Sweeney Foot and Ankle Specialists
Please fill out all information completely!

Date: _____

Personal Information

Name:_____
Last First Middle Initial Language Spoken

Date of Birth:_____**Age:**_____**Weight:**_____ **Height:**_____**Shoe Size:** _____

Gender: M or F **Race:** _____**Ethnicity:**_____**Social Security #:** _____
(e.g., White, Asian, Hispanic) (e.g., Hispanic, Latin, Other)

Home Address:_____**City:**_____**State/Zip:**_____

Phone 1:_____**Phone 2:**_____

May we leave phone messages? Yes or No **Email:**_____
@gmail @yahoo @aol @sbcglobal @hotmail

Occupation:_____**Employer Name:** _____

Address:_____**City:**_____**State/Zip:** _____

Work #_____**Extension:** _____

Who may we thank for referring you to our office? _____

Marital Status: (circle one) **Single** **Married** **Divorced** **Widowed**

Medical History

What is the reason for today's visit?_____

Name of your Primary Care Physician?_____**Phone #**_____**Last Visit:**_____

Have you ever been seen by a foot specialist prior to today? Yes or No **Name of specialist:** _____

Please list ALL medications you are currently taking:_____

_____

Do you have any allergies to medications? _____

Please list all previous surgeries and dates:_____

Have you ever had the following?

Y N Liver Problems	Y N High Blood Pressure	Y N Thyroid
Y N Tuberculosis	Y N Epilepsy	Y N Depression/ Anxiety
Y N Kidney Problems	Y N Rheumatic Fever	Y N Bipolar Disorder
Y N HIV	Y N Heart Problems	Y N Fibromyalgia
Y N Stomach Ulcer	Y N Diabetes	Y N Rheumatoid Arthritis
Y N Difficulty in Healing	Y N High Cholesterol	Y N Blood Clots/Disorders
Y N Shortness of Breath	Y N ADD/ADHD	

Any Health issues not listed? _____

Pharmacy: **Phone #** **Location:**_____

Smoke? Yes or No **Drink?** Yes or No

By signing below, I acknowledge that all information provided is true and correct to the best of my knowledge.

_____ _____

Signature of Patient/Responsible Party **Date**

PATIENT CONSENT FORM

Disclosure of Physician Ownerships: Please be informed that Dr. Sweeney and the physicians of **Sweeney Foot and Ankle Specialists** have direct and indirect financial ownership interests and may receive remuneration from affiliated entities, including **Aspire Hospital**. All recommendations, referrals, or arrangements for specific services or facilities are made with the patient's best interest in mind. You have the right to choose your healthcare provider and will not be treated differently should you choose an alternative provider. If you have any questions about this notice, please speak with your physician. _____**(initials)**

Assignment of Benefits: By my initials and signature below, I authorize **Sweeney Foot and Ankle Specialists** to release any medical, surgical, or demographic information necessary to determine third-party coverage and process insurance claims on my behalf. I understand that I am financially responsible for any services or supplies not covered by my insurance or health benefit plan, including but not limited to copays, coinsurance, and deductibles. _____**(initials)**

Consent to treat: My initials and signature below acknowledge that I voluntarily consent to receive medical treatment and procedures deemed necessary during all current and future visits to **Sweeney Foot and Ankle Specialists**. This includes, but is not limited to, medical treatment, physical therapy, surgical care, x-rays, medications, laboratory tests, and other services ordered by the provider participating in my care. _____(**initials**)

Acknowledgment of Notice of Privacy Practices: By my initials and signature below, I acknowledge that I was offered a copy of the **Notice of Privacy Practices** prior to receiving medical services. I was given the opportunity to ask questions and understand that this notice includes a section detailing my rights under HIPAA. I authorize the use and disclosure of my health information for treatment, payment, and healthcare operations. I understand this authorization remains in effect until revoked in writing and that such revocation does not affect disclosures made prior to that time. _____**(initials)**

Consent for Prescription Drug Monitoring Program: By my initials and signature below, I authorize the provider to access my prescription history as required by **Section 22 TAC 170.3** of the Texas Administrative Code, for the purpose of managing and treating chronic pain. _____ **(initials)**

Communication: By my initials and signature below, I authorize **Sweeney Foot and Ankle Specialists** to contact me at the phone numbers and email address I have provided regarding appointment reminders, outstanding balances, and other practice-related information. This may include communication through electronic or automated technology. This authorization also applies to any new phone number or email I may acquire in the future. _____ **(initials)**

Surgery Deposit: By signing below, I acknowledge and consent to the payment of a non-refundable surgical **deposit of $250** to schedule my surgery. This amount will be applied toward the total cost of the procedure. I understand that if the surgery is canceled within two weeks of the scheduled date, the deposit will be forfeited. I also understand that the surgery may be rescheduled one time without penalty, as long as it is rescheduled within six months of the original surgery date. _____**(initials)**

Biopsies and Cultures: My initials and signature below acknowledge that I have been informed and understand that all biopsies and cultures are sent to an outside laboratory for pathology review. I consent to this process and understand that I may receive a separate bill directly from the laboratory for these services. _____**(initials)**

Authorization For Release of Protected Health Information: I authorize **Sweeney Foot and Ankle Specialists** to discuss my medical history, diagnosis, treatment, and prognosis with the following individuals:

_____

_____

By signing below, I acknowledge that I have read, understand, and agree to all the consents and authorizations above.

Signature of Patient/Responsible Party: **Date:**

_____ _____

OFFICE AND FINANCIAL POLICIES

Welcome, and thank you for choosing **Sweeney Foot and Ankle Specialists** for your foot health needs. We are committed to providing the highest quality medical care in an efficient, timely, and compassionate manner. A key part of your care is understanding your financial responsibilities. By reviewing our policies in advance, we hope to prevent any misunderstandings or frustration during your visit

Your insurance policy is a contract between you and your insurance company. It is **your responsibility** to verify that our physician is currently in-network with your plan. As a courtesy, we will file insurance claims on your behalf. We allow up to **60 days** from the date of claim submission for insurance payment. If the claim is not paid within that time frame, the balance becomes **your responsibility**.

We participate with most insurance plans, each of which may have unique rules. Please familiarize yourself with your benefits and plan requirements. Some plans require a **referral authorization** from your Primary Care Physician before seeing a specialist. You are responsible for obtaining this referral and tracking the number of authorized visits, along with start and end dates. Patients are responsible for **deductibles, co-insurance, non-covered services**, and any other charges not covered by insurance. An **Insurance Waiver** may be required to confirm your understanding of financial responsibility for non-covered services. Monthly statements will be sent for any outstanding balances.

Please verify all personal information to ensure the accuracy of our records. Inform us immediately of any **address, insurance, or telephone** changes. Failure to provide updated insurance information in a timely manner may result in the balance becoming your responsibility.

Payment is due at the time of service for any **co-pay, deductible, or co-insurance** amounts. Some services or supplies may not be covered by your plan. While we do our best to verify your insurance benefits, errors may occur—especially for custom foot orthotics, routine foot care, and durable medical equipment. If your insurance denies a claim, **you are responsible** for the full amount.

WE DO NOT ACCEPT RETURNS OR OFFER REFUNDS FOR ANY DURABLE MEDICAL SUPPLIES OR CUSTOM-MOLDED ORTHOTICS.

We require **24-hour notice** for any appointment cancellation. Our office will attempt to remind you of upcoming appointments, but it is ultimately your responsibility to cancel or reschedule when needed. A $45.00 fee may be charged for missed appointments or failure to provide proper cancellation notice.

If you arrive more than 15 minutes late, you may be rescheduled to avoid delaying other patients.

A **surgical estimate** will be collected at your **pre-operative appointment**. Once your surgery is scheduled, we will notify your insurance provider and verify your **surgical benefits**, **deductible**, and **co-insurance** amounts. While we do our best to provide an accurate estimate, we cannot guarantee what your insurance will pay until the claim is processed.

Important: Your surgeon's fee is **separate** from any charges billed by the **surgical facility, anesthesia, laboratory, pre-op testing, pathology, or DME (Durable Medical Equipment). If required by your insurance, pre-certification will be obtained.**

A fee of **$25.00** will be charged for each disability or insurance form, and payment is required before processing; please allow up to **5 business days** for completion. Copies of X-rays are available for **$10.00**, and medical records may be obtained for a fee of **$15.00**. A **$45.00** fee will be applied for any returned checks.

By signing below, I confirm that I have read, understood, and agree to the office and financial policies outlined above. I attest that the demographic and insurance information provided is accurate and current, and I authorize the release of information as needed for insurance processing and pre-certification.

_____

Signature of Patient/Responsible Party **Date**