that will participate in my care. I understand that by signing this form I am seeking care until I withdraw consent to Moore Foot and Ankle Specialists privacy officer in writing.

Patient Signature/Guardian Date Witness

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PATIENT INFORMATION

Last name:	First Name:
DOB:	Social Security #:

RADIOLOGICAL EXAM FOR ALL PATIENTS

☐ I understand that X-rays are needed to diagnose my condition & give my permission to have all necessary x-rays performed.

RADIOLOGICAL EXAM FOR FEMALE PATIENTS BETWEEN THE AGES OF 10-55 YEARS OF AGE ONLY

I understand that if I am pregnant & have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus. I have been advised that the ten (10) days following onset of a menstrual period are generally considered to be safe for x-ray exams. With those factors in mind, I am advising my doctor that:

☐ To my knowledge: I am pregnant
☐ I am not pregnant ☐ I am unsure
☐ My menstrual period is late
☐ I have an IUD
☐ I have had a tubal ligation
☐ I have had a hysterectomy
☐ I have begun menopause
☐ Initial/Date:_____

COMPLIANCE & DISCLOSURE UNDER TEXAS OCCUPATIONS CODE SECTION 102.006

☐ In compliance with Section 102.006 of Texas Occupations Code, Dr. Robert J. Moore III &/or Dr. Eric R. Blanson; for better care & in the best interest of their patients have an affiliation &/or remunerations with: Keystone Surgery Center, TOPS Specialty Surgical Hospital, The Woodlands Surgery Center, Houston Northwest Hospital, St Luke's Springwood, Kingwood Memorial Hermann, Kindred Hospital-Kingwood, Day Spring Pharmacy, & Principle Pharmacy. I certify that I was informed of the alternate resources at the time of my decision-making & was assured by my attending physician that Moore Foot & Ankle Specialists, its affiliates, & the staff will not treat me differently if I choose an alternate provider or entity. I certify that my attending physician(s) have made referrals to the other non-participating providers or entities based only on the needs of my individual healthcare needs. I understand that the provider's professional assessment in an effort to provide me with quality & affordable healthcare has advised me of (a) his/her affiliation, if any, with other doctors, facility that I am being referred (B) that he/she will receive, directly or indirectly remuneration for referring my care to the facility under the in-network or out of network coverage provided by my health carrier. I have read & understood this disclosure & authorize this referral to both in-network or a non-participating & out of network provider(s) or entities.

OFFICE FINANCIAL POLICY-PLEASE READ

☐ We are happy you selected Moore Foot & Ankle Specialists for your healthcare needs & look forward to working with you. To help you understand your financial responsibility in relation to your medical care all services provided are expected at the time of service. If the patient is a minor the parent, guardian or adult accompanying the child will be financially responsible regardless of legal guardianship. **As a courtesy to you, we will bill your insurance provider with your consent however it will be your responsibility for payment of co-pays & deductibles not met at the time of service. In addition, any additional services such as X-rays, orthotics, injections, & durable medical equipment (DME) will be your responsibility if not covered by your insurance carrier. Moore Foot & Ankle Specialists automatically charges a $50.00 fee for appointments not cancelled within 24 hours that is the sole responsibility of the patient & not the insurance. In addition, our office charges for medical records, medical forms, disability forms, FMLA paperwork, disability placard, notary signatures & any document requiring a physician signature or staff documentation. This is the sole responsibility of the patient.**

If payment cannot be made, & a patient's condition allows, appointments will be rescheduled until payment arrangements for services can be paid. Per the Moore Foot & Ankle Specialists policy, if a balance on your account is unpaid for 30 days your care & access to Moore Foot & Ankle Specialists, our providers &/or affiliates will be subject to permanent termination. Your account will also be referred for collection action &/or listed with an outside agency. There will be a $50.00 fee for any returned checks. This notice fulfills our obligation to notify you of the possibility of collection action if your account is not resolved within 30 days. Expenses incurred by Moore Foot & Ankle Specialists to collect this account shall be the responsibility of the person signing this agreement.

I ACKNOWLEGE I HAVE BEEN INFORMED OF MOORE FOOT & ANKLE SPECIALISTS OPERATING PRACTICES & PROCEDURES. MY SIGNATURE AUTHORIZES MY PERMISSION TO CONTINUE CARE WITH MOORE FOOT & ANKLE SPECIALISTS & ITS AFFILIATES.

Signature: _____ Date: _____

Witness: _____Title: _____

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PATIENT INFORMATION

Patient Last name:	First Name:	DOB:

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

☐ I have reviewed this office's Notice of Privacy Practices that explains how my protected health information (PHI) will be used and disclosed. I understand that I am entitled to receive a copy of this document and authorize the use and distribution as described.

HIPAA PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

☐ I give my authorization to release my protected health information including results of my laboratory test, X-ray and/or any test and treatment plans to the listed designated individuals/entities. I understand that Moore Foot and Ankle Specialists may leave voice mail, send electronic correspondence or fax results pertaining to appointment information, financial information and/or treatment plans. I understand that this authorization is valid for an effective period of one year. I understand that I may withdrawal my consent at any time and will submit my request in writing to Moore Foot and Ankle Specialist's privacy officer.

Name:	Relationship to patient:	Phone No.:
Name:	Relationship to patient:	Phone No.:
Name:	Relationship to patient:	Phone No.:
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Name:	Relationship to patient:	Phone No.:

☐ I do not wish to share any information to anyone other than myself.

FOR MINORS ONLY

I being the parent of the above listed patient give my authorization to release my child's protected health information including results of my laboratory test, X-ray and/or any test and treatment plans to the listed designated individuals/entities who are authorized to bring my child to his/her appointments.

Name:	Relationship to patient:	Phone No.:
Name:	Relationship to patient:	Phone No.:

Signature: _____ Date: _____

Witness:_____ Date:_____

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PATIENT INFORMATION

Last name:	First Name:	Height/Weight:
DOB:	Social Security #:	Shoe Size:

Reason for today's Visit: Is this due to an injury? ☐ Yes ☐ No (Please explain)

Treating extremity: ☐ Left Foot ☐ Left Ankle ☐ Right Foot ☐ Right Ankle

MEDICAL/FAMILY HISTORY

Please mark yes (Y) or no(N); Indicate any family history (F)

Y	N	F	Condition	Y	N	F	Condition	Y	N	F	Condition	Y	N	F	Condition
			Alcoholism				Chest Pain				HIV Positive				RSD
			Anemia				Circulatory Problems				Kidney Problems				Stroke
			Anxiety				Depression				Leg Cramps				Thyroid Problems
			Arthritis				Diabetes				Liver Disease				Tuberculosis
			Articifial Heart Valve				Eating Disorder				Lung/Respiratory				Ulcers (Stomach)
			Artificial Joint				Epilepsy				Mental Illness				Venereal Disease
			Asthma				Fibromyalgia				Plebitis/Clots				Weight Change
			Back Problems				Gout				Psoriasis				
			Bleeding Disorder				Heart Disease	Other Conditions:							
			On Coumadin				Hemophilia								
			Cancer				Hepatitis								
			Chemical Dependency				High Blood Pressure								
			Tobacco User				High Cholesterol								

DIABETICS ONLY

Check One: ☐ Diet-Controlled (No Medication) ☐ Oral Medication ☐ Insulin Dependent

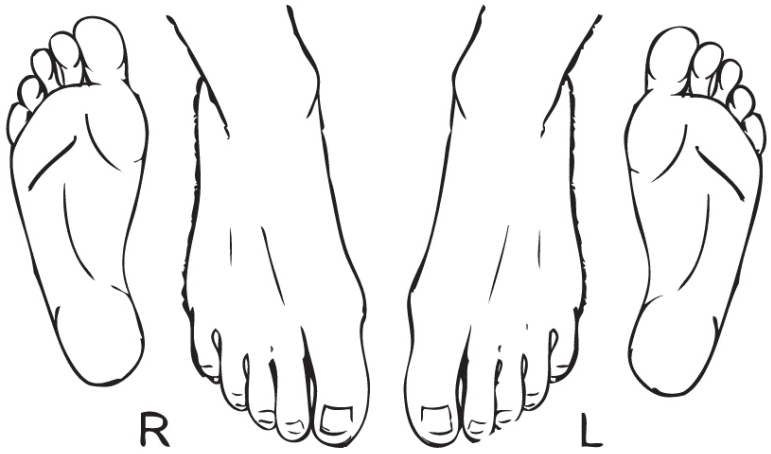
Insulin Dosage:_____ Years diagnosed with diabetes: _____

Physician treating diabetes:_____ Date last seen:_____/_____/_____

FOOT DIAGRAM

PLEASE INDICATE AREA OF CONCERN/ISSUE:

PAIN:
☐ DULL ACHE
☐ SHOOTING
☐ BURNING
☐ SHARP
☐ THROBBING



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MEDICATION LIST (PLEASE LIST DOSAGE & FREQUENCY)	

MEDICATION/PRESCRIPTION POLICY

☐ It is the goal of Moore Foot and Ankle Specialists and its physicians to provide the best care possible. We do not deny that you often have pain however the treatment of that pain will be determined in accordance with your treating physician's recommendations and/or surgical options. Narcotics are proven to be habit forming. Dependency on pain medication can start in as little as 2 weeks after beginning their use and for this reason we do not prescribe narcotic medication as a form of treatment. Chronic pain patients will be referred to a pain management specialist. If you are under the supervision of a pain management physician, we expect you to disclose this information to us on your first visit. Failure to do so would be fraud, and would violate your contract with your pain management physician. **Initial:**_____

☐ Medications prescribed by Moore Foot and Ankle Specialists will be electronically submitted. We do not refill prescriptions Friday, Saturday or Sunday. If you require a refill on your prescriptions, you must contact your pharmacy to submit an electronic request. Expired prescriptions will require a scheduled office visit. **Initial:**_____

SURGICAL HISTORY (PLEASE LIST ANY SUGERIES DATE & PROCEDURE DONE)	

ALLERGIES (PLEASE LIST ANY KNOWN ALLERGIES)	☐ NO KNOWN ALLERGIES OF ANY KIND

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Signature: _____ Date: _____

Witness: _____ *Title:* _____