

**ALEX W. GARCIA, DPM**

**PATIENT INFORMATION**

**NAME:** \_\_\_\_\_ **TODAY'S DATE:** \_\_\_\_\_

**GENDER:**  Male  Female

**Marital Status:**  Single  Married  Domestic Partnership  Widowed  Divorced/Separated

**Address** \_\_\_\_\_ **Apt. #:** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip code** \_\_\_\_\_

**Home #:** \_\_\_\_\_ **Work#:** \_\_\_\_\_ **Cell#** \_\_\_\_\_

**Date of birth:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Shoe Size:** \_\_\_\_\_ **Shoe Width:** \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

**NAME:** \_\_\_\_\_ **Relation:** \_\_\_\_\_

**Social Security #:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Home #** \_\_\_\_\_

**INSURANCE INFORMATION**

Is there a referral required from your PCP?  Yes  No **Specialist Copay:** \_\_\_\_\_

<b>Primary Company:</b>	<b>Secondary Company:</b>
<b>Subscriber:</b>	<b>Subscriber:</b>
<b>Subscriber DOB:</b>	<b>Subscriber DOB:</b>
<b>Subscriber SS#:</b>	<b>Subscriber SS#:</b>
<b>Policy/ID #:</b>	<b>Policy/ID #:</b>
<b>Group #:</b>	<b>Group #:</b>

**EMERGENCY CONTACT INFORMATION**

**NAME** \_\_\_\_\_ **Relationship** \_\_\_\_\_

**Home #** \_\_\_\_\_ **Cel #** \_\_\_\_\_ **Other** \_\_\_\_\_

**PRIMARY CARE DOCTOR AND PHARMACY INFORMATION**

**Name of you Doctor** \_\_\_\_\_ **phone #:** \_\_\_\_\_

**When was your last visit to your PCP?** \_\_\_\_\_

**Pharmacy Name** \_\_\_\_\_ **phone #** \_\_\_\_\_

**HOW DID YOU HEAR ABOUT US?**

Doctor  Phone Book  Insurance Co.  Internet  Other \_\_\_\_\_

# PERSONAL HEALTH HISTORY

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please circle either Yes or No for ALL of the following questions:

## Cardiovascular

- Y or N Anemia
- Y or N Angina or chest pain
- Y or N Bleeding problems
- Y or N Blood or plasma transfusions
- Y or N Blood pressure, high or low
- Y or N Cramps in legs with walking
- Y or N Heart trouble (pacemaker/valve replacement)
- Y or N Mitral value prolapse
- Y or N Shortness of breath with walking
- Y or N Swelling in feet, ankles, or hands
- Y or N Varicose veins or phlebitis
- Y or N Stroke

## Gastro Intestinal

- Y or N Reflux
- Y or N Ulcers
- Y or N Spastic Colon
- Y or N Chron's Disease
- Y or N Hepatitis

## Genito Urinary

- Y or N Kidney disease
- Y or N Venereal disease
- Y or N Burning on urination or frequently voiding

## Respiratory

- Y or N Asthma
- Y or N Bronchitis
- Y or N Pneumonia
- Y or N Shortness of Breath
- Y or N Tuberculosis Dale

## Dermatological

- Y or N Allergies
- Y or N Eczema
- Y or N Psoriasis

## Musculoskeletal

- Y or N Arthritis
- Y or N Gout
- Y or N Fibromyalgia

## Other

- Y or N Thyroid
- Y or N Pregnant
- Y or N Diabetic**
- Y or N Cancer**

## Social History

- Y or N Use of alcohol
- Y or N Use of tobacco
- Y or N Use of drugs
- Y or N AIDS or HIV

Please list any other health condition:

\_\_\_\_\_  
\_\_\_\_\_

Please list all pertinent matters. If none apply, please write NONE in the correct place

Previous Hospitalizations, surgeries, serious illness. List in chronological order (dates)
Medications (List all including non-prescriptions):
Allergies to foods, medications, materials. List ALL:

Family History	Disease	If deceased cause and age
Father	_____	_____
Mother	_____	_____

Reviewed by : \_\_\_\_\_ D.P.M.

Patient Signature: \_\_\_\_\_

ALEX W. GARCIA, DPM

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

I, \_\_\_\_\_, hereby authorize Dr. Alex Garcia and his staff to disclose information to the following person(s) about my procedures, as well as any other information concerning my health. I also authorize the following person(s) to receive information concerning my financial statement.

Name	Relationship	Date	Initials
1 _____	_____	_____	_____
2 _____	_____	_____	_____
3 _____	_____	_____	_____
4 _____	_____	_____	_____
5 _____	_____	_____	_____
6 _____	_____	_____	_____

Note:

There will be times that this office will call and leave messages regarding appointments, prescriptions, medical equipment and orthotics, or materials regarding my financial status.

I understand that I have the right to revoke this authorization at any time by written notification.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Alex W. Garcia, DPM**

**INSURANCE AUTHORIZATION / PAYMENT POLICY**

Our office is glad to assist you in filing claims with your insurance company for reimbursement of expenses. We will wait 90 days for your insurance company to pay your claim and if they do not we will give you 30 days to pay the balance.

1. The patient is responsible to pay any deductible and co-payments at the time services are rendered.
2. Any portion of a billed amount that is labeled "disallowed" or "over reasonable and customary" will become the patient's responsibility.
3. Our office NEVER guarantees that your insurance will pay. We will make every attempt at the beginning of your health care to receive verification of your policy benefits. However, if for some reason your insurance claim is denied, you are responsible for the amount due on your account.
4. As a courtesy to our patients, we attempt to verify all pertinent insurance information, but it is the responsibility of the patient to verify the care received will be covered by their insurance plan. Referrals are also the responsibility of the patient.
5. Any costs incurred due to lack of coverage, referral, or restrictions on coverage will be the sole responsibility of the patient.
6. We will not file insurance for patients that do not live in Texas. We will provide you with a receipt so you may get reimbursement.

**PATIENT CONSENT**

**Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations**

As part of your healthcare, the office of ALEX W. GARCIA, DPM originates and maintains health records describing your health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. This information is utilized to plan Treatment, Payment, and other healthcare Operations (TPO) such as assessing quality and reviewing competence of healthcare professionals. All records are the physical property of ALEX W. GARCIA, DPM.

With this consent, the office of ALEX W. GARCIA, DPM is allowed the call the patient's home or other alternative location and leave a message on voicemail or other person in reference to any items that assist in the process of carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. The office of ALEX W. GARCIA, DPM is also given consent to send mail, including appointment reminders and patient statements, to the Patient's home or other alternative location provided that the mail is marked as Personal and Confidential.

The office of ALEX W GARCIA, DPM *Notice of Privacy Practices* provides specific information and a complete description of how personal health information may be used and disclosed. Patients will be provided a copy of or access to the *Notice of Privacy Practices* and they have the right to review the notice prior to signing consent. The office of ALEX W. GARCIA, DPM reserves the right to change the *Notice of Privacy Practices*. Prior to implementation of the revised *Notice of Privacy Practices*, a copy will be provided to all patients. Patients have the right to restrict the use and/or disclosure of personal health information for treatment, payment or healthcare operations. The office of ALEX W GARCIA, DPM is not required to agree to the restrictions requested. Patients may revoke this consent at any time in writing except to the extent that the office of ALEX W GARCIA, DPM has already taken action in reliance on prior consent. This consent is valid until revoked by the patient in writing.

Any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without prior written authorization, except as otherwise provided by law.

**ERISA RIGHTS**

The right to payment for all medical benefits is assigned directly to Alex W. Garcia, DPM in consideration for medical services and supplies provided pursuant to the patients health insurance plan. In the event the patient's health insurance plan refuses to pay for provided, medically necessary services, ERISA\* rights are also assigned to Alex W. Garcia, DPM for a full and fair review of any and all denied claims. This ERISA assignment is in consideration for the unpaid services provided and in consideration for the continued willingness of Alex W. Garcia, DPM to see patients on an insurance assignment basis. If the treating doctor prevails in any such payment dispute, the patient may be liable for co-payment for the contested services.

Patients give consent to release medical information to Alex W Garcia, DPM., and give consent to Alex W. Garcia, DPM to release medical information to other healthcare providers for the purpose of treatment, when necessary for my care. Patients give consent to Alex W. Garcia, DPM to send medical information, as necessary, to their insurance plan.

*\*ERISA is an acronym for the Employee Retirement Income Security Act. The Employee Retirement Income Security Act includes federal laws requiring insurance companies to process submitted insurance claims and appealed (denied) insurance claims according to ERISA regulations. The failure to process submitted insurance claims and appealed (denied) insurance claims according to ERISA regulations may result in fines charged to the insurance company in amounts up to \$110 a day for each infraction.*

**ALEX W GARCIA, DPM**

**AUTHORIZATION OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided with a copy of the Notice of Privacy Practices. I have read and understood the notice. By signing this consent form, I am consenting to GP PODIATRY ASSOCIATES, and ALEX W. GARCIA, DPM use and disclosure of my PHI to carry out PPO.

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name (if different from Responsible Party) \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF FINANCIAL POLICY**

I acknowledge that I have read and understood the financial policy. I understand that ALEX W. GARCIA, DPM is not ultimately responsible for collecting my Insurance or negotiating the settlement of claims.

I understand that, in order to control the cost of invoicing, I will pay all Co-payment portions of my visit at the time of the visit.

I understand the financial policies and accept responsibility for payment of any balance owed on my account.

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name (if different from Responsible Party) \_\_\_\_\_

**AUTHORIZATION TO RELEASE MEDICAL BENEFITS**

I hereby authorize the release of all medical information necessary to process insurance claims and I hereby assign and authorize direct payment of all medical and/or surgical benefits, including major medical, private insurance, and other health plans to GP PODIATRY ASSOCIATES

Please remember that medical insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some insurances pay fixable allowances for certain procedures, and others pay a percentage of charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance

To the extent necessary to determine liability and to obtain reimbursement, I authorize disclosure of portions of the patient's record.

This assignment will remain in effect until revoked by the patient in writing. A signed copy of this assignment will be considered as valid as an original.

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name (if different from Responsible Party) \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF ERISA RIGHTS**

I acknowledge that I have received a copy of the notice of ERISA rights. By signing below, I am confirming that I have read and understood the notice.

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name (if different from Responsible Party) \_\_\_\_\_