NEUROPATHY CARE CENTER OF HOUSTON

14441 Memorial Drive • Suite 16
Houston, TX 77079
Office (281) 497-2850 • Fax (281) 531-7910
www.ParkerPodiatry.com

Patient Information: Please fill this section out completely with the patient's information, even if the patient is a minor.

Legal Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home _____ Work: _____ Cell: _____

E-mail Address: _____

Date of Birth: _____ Male: ☐ Female: ☐ SSN: _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Significant Other ☐

Race: Caucasian ☐ African American ☐ Hispanic ☐ Other ☐ Other ☐

Primary Language: English ☐ Spanish ☐ Other ☐ _____

Guarantor Information: Please fill this section out ONLY if the patient is a child or is not the primary policy holder (spouse, adult child, etc.)

Guarantor Legal Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home _____ Work: _____ Cell: _____

Insurance Information: Please fill out the following information to the best of your ability. If you have provided us with a copy of your insurance card, you do not need to fill out the policy information.

PRIMARY Insurance Name: _____ Policy ID # _____

SECONDARY Insurance Name: _____ Policy ID # _____

Primary Care Physician: Whenever possible, we like to work with your primary physician so that we may provide you with the most comprehensive treatment plan possible.

Primary Care Physician: _____ Phone: _____

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Patient Name:_____ **DOB:** _____

This questionnaire must be completed prior to your first appointment with our office. Your careful answers will help us to understand your pain problem and to better assess your treatment plans. It is understandable that you might be concerned about what happens to the information you provide, as much of it is personal. Our records are strictly confidential, and no outsider is permitted to see your file without your written permission.

Chief Complaint:

1. What is the reason for your visit today? _____
2. How did you hear about the Neuropathy Care Center of Houston? _____
3. Do you have diabetes? ☐ YES ☐ NO
   a. When were you diagnosed? _____
   b. What was your blood sugar this morning? _____
   c. What was your last HgA1c? _____
4. Have you ever had chemotherapy? ☐ YES ☐ NO
5. Have you ever been exposed to heavy metals? ☐ YES ☐ NO
6. Have you ever been exposed to solvents? ☐ YES ☐ NO
7. Did you serve in the military? ☐ YES ☐ NO
8. Do you drink alcohol? ☐ YES ☐ NO
   a. How much do you drink per week? ____
9. Do you have a history of alcohol abuse? ☐ YES ☐ NO
10. Do you now, or have you ever smoked? ☐ YES ☐ NO
    a. How much do / did you smoke? _____
    b. For how long? _____
    c. How long ago did you quit? _____
11. Have you ever been treated for high cholesterol or triglycerides? ☐ YES ☐ NO
12. Do you have any medical allergies? ☐ YES ☐ NO
13. Do you currently use a pacemaker or defibrillator? ☐ YES ☐ NO
14. Have you ever had shingles? ☐ YES ☐ NO
15. Do you have kidney failure? ☐ YES ☐ NO
16. Do you have a thyroid condition? ☐ YES ☐ NO

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17. Have you ever had carpal tunnel symptoms? ☐ YES ☐ NO

18. Do you have any other neurological problems? ☐ YES ☐ NO

19. Do any foods bring on your symptoms? ☐ YES ☐ NO

20. Have you ever been diagnosed with?

- ☐ Chronic pain
- ☐ Lower back stenosis or herniated discs
- ☐ Sciatica or Radiculopathy
  a. Who made this diagnosis and when? _____

21. Have you ever had any of the following tests?

☐ NCV/EMG (test with needles poking you) Year:_____ Result: _____

☐ Nerve skin biopsy Year:_____ Result: _____

Associated Symptoms: Are there any symptoms associated with your pain? - *Please check all that apply.*

☐ Burning Pain	☐ Cold Feet	☐ Urinary Incontinence
☐ Tingling	☐ Hot Feet	☐ Bowel Incontinence
☐ Numbness	☐ Stinging Pain	☐ Lack of Balance
☐ Weakness	☐ Squeezing Pain	☐ Difficulty Walking
☐ Pale Skin	☐ Pain in Lower Back	☐ Hands Tingling
☐ Throbbing Pain	☐ One Foot Affected	☐ Pain at Night
☐ Electric Pain	☐ One Leg Affected	☐ Pain with activity
☐ Aching Pain	☐ Both Feet Affected	☐ Pain with Sitting
☐ Shooting Pain	☐ Both Legs Affected	☐ Pain with Shoes On

22. When the symptoms arise, are they:

☐ Mild ☐ Uncomfortable ☐ Moderate ☐ Severe ☐ Intolerable ☐ Excruciating

23. How does your pain effect the following?

Memory: (not at all) 0 1 2 3 4 5 6 7 8 9 10 (greatly effects)
Mood / Temper: (not at all) 0 1 2 3 4 5 6 7 8 9 10 (greatly effects)
Fatigue: (not at all) 0 1 2 3 4 5 6 7 8 9 10 (greatly effects)
Ability to Sleep: (not at all) 0 1 2 3 4 5 6 7 8 9 10 (greatly effects)

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24. How long do your symptoms last when they occur? _____

Timing of Pain – Alleviating and Aggravating Factors:

25. What makes your pain feel better? _____

_____

26. What makes your pain feel worse? _____

_____

27. How long have you had the pain that you are currently experiencing?_____months_____years

28. What caused your pain to start? _____

29. How often do you feel pain?

☐ Constantly (80-100% of time) ☐ Nearly Constant (50-80% of time) ☐ Intermittently (25-50% of time) ☐ Occasionally (less than 25% of time)

Past and Current Treatments for Symptoms – *Please check and answer all treatments that apply.*

Treatment Name	Dosage	Still Taking?	Was It Helpful?	Reason for Stopping
Neurontin / Gabepentin		Y / N	Y / N / Some	
Cymbalta		Y / N	Y / N / Some	
Lyrica		Y / N	Y / N / Some	
Painkillers		Y / N	Y / N / Some	
Acupuncture		Y / N	Y / N / Some	
Physical Therapy		Y / N	Y / N / Some	
Spinal Injections		Y / N	Y / N / Some	

How does your medication affect the following?

Treatment Name	Memory	Mood / Anger	Energy	Ability to Sleep
Neurontin / Gabepentin		Y / N	Y / N / Some	
Cymbalta		Y / N	Y / N / Some	
Lyrica		Y / N	Y / N / Some	
Painkillers		Y / N	Y / N / Some	
Acupuncture		Y / N	Y / N / Some	
Physical Therapy		Y / N	Y / N / Some	
Spinal Injections		Y / N	Y / N / Some	

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Initial Treatment Goals: - *Please list specific goals that you would like to achieve from your treatments.*

Ex: Running, playing with kids, shopping, etc.	*1.*
2.	*3.*
4.	*5.*

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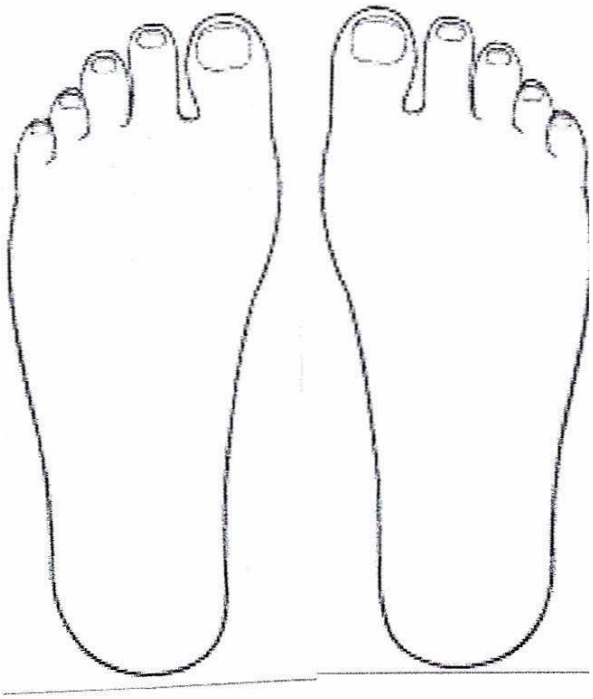
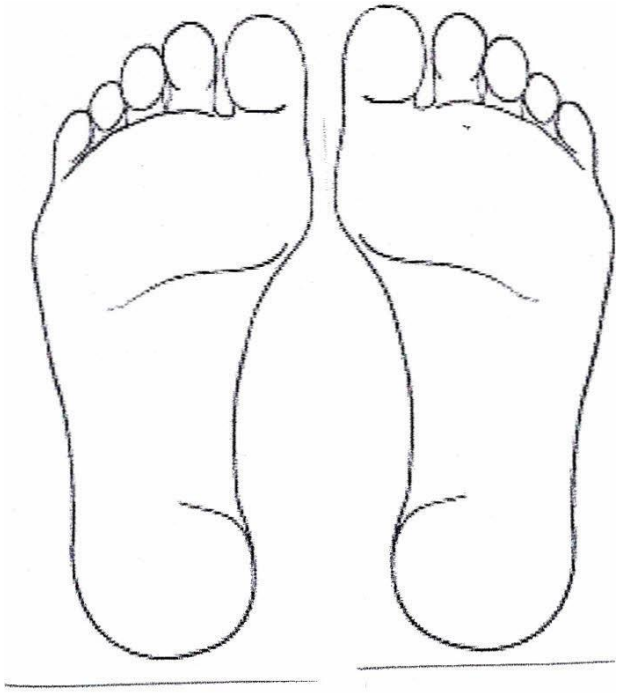
Describe the location of your pain: On the diagrams below, indicate all the areas where you feel pain.If there is more than one location, then please write #1 for the worst, # 2 for the second, etc.



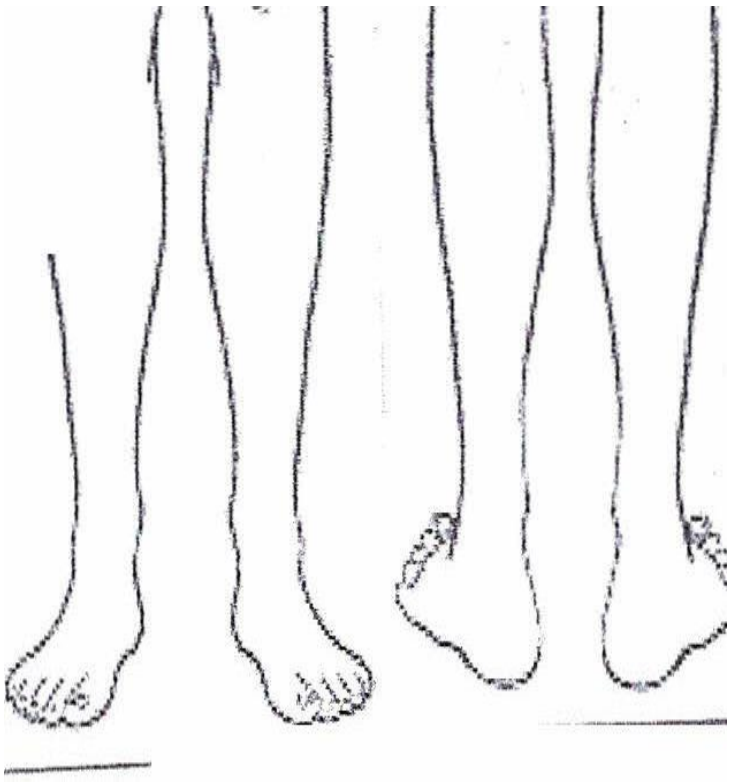
LEFT RIGHT



RIGHT LEFT

Please Use the Following Symbols to Indicate Where Your Symptoms Are

B = Burning **T = Tingling**
N = Numbness **P = Pain**



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Severity of Pain – *Please rate all of these on a scale of 0 -10, with 0 being none and 1- being the worst possible case.*

1. Your PAIN at its WORST this past month was: (no pain) 0 1 2 3 4 5 6 7 8 9 10
2. Your PAIN at its LEAST this past month was: (no pain) 0 1 2 3 4 5 6 7 8 9 10
3. Your PAIN at its AVERAGE this past month was: (no pain) 0 1 2 3 4 5 6 7 8 9 10
4. Your PAIN RIGHT NOW is: (no pain) 0 1 2 3 4 5 6 7 8 9 10

The SYMPTOMS you have is INTERFERING with:

5. Your ability to walk: (no effect) 0 1 2 3 4 5 6 7 8 9 10
6. Ability to stand without use of a cane, walker (no effect) 0 1 2 3 4 5 6 7 8 9 10
7. Ability to sit: (no effect) 0 1 2 3 4 5 6 7 8 9 10
8. Ability to stand: (no effect) 0 1 2 3 4 5 6 7 8 9 10
9. Ability to climb stairs: (no effect) 0 1 2 3 4 5 6 7 8 9 10
10. Ability to perform daily activities such as carrying groceries or holding a book. (no effect) 0 1 2 3 4 5 6 7 8 9 10
11. Ability to bathe self: (no effect) 0 1 2 3 4 5 6 7 8 9 10
12. Strength and endurance: (no effect) 0 1 2 3 4 5 6 7 8 9 10
13. Physical activity (no effect) 0 1 2 3 4 5 6 7 8 9 10
14. Ability to exercise or be active for fear of injury: (no effect) 0 1 2 3 4 5 6 7 8 9 10
15. Overall energy: (no effect) 0 1 2 3 4 5 6 7 8 9 10
16. Self-esteem or self-worth: (no effect) 0 1 2 3 4 5 6 7 8 9 10
17. Overall concentration: (no effect) 0 1 2 3 4 5 6 7 8 9 10
18. Overall mood: (no effect) 0 1 2 3 4 5 6 7 8 9 10
19. Normal work: (no effect) 0 1 2 3 4 5 6 7 8 9 10
20. Sleep: (no effect) 0 1 2 3 4 5 6 7 8 9 10
21. Family relationship: (no effect) 0 1 2 3 4 5 6 7 8 9 10
22. Spousal / Partner relationship: (no effect) 0 1 2 3 4 5 6 7 8 9 10
23. Social activities with others: (no effect) 0 1 2 3 4 5 6 7 8 9 10
24. Enjoyment of life: (no effect) 0 1 2 3 4 5 6 7 8 9 10

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Medications- Please list all your medications below including vitamins and herbal supplements. If you have a list of medications, you may provide us with a copy of that instead of listing them.

☐ Medication list provided for insertion to my medical chart.

Medication:_____ Dosage: _____

Medication:_____ Dosage: _____

Medication:_____ Dosage: _____

Medication:_____ Dosage: _____

Medication:_____ Dosage: _____

Medication:_____ Dosage: _____

Medication:_____ Dosage: _____

Medication:_____ Dosage: _____

Medication:_____ Dosage: _____

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Do I need a Test for PAD?

Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain, and kidneys become narrowed or clogged. It affects over 8 million Americas, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sore/ulcers, difficulty to control blood pressure, or symptoms of stroke. People with PAD are at significantly higher risk of stroke and heart attack. Answers to these questions will help determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Circle the number of each statement that applies to you.

1. Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain)? when you walk which is relieved by rest and is not related to an injury?

2. Do you have a history of cardiovascular (heart) disease or diabetes and experience any pain or swelling? at rest in your lower legs or feet that is not related to an injury?

3. Do you have a history of cardiovascular (heart) disease or diabetes and experience any leg, foot, or toe pain that is not related to an injury an often disturbs your sleep?

4. Do you have an ulcer on your thigh, calf, ankle, foot, or toe that is slow to heal?

5. Do you have diabetes and unusual hair loss or skin discoloration in your legs?

6. Do your fingers or toes feel numb or cold in response to temperature changes or stress?

7. Have you suffered a severe injury to your leg(s) or feet?

8. Do you have an injection of the leg(s) or feet that may be gangrenous (black skin tissue)?

9. None of the above apply to me.

Patient Name: _____

Patient Signature: _____ Date: _____

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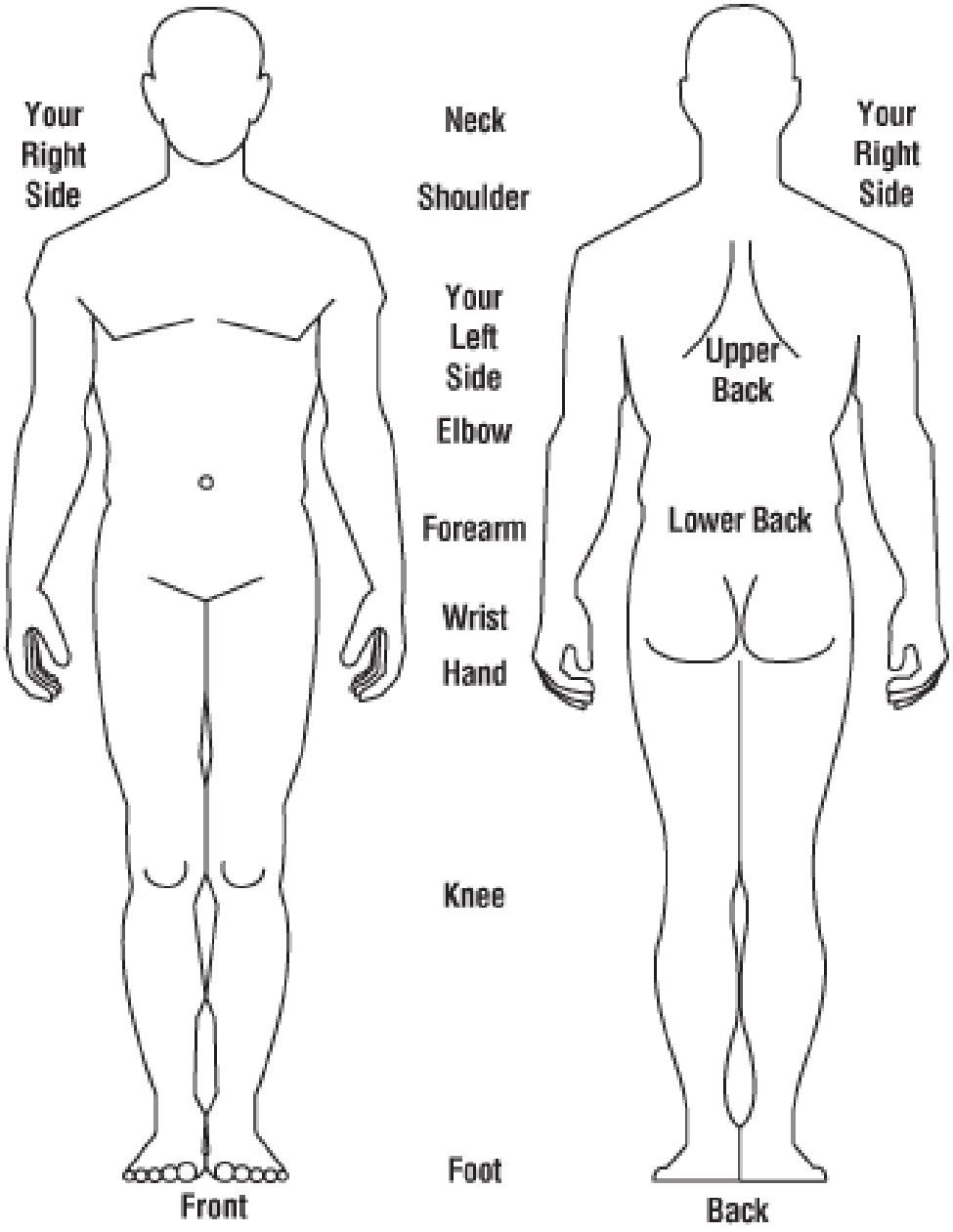
Name: _____ **Date:** _____

We are an integrated practice combining foot & ankle care with orthopedic and vascular medicine. If you are experiencing pain in parts of your body other than your lower legs and feet and would like more information about the services we provide, please use the diagram below to circle all points of pain.



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Office Policy – Welcome to our office! Please read this policy carefully and feel free to ask questions regarding any part of this form. We believe that a clear definition of our office and financial policies will allow us to concentrate on the primary goal of restoring or maintaining the health of your feet. Our practice will strive to provide you with the finest quality podiatric care. If you have any questions regarding your treatment, please do not hesitate to ask. We welcome referrals and look forward to establishing a satisfactory doctor-patient relationship.

Appointments: If you are unable to keep an appointment, please call the office to reschedule at least 24 hours in advance. Patients with three missed appointments may be asked to transfer their records to another doctor.Patients who are more than 15 minutes late may be asked to reschedule.

At times it will be necessary for the office to change your appointment due to emergencies that arise or a change in the physician's schedule. We will make every attempt to limit these changes and will give you as much prior notice as possible. We ask that you understand this and work with us so that we may get you rescheduled quickly.

Transferring Records: Patient requests for copies of records may take 2-4 weeks or longer to receive and requires a current signed patient HIPPA release form on the date of the request. Charges of $25 or more may apply to all record requests. To protect your security, faxed requests for records are not acceptable.

Financial Policy: 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 you to read the policy carefully and sign prior to any treatment.

- We may accept any assignable insurance with applicable coverage.
- We offer financial assistance (discount, waiver or reduction of deductibles, co-pays, and coinsurance)under our indigency policy to all eligible patients on case-to-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 $25.00.

Insurance: We may accept assignment of insurance benefits at our discretion if acceptable insurance identification is provided. Acceptable insurance identification is defined as a valid insurance card, policy/plan with applicable coverage, or telephone verification. As a courtesy to our patients, verifiable and assignable

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insurance will be filed by our office. However, you will be personally responsible for your account balance regardless of whether your insurance will pay for the total balance of your claims, unless you are eligible for discounts under our indecency policy, which should be predetermined 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. In the event we do not accept assignment of benefits, we require that you be preapproved on our extended payment plan by providing a credit card or personal checking account with authorization to charge that amount for the balance due if your insurance company/employee benefits plan has not paid your account in full within 45 days or has determined your claims to be your responsibility for the reasons of annual deductible, co-payment, non-covered servicesand not medically necessary.

We encourage our patients to contact their plans for clarification of benefits prior to services rendered. As our patient, you are responsible for all authorizations/referrals needed to seek treatment. If a patient chooses or is required to bill his/her own insurance, this office will provide an itemized statement and a HCFA-1500 Form to the patient but will treat the account as a self-pay.

Patients must inform the office of all insurance changes and authorization referral requirements. In the event the office is not informed in a timely manner, you will be responsible for any charges denied. Regarding Discount due to the Affordable Healthcare Act, we may offer discounts, reduction or waiver of deductibles, coinsurance, and co-pay to any eligible patient under our Indecency Policy in accordance with applicable federal and state laws. These discounts are based on medical needs and ability to pay on a case-by-case basis and patients may apply for financial indulgency discount assistance by asking our staff to determine if you are eligible.

Referrals: If your insurance company requires a referral and/or preauthorization/pre-certification you are responsible for obtaining it. We will not be able to obtain a referral on the date of service. If you arrive for your appointment without your referral, you have 3 options available to you:

1) You may attempt to contact your PCP and obtain the referral. However, if you do not have the referralby your appointment time, you will need to choose one of the other two options.
2) You may reschedule your appointment without penalty.
3) You may leave us two checks at the end of your appointment. One check will be for your co-pay/co- insurance. The second check will be for the full amount of your visit. If you can obtain a referral within 48 hours of your appointment, we will return the full amount check to you un-cashed. Otherwise, we will return the co-pay check to you.

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Regarding Surgeon and Facility Charges: We will disclose to every patient our surgeon charges as clearly as practically possible before your medical or surgical 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. As you may be aware, your insurance company requires your doctors and surgeons to charge and bill the services separately from surgical facilities or hospitals. You shall not be surprised that you will receive separate surgeon, anesthesiologist, diagnostic labs, radiologists, pathologists, and others in addition to the surgical facility bills for your surgery. If you have any questions about your surgical facility bills, please direct your questions to that surgical center. For most services provided we will bill your health plan. Any balance due is your responsibility.

While we do not anticipate any unforeseeable circumstances, we have no control over any such events that may arise. Should you require additional medical or surgical care due to any post-surgical complications and reactions, you may incur additional expenses at this facility or outside this facility, such as a hospital. The charges only include the stated date of services at this facility and do not include any other date of services from us or other providers and facilities.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We do not accept "Letters of Protection" and subsequently cannot bill your attorney for charges incurred due to a personal injury case.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for the child will be responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. Unless other arrangements have been made, the balance on your statement is due in full when the statement is issued. Accounts not paid in full by the next statement period will incur a late fee.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we must litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment in our office may become a matter of public record.

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FMLA and Disability Forms: We are happy to complete disability paperwork for you as required by your employer. Please submit the forms one week prior to the due date. We will fax the forms to the appropriate department for you, however, if after several attempts they have still not received the forms, it will become your responsibility to send them in. There will be a fee of $25.00 to have the initial disability forms completed, and a $10.00 fee per set after that.

Medical Information: I authorize the release of medical information to my insurance company necessary to process my claim. I also authorize the payment medical benefits directly to my physician. I understand I am financially responsible for charges not covered by my insurance carrier.

Effective Date: Once you have signed this document, you agree to all the terms and conditions contained herein. This agreement will be in full force until terminated in writing.

I have read the above office policy and have had the opportunity to have all my questions answered.

Patient Signature:_____ **Date:** _____

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PHYSICIAN DISCLOSURE

As required by Section 102.006 of the Texas Occupations Code

Texas law requires a physician to disclose to a patient those arrangements permitted under applicable Texas law whereby such physician accepts remuneration to secure or solicit a patient or patronage for a person licensed, certified or registered by a Texas health care regulatory agency. The purpose of this Disclosure is to notify you, the patient, that your attending physician(s) may receive remuneration for referring you to any of the following ancillary healthcare providers for certain healthcare services:

Texas MSS Management Group, LLC

Accordingly, I hereby acknowledge that my attending physician(s) have disclosed to me, at the time of initial contact and at the time of referral (i) his or her affiliation with the foregoing ancillary healthcare provider(s) for whom, I, the patient am being referred, and (ii) that he/she will receive, directly or indirectly, remuneration for the referral to such ancillary healthcare provider. I understand that I, the patient, have the right to choose the providers of my healthcare services and/or products and, as such, I have the option of receiving ancillary healthcare services from any ancillary healthcare provider and/or facility that I choose.

Patient Signature:_____ **Date:** _____

Robert Parker, DPM, FACFAS, FAENS, FASPS has a financial interest(s) and/or serves in capacities for consultation (i.e. medical director/consultant) and may receive renumeration from all of the following entities: *West Houston Surgicare, Northwest Surgery Center, and Victory Medical Center.*

"I have been advised of my physician's affiliation with West Houston Surgicare, Northwest Surgery Center, and Victory Medical Center and that if I choose to have my surgery performed at any of these facilities, my physician may receive a return on his investment. I understand that I have the right to choose an alternative source of service. I will make an informed choice on where to have my surgery performed."

Patient Signature:_____ **Date:** _____

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E-Prescribing Consent Form

ePrescribing is defined by a Physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) 2003 listed standards that must be included in an ePrescribe program.

These include:

Formulary and benefit transactions - gives the prescriber information about which drugs are covered by the drug benefit plan.

Medication history transactions – provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

By signing this consent form, you are agreeing that Parker Foot & Ankle can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes.

Understanding all the above, I hereby provide informed consent to Parker Foot & Ankle to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

This consent will remain enforce until revoked or changed.

Patient Name (Print):_____ **DOB:** _____

Patient Signature:_____ **Date:** _____

Pharmacy (Name & Location) _____

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Patient HIPAA Acknowledgement and Designation Disclosure Form

I. Acknowledgement of Practice's *Notice of Privacy Practices*:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

Patient Name (Print):_____ **DOB:** _____

Patient Signature:_____ **Date:** _____

Designation of Certain Relatives, Close Friends, and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain pieces of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my health care.

Print Name: _____ **Last four digits of SSN or other identifier:** _____

Print Name: _____ **Last four digits of SSN or other identifier:** _____

Print Name: _____ **Last four digits of SSN or other identifier:** _____

II. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home Telephone Number: _____

Written Communication Address: _____

____ OK to leave message with detailed information ____ OK to mail to address listed above.

_____ Leave message with call back numbers only_____E-mail me at:_____