Houston Foot and Ankle Professional Group

Dr. Brian Selbst Dr. Kelli Stevens
http://www.HouFootAnklePro.com/

Downtown
1724 Richmond Ave.
Houston, TX 77098
Tel: (832) 930-0362
Fax: (832) 779- 4362

North
17115 Red Oak Drive, Ste. 218
Houston, TX 77090
Tel: (832) 930-0362
Fax: (832) 779- 4362

South
131 Circle Way, Suite A
Lake Jackson, TX 77566
Tel: (979) 429-3621
Fax: (832) 779- 4362

PATIENT INFORMATION

PATIENT NAME _____

PARENT/GUARDIAN NAME (*if patient under 21 years*) _____

SSN _____-_____-_____ **DATE OF BIRTH** ___/___/_____ **(mm/dd/yyyy)** **AGE** _____

ADDRESS _____ **APT #**_____

CITY_____ **STATE** _____ **ZIP** _____

HOME PHONE # _____ **CELL PHONE #** _____

EMAIL_____ **WORK PHONE #** _____

PRIMARY LANGUAGE _____

SEX: **M / F** **RACE** _____ **ETHNICITY**_____

HEIGHT _____ **WEIGHT** _____ **SHOE SIZE**_____

OCCUPATION _____ **EMPLOYER**_____

GAURANTOR INFORMATION (*holder of insurance policy*)

GUARANTOR'S NAME _____

SSN _____-_____-_____ **DATE OF BIRTH** ___/___/_____ **(mm/dd/yyyy)** **AGE** _____

ADDRESS _____ **APT #**_____

CITY_____ **STATE** _____ **ZIP** _____

HOME PHONE # _____ **CELL PHONE #** _____

EMAIL_____ **WORK PHONE #** _____

PRIMARY DOCTOR (NAME) __DR._ _____ **PHONE**_____

HOW DID YOU HEAR ABOUT US? _____

Houston Foot and Ankle Professional Group
Dr. Brian Selbst Dr. Kelli Stevens
http://www.HouFootAnklePro.com/

Downtown
1724 Richmond Ave.
Houston, TX 77098
Tel: (832) 930-0362
Fax: (832) 779- 4362

North
17115 Red Oak Drive, Ste. 218
Houston, TX 77090
Tel: (832) 930-0362
Fax: (832) 779- 4362

South
131 Circle Way, Suite A
Lake Jackson, TX 77566
Tel: (979) 429-3621
Fax: (832) 779- 4362

REASON FOR VISIT

Current foot/ankle problem _____

How long has problem been occurring? _____

What treatments have been tried? _____

Is your problem accident related? _____ Work related? _____

MEDICAL HISTORY (*past and current conditions*)

☐ Diabetes Type I ☐ Diabetes Type II ☐ Neuropathy

☐ Poor Circulation ☐ Veins ☐ Arteries ☐ Bleeding Disorder

☐ Kidney disease ☐ Dialysis ☐ Anemia ☐ Sickle Cell Anemia

☐ Cancer (*type*:_____) ☐ Varicose Veins

☐ High Blood Pressure/hypertension ☐ Heart Disease ☐ Liver Problem

☐ Arthritis ☐ Rheumatoid ☐ Gout ☐ Psoriasis

☐ Prone to infection ☐ Thyroid Disease ☐ Stomach Ulcers ☐ Eczema

☐ HIV/AIDS ☐ Hepatitis (A, B, C) ☐ Lower Back Pain

☐ Other: _____

Houston Foot and Ankle Professional Group
Dr. Brian Selbst Dr. Kelli Stevens
http://www.HouFootAnklePro.com/

Downtown
1724 Richmond Ave.
Houston, TX 77098
Tel: (832) 930-0362
Fax: (832) 779- 4362

North
17115 Red Oak Drive, Ste. 218
Houston, TX 77090
Tel: (832) 930-0362
Fax: (832) 779- 4362

South
131 Circle Way, Suite A
Lake Jackson, TX 77566
Tel: (979) 429-3621
Fax: (832) 779- 4362

PAST SURGICAL HISTORY	DATE
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____

FAMILY HISTORY

☐ Diabetes – Insulin Y/N ☐ Heart Disease/High Blood Pressure/Hypertension

☐ Liver Problem ☐ Kidney problems ☐ Arthritis ☐ Thyroid Disease

☐ Poor Circulation ☐ Cancer () Other: _____

SOCIAL HISTORY

Tobacco (Packs per day) _____ Number Of Years _____ Date Quit _____

Alcohol (Drinks per day) _____ Number Of Years _____ Date Quit _____

Drug Use _____

ALLERGIES

☐ No known drug allergies	TYPE OF REACTION:
Drug Name _____	_____
Food Name _____	_____
Environmental Name _____	_____

Houston Foot and Ankle Professional Group

Dr. Brian Selbst Dr. Kelli Stevens

http://www.HouFootAnklePro.com/

Downtown
1724 Richmond Ave.
Houston, TX 77098
Tel: (832) 930-0362
Fax: (832) 779- 4362

North
17115 Red Oak Drive, Ste. 218
Houston, TX 77090
Tel: (832) 930-0362
Fax: (832) 779- 4362

South
131 Circle Way, Suite A
Lake Jackson, TX 77566
Tel: (979) 429-3621
Fax: (832) 779- 4362

MEDICATION	STRENGTH	FREQUENCY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

PHARMACY

NAME _____

ADDRESS _____ **UNIT #**_____

CITY_____ **STATE** _____ **ZIP** _____

PHONE # _____

Houston Foot and Ankle Professional Group
Dr. Brian Selbst Dr. Kelli Stevens
http://www.HouFootAnklePro.com/

Downtown
1724 Richmond Ave.
Houston, TX 77098
Tel: (832) 930-0362
Fax: (832) 779- 4362

North
17115 Red Oak Drive, Ste. 218
Houston, TX 77090
Tel: (832) 930-0362
Fax: (832) 779- 4362

South
131 Circle Way, Suite A
Lake Jackson, TX 77566
Tel: (979) 429-3621
Fax: (832) 779- 4362

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ (name of insurance plan/carrier) and assigns to Dr. Selbst/Dr. Stevens all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for costs not covered or reimbursed by third party payers. I hereby authorize the doctor to release all information, including information which may be considered a communicable or venereal disease, including hepatitis, syphilis, gonorrhea, HIV, AIDS, necessary to secure the payment of benefits to any responsible party. I authorize the use of this signature on all insurance submissions certifying that the information provided here is true and correct.

_____ _____
Patient's Signature (or Legal Guardian) Date

_____
Print Name

CONSENT TO TREAT

I request and authorize the physician and his staff to provide me with treatment, and to perform any procedures now contemplated or such additional procedures as my doctor may deem reasonable and necessary. I authorize the Social Security Administration to disclose information regarding my Medicare coverage. The undersigned certifies that he/she has read the foregoing and is the patient, or is duly authorized by that patient as patient's general agent to execute the above and accept the terms. It is further understood that this release remains in effect for as long as I am a patient of Dr. Selbst/Dr. Stevens unless otherwise revoked.

_____ _____
Patient's Signature (or Legal Guardian) Date

_____
Print Name

HIPAA STATEMENT

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understood the Notice.

_____ _____
Patient's Signature (or Legal Guardian) Date

_____
Print Name

FINANCIAL POLICY

I acknowledge that I was provided a copy of the Financial Policy and that I have read or had the opportunity to read, if I so choose, and understood the Policy. Also, I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

_____ _____
Patient's Signature (or Legal Guardian) Date

_____
Print Name

Houston Foot and Ankle Professional Group

Dr. Brian Selbst Dr. Kelli Stevens

http://www.HouFootAnklePro.com/

Downtown
1724 Richmond Ave.
Houston, TX 77098
Tel: (832) 930-0362
Fax: (832) 779- 4362

North
17115 Red Oak Drive, Ste. 218
Houston, TX 77090
Tel: (832) 930-0362
Fax: (832) 779- 4362

South
131 Circle Way, Suite A
Lake Jackson, TX 77566
Tel: (979) 429-3621
Fax: (832) 779- 4362

HIPAA Notice of Privacy Practices

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you that relates to your past, present or future physical, mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information (PHI): Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, we would disclose your PHI as necessary to a home health agency that provides care to you or provide to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for a hospital stay may require that your relevant health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of an appointment. We may use or disclose your PHI in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight, Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses.

Your Rights: You have the right to inspect and have copied (at your expense) your PHI under federal law; however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. You have the right to request a restriction of our PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care of for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit and use disclosure of your PHI, your PHI will not be restricted. You have the right to use another healthcare professional. You have the right to request to receive confidential communications from us by alternative means or at an alternative location within reason. You have the right to obtain a paper copy of this notice from us, even if you have agreed to accept this notice alternatively, i.e. electronically. You may have the right to have your physician amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. We reserve the right to change the terms of this notice and will inform you at your next office visit following the change. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact. We will not retaliate against you for filing a complaint. This notice was published and became effective on/or before April 14, 2013 and updated on February 24, 2015. Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 164.500.

Other Permitted and Required Uses and Disclosures: Will be made only with your written consent, authorization or opportunity to object unless required by law, this includes inquiries about your scheduled appointments. You may revoke this authorization in writing at any time, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Treatment of Minors: It is our policy that only a natural, adoptive parent or legal guardian is authorized to present a child for treatment UNLESS a written authorization is given on the form provided. I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my PHI. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operation such as quality assessments and physician certifications

I have been given the right to review the Notice of Privacy Practices prior to signing this acknowledgement I understand that Houston Foot and Ankle Professional Group reserves the right to change these policies at any time and I may contact this office for an updated copy at any time. 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 healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____ _____

Patient's Signature (or Legal Guardian) Date

_____

Print Name

Houston Foot and Ankle Professional Group

Dr. Brian Selbst Dr. Kelli Stevens

http://www.HouFootAnklePro.com/

Downtown
1724 Richmond Ave.
Houston, TX 77098
Tel: (832) 930-0362
Fax: (832) 779- 4362

North
17115 Red Oak Drive, Ste. 218
Houston, TX 77090
Tel: (832) 930-0362
Fax: (832) 779- 4362

South
131 Circle Way, Suite A
Lake Jackson, TX 77566
Tel: (979) 429-3621
Fax: (832) 779- 4362

Financial and Office Policy

Thank you for choosing us for your podiatry needs. Our goal is to provide you with the highest quality care at an affordable cost. To make our services available to as many patients as possible on an affordable basis, we have adopted the financial collection policy outlined below. We ask that you read the policy carefully and sign prior to initial treatment as this will be in effect until you unless you receive written notice of changes, cancellations, and/or modifications.

- WE MAY ACCEPT ANY ASSIGNABLE INSURANCE WITH APPLICABLE COVERAGE
- WE OFFER FINANCIAL ASSISTANCE (ACA DISCOUNT) UNDER OUR INDIGENCY POLICY TO ALL ELIGIBLE PATIENTS ON A CASE BY CASE BASIS
- FULL PAYMENT IS DUE AT TIME OF SERVICE UNLESS ARRANGED OTHERWISE
- WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS AND DISCOVER

Dishonored checks will be charged back to the patient's account with a service fee of $45.00. Dishonored checks not redeemed within 20 working days of written notice to the maker will be referred to the prosecutor for collection. We do not accept post-dated checks.

Regarding Insurance
We accept assignment of most insurance benefits at our discretion. A valid insurance card, policy/plan number is needed to verify coverage. As a courtesy to our patients, verifiable and assignable insurance will be billed by our office. However, you will be personally responsible for your account balance regardless of whether or not if your insurance will pay for your total balance of your claims, unless you're eligible for discounts under our "Indigent Policy" pre-determined before the services are rendered. Your insurance policy/employee benefits plan is a contract between you and your insurance company/employee benefits plan. We are not a party to that contract.

Regarding Discount
If eligible, you may qualify for certain discounts, reduction or waiver of deductibles, coinsurance and co-pay to any eligible patients based on medical needs and ability to pay, on a case by case basis under our "Indigent Policy" in accordance with applicable federal and state laws. You may apply for financial indigent discount assistance by asking our staff to determine if you're eligible.

Regarding Surgeon and Facility Charges
We will disclose to every patient our charges as clearly as practically possible before your medical procedures, if it is known to us. Please feel free to ask our staff if you have any questions about charges and your payment responsibilities. Please be advised, your insurance company requires us, your physician, to file services separately from the surgical facility/hospital where services are rendered along with the anesthesiologist, diagnostic labs, radiologists, pathologists and any other entity involved in your surgery. If you have any questions about your surgical facility bills, please direct them to that surgical facility or hospital. While we do not anticipate any unforeseeable circumstances, we have no control over any such event(s) that may arise. Should you require additional medical or surgical care in any event of the post-surgical complications and reactions, you may incur additional expenses at this facility or outside this facility, such as a hospital.

Regarding PPO and HMO Network Participation
You may have the choice to choose a physician or surgical facility with or without PPO or HMO participation under difference insurance coverage and benefits levels. We are dedicated to providing the highest quality care to every patient; however we have no power to change your insurance coverage or network limitations. Most health care plans or insurance policies may provide coverage to non-PPO providers and facilities, but at lower percentage of insurance reimbursement. Although it is your responsibility to verify your insurance coverage for non-PPO/HMO providers, we will always disclose to you as to our participation status with your insurance plan. We also provide financial assistance or discounts for high deductibles and co-insurance through our "Indigency Policy" in accordance with applicable federal and state laws, on a case by case basis.

Most health plans or insurance policies may have coverage for out of network providers or facilities, but at a different or lower percentage level of reimbursement rates.

We will verify your insurance coverage and obtain pre-certification if applicable for all services as a courtesy to you before your treatment.

Please understand that verification of insurance is not a guarantee of insurance payment.

Diabetic Medicare Patients
In order to file your claim for routine foot care, we must have the date you last saw your diabetic doctor, which must be within six months.

Houston Foot and Ankle Professional Group

Dr. Brian Selbst Dr. Kelli Stevens

http://www.HouFootAnklePro.com/

Downtown
1724 Richmond Ave.
Houston, TX 77098
Tel: (832) 930-0362
Fax: (832) 779- 4362

North
17115 Red Oak Drive, Ste. 218
Houston, TX 77090
Tel: (832) 930-0362
Fax: (832) 779- 4362

South
131 Circle Way, Suite A
Lake Jackson, TX 77566
Tel: (979) 429-3621
Fax: (832) 779- 4362

HMO Patients
You are required to obtain your own referral from your primary care doctor prior to your visit.

Medical Records Release/Copying
Please allow 48 hours for requested medical records. Our office charges a fee for medical records in accordance with state guidelines. No recordings of any kind at any time of the staff, physicians, or affiliated contractors are allowed without the express written consent from Hou Foot Ankle Pro, LLC.

Disability/FMLA Forms
Due to the length and time to complete and/or process these forms, we charge $10.00 for each page to be submitted.

Refunds/Credits
Please notify us in writing in the event that you have a true credit. We will happily issue a refund in a timely fashion. If your request is more than 60 days from the date of your most recent payment, you may be charged 4% of the amount to be refunded as a fee to process/return dated financial records. We do not refund, credit, or take back any supplies dispensed. Unfortunately, every supply does not work for every patient.

Compliance & Disclosure under Texas Occupations Code - Section 102.006
In compliance with section 102.006 of the Texas Occupations Code, I consent that I have been informed of the following information: The choice of doctor or facility I am being referred to is solely based on the quality and safety of care, reputation and patient satisfaction I recognized my rights with respect to in-network or out-of-network coverage. My attending doctor(s) and/or clinic (facility) have disclosed to me at the time of initial contact and at the time of referral: (A) his or her affiliation, if any, with the doctor or facility for whom I, the patient, am being referred and (B) that he/she will receive, directly or indirectly, remuneration for referral: It is my request to exercise my right of freedom of choice for the provider(s) and facility under the in-network or out-of-network coverage as provided by my health plan, in compliance with all applicable federal and state laws, Medicare, ERISA, PPACA and the section of 102.006 of the Texas Occupations Code.

Your Responsibility for Cooperation
If we accept your insurance assignment as a form of payment for reimbursement, you agree to timely cooperate with your insurance company or health plan in the course of claim processing, such as insurance inquiries, requests for additional information, claims status verification or any inquiries for the purpose of your claim processing. You also agree to notify us immediately of any insurance inquiry or request for additional information and provide us with a copy of any documentation received from the insurance company or submitted to insurance company from you.

Payment for each visit is due at the time of the visit, unless otherwise discussed prior to treatment. We are committed to serving you with the highest quality of care possible at an affordable cost. Our staff is ready to help you. If you have any questions regarding our financial policies, please do not hesitate to ask. We thank you for your cooperation.

I have read the Financial Policy and I understand and agree to this Financial Policy.

_____ _____
Patient's Signature (or Legal Guardian) Date

_____
Print Name