Victoria Foot & Ankle Center

New Patient Forms

1 OF 5 - PATIENT INFORMATION

Welcome to our office. Please print clearly and complete each section.

PATIENT DETAILS

PATIENT NAME (LAST, FIRST, MI) _____ DATE _____

BIRTHDATE _____ AGE _____ SOCIAL SECURITY NUMBER _____

EMAIL _____ SEX: ☐ MALE ☐ FEMALE

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ PREFERRED CONTACT _____

EMPLOYMENT AND HOUSEHOLD

EMPLOYER _____ OCCUPATION _____

MARITAL STATUS ☐ Married ☐ Widowed ☐ Single ☐ Separated ☐ Divorced

STUDENT ☐ Yes ☐ No School: _____

SPOUSE'S NAME _____ SPOUSE'S BIRTHDAY _____

SPOUSE'S EMPLOYER _____ OCCUPATION _____

EMERGENCY AND CARE CONTACTS

EMERGENCY CONTACT _____ PHONE NUMBER _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

FAMILY PHYSICIAN _____ PHONE NUMBER _____ LAST VISIT _____

PHARMACY _____ PHONE NUMBER _____

SHOE SIZE _____ HEIGHT _____ WEIGHT _____

INSURANCE

INSURANCE COMPANY

MEMBER / POLICY ID

GROUP NUMBER

PLAN NAME / TYPE

INSURANCE PHONE NUMBER

EFFECTIVE DATE

RELATIONSHIP TO SUBSCRIBER

☐ Self ☐ Spouse ☐ Child ☐ Other: _____

SUBSCRIBER / POLICYHOLDER INFORMATION *Complete if the subscriber is someone other than the patient.*

SUBSCRIBER NAME (LAST, FIRST, MI)

DATE OF BIRTH

RELATIONSHIP TO PATIENT

SOCIAL SECURITY NUMBER

ADDRESS

CITY

STATE

ZIP

EMPLOYER

EMPLOYER PHONE NUMBER

GUARANTOR / RESPONSIBLE PARTY *Complete if different from the patient.*

GUARANTOR NAME (LAST, FIRST, MI)

DATE OF BIRTH

RELATIONSHIP TO PATIENT

PHONE NUMBER

ADDRESS

CITY

STATE

ZIP

Victoria Foot & Ankle Center

Medical History

3 OF 5 - HEALTH INFORMATION

MEDICAL HISTORY *Check all that apply.*

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joint
- ☐ Blood Clots / DVT
- ☐ Cancer
- ☐ Chest Pains
- ☐ Circulation Problems
- ☐ COPD / Tobacco Use
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Foot / Leg Cramps
- ☐ Gout
- ☐ Heart Disease
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Neuropathy
- ☐ Phlebitis / Varicose Veins
- ☐ Respiratory Disease
- ☐ Stroke
- ☐ Swelling in Ankle / Feet
- ☐ Ulcers

ALLERGIES *Check all that apply.*

- ☐ Adhesive Tape
- ☐ Aspirin
- ☐ Codeine
- ☐ Iodine (seafood)
- ☐ Latex
- ☐ None
- ☐ Other: _____
- ☐ Penicillin
- ☐ Sulfa

MEDICATION LIST *List all current medications and strengths.*

Medication	Strength

Victoria Foot & Ankle Center

History of Symptoms

4 OF 5 - TODAY'S CONCERNS

Please answer the following questions to the best of your ability.

What is the main reason for your visit?

_____

_____

How long have your symptoms been present? If more than one episode, please list the date of the most recent episode.

_____

_____

What treatments have you done thus far to alleviate your pain?

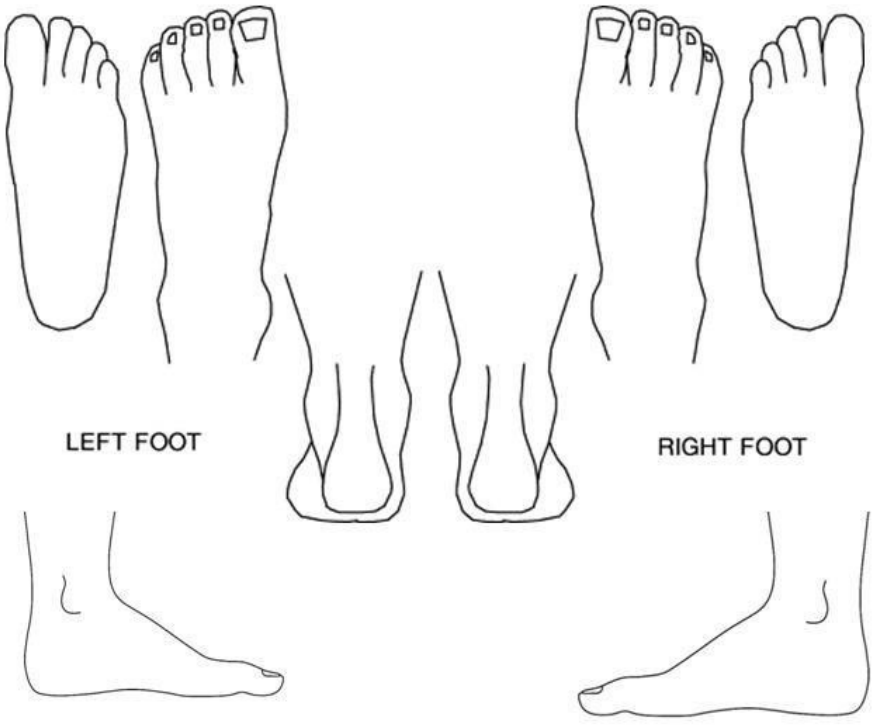
_____

_____

On a scale of 1–10, with 10 being the worst pain of your life, how would you rate your pain?

_____

Mark the area(s) below that are bothering you today.



VICTORIA FOOT & ANKLE CENTER

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Victoria Foot & Ankle Center is committed to protecting the privacy and confidentiality of your health information. We are required by federal and Texas law to maintain the privacy and security of your protected health information, provide you with this Notice of our legal duties and privacy practices, and notify you if a breach occurs that may have compromised the privacy or security of your information. We are required to follow the terms of the Notice currently in effect.

How We May Use and Disclose Your Health Information

We may use or disclose your health information without your written authorization for the following purposes:

Treatment. We may use and share your information to provide, coordinate, or manage your medical care. For example, we may share information with another physician, pharmacy, laboratory, hospital, imaging center, home health provider, or other health care professional involved in your care.

Payment. We may use and disclose your information to bill and obtain payment from you, your insurance company, Medicare, Medicaid, or another responsible party. This may include determining eligibility or benefits, obtaining prior authorization, and reviewing whether services are medically necessary.

Health Care Operations. We may use and disclose your information to operate our practice, improve the quality of care, train staff, conduct audits, manage risk, perform credentialing, and evaluate the performance of our providers and employees.

Business Associates. We may share information with companies that perform services for our practice, such as billing, electronic health records, technology support, document storage, legal, accounting, and practice-management services. These companies are required to appropriately protect your information.

Clinical Documentation Technology. Victoria Foot & Ankle Center may use artificial intelligence-assisted technology to support patient care and administrative activities. These tools may assist with preparing visit documentation, summarizing information, organizing medical records, coding, billing, scheduling, or other practice operations. Information processed through these tools may include your symptoms, medical history, examination findings, treatment plan, and other protected health information. We use appropriate safeguards and require outside service providers that handle protected health information on our behalf to protect it as required by applicable law. Artificial intelligence does not replace the professional judgment of your healthcare provider. Information generated by these tools is reviewed by the provider or authorized staff, and decisions regarding your diagnosis and treatment remain the responsibility of your healthcare provider.

Appointment Reminders and Care Communications. We may contact you by telephone, voicemail, text message, email, mail, or patient portal regarding appointments, test results, prescriptions, treatment instructions, billing, or other matters related to your care. Please tell us if you prefer that we contact you in a particular way or at a particular location.

Individuals Involved in Your Care. Unless you object, we may share information relevant to your care or payment with a family member, friend, caregiver, or other person involved in your care. If you are unable to tell us your preference, we may use our professional judgment to determine whether a disclosure is in your best interest.

As Required or Permitted by Law. We may disclose your information when required or permitted by federal or Texas law, including for public-health activities, reporting suspected abuse or neglect, health oversight, workers' compensation, organ or tissue donation, certain judicial or administrative proceedings, certain law-enforcement purposes, coroners or medical examiners, military or veterans' activities, national-security activities, disaster-relief efforts, or to prevent a serious and imminent threat to health or safety.

Uses and Disclosures Requiring Written Authorization

We will obtain your written authorization before using or disclosing your health information for purposes not described in this Notice, unless the use or disclosure is otherwise permitted or required by law. Most uses and disclosures involving psychotherapy notes, marketing, or the sale of protected health information require written authorization.

If we receive records protected by federal substance-use-disorder confidentiality laws, those records will receive the protections required by applicable federal law. Such records generally may not be used or disclosed in civil, criminal, administrative, or legislative proceedings against you without your written consent or an appropriate court order.

You may revoke an authorization in writing at any time. Revocation will not affect information already used or disclosed in reliance on the authorization.

Your Privacy Rights

Inspect or Obtain a Copy. You may request to inspect or receive a paper or electronic copy of your medical and billing records. We may charge a reasonable, legally permitted fee. When applicable Texas law requires a shorter response period than federal law, we will follow the Texas requirement.

Request a Correction. You may ask us to amend information you believe is incorrect or incomplete. We may deny the request in certain circumstances, but we will explain the denial in writing.

Request Confidential Communications. You may ask us to contact you in a particular way or at a particular location. We will accommodate reasonable requests.

Request Restrictions. You may ask us not to use or disclose certain information for treatment, payment, or health care operations. We are generally not required to agree. However, if you pay in full out of pocket for a service and ask us not to disclose information about that service to your health plan for payment or health care operations, we will honor the request unless disclosure is required by law.

Receive an Accounting of Disclosures. You may request a list of certain disclosures we made of your health information during the applicable time period. The list will not include every disclosure, such as many disclosures made for treatment, payment, or health care operations.

Receive a Paper Copy. You may request a paper copy of this Notice at any time, even if you previously agreed to receive it electronically.

Choose a Personal Representative. You may authorize another person to exercise your privacy rights. A legal guardian, medical power of attorney, or another person legally authorized to act for you may also exercise these rights, subject to applicable law.

File a Complaint. You may complain if you believe your privacy rights have been violated. You will not be retaliated against or denied treatment for filing a complaint.

Our Responsibilities

- Maintain the privacy and security of your protected health information.
- Follow the privacy practices described in this Notice.
- Provide you with a copy of this Notice upon request.
- Notify you as required by law if a breach occurs that may have compromised your information.
- Honor restrictions and confidential-communication requests when required by law.
- Obtain your written authorization before using or disclosing your information when authorization is required.

Changes to This Notice

We may revise this Notice and make the revised Notice effective for health information we already maintain as well as information we receive in the future. The current Notice will be posted in our office and on our website, if applicable. A paper copy is available upon request.

Questions or Complaints

If you believe your privacy rights have been violated, you may file a complaint with Victoria Foot & Ankle Center or with the agencies listed below. You will not be retaliated against for filing a complaint.

U.S. Department of Health and Human Services, Office for Civil Rights
200 Independence Avenue SW, Washington, DC 20201
Telephone: 1-800-368-1019
Website: www.hhs.gov/ocr/privacy/hipaa/complaints/

Texas Office of the Attorney General, Consumer Protection Division
P.O. Box 12548, Austin, Texas 78711-2548
Website: www.texasattorneygeneral.gov

PATIENT CONSENTS

I consent to the evaluation and treatment considered medically appropriate by the physicians, providers, and staff of Victoria Foot & Ankle Center. This may include examinations, diagnostic testing, imaging, wound care, injections, application or removal of dressings or medical devices, and other routine office-based care. I understand that no particular result has been promised and that I may ask questions or decline any proposed treatment. Procedures requiring additional informed consent will be explained separately when appropriate.

I authorize Victoria Foot & Ankle Center to release information reasonably necessary to obtain payment from my health plan and to submit claims on my behalf. I assign directly to Victoria Foot & Ankle Center any insurance benefits payable for services provided to me. I understand that insurance coverage and benefit estimates are not guarantees of payment. I am financially responsible for deductibles, copayments, coinsurance, noncovered services, denied claims, and other balances permitted by law, regardless of whether I have insurance. I agree to provide accurate insurance information and promptly notify the practice of any changes.

I authorize Victoria Foot & Ankle Center and its authorized service providers to contact me regarding appointments, treatment, test results, prescriptions, referrals, billing, account balances, and other matters related to my care. Communications may be made by telephone call, voicemail, patient portal, mail, fax, text message, or email using the contact information I provide. I understand that reasonable safeguards will be used, but communications transmitted electronically or through third-party systems may carry some risk of unauthorized access. This consent also permits the practice to exchange information with pharmacies, laboratories, imaging facilities, hospitals, referring providers, other healthcare professionals, health plans, and organizations involved in my treatment or payment as permitted by law. Standard message and data rates may apply.

I understand that Victoria Foot & Ankle Center may use secure clinical documentation technology, including artificial intelligence-assisted tools, to support patient care and administrative activities. These tools may assist with preparing visit documentation, summarizing information, organizing medical records, coding, billing, scheduling, and other practice operations. Information processed through these tools may include my symptoms, medical history, examination findings, treatment plan, and other protected health information. Appropriate safeguards are used, and outside service providers that handle protected health information on behalf of the practice are required to protect it as required by applicable law. This technology does not replace the professional judgment of my healthcare provider. Information generated by these tools is reviewed by the provider or authorized staff, and decisions regarding my diagnosis and treatment remain the responsibility of my healthcare provider.

I acknowledge that I have been provided with, or given the opportunity to review, Victoria Foot & Ankle Center's Notice of Privacy Practices. The notice is available in the reception area, and I may request a printed or electronic copy at any time. I understand that the notice describes how my health information may be used and disclosed and explains my rights concerning that information.

I understand that these consents remain in effect for future visits unless I revoke or modify them in writing, except to the extent that the practice has already acted in reliance on them. Revocation will not affect disclosures or actions otherwise permitted or required by law. I have had the opportunity to read this form, ask questions, and receive answers. By signing below, I indicate that I understand and agree to the consents stated above.

PATIENT NAME

SIGNATURE **DATE**

PARENT/GUARDIAN OF PATIENT (IF APPLICABLE)

RELATIONSHIP TO PATIENT