1120 MEDICAL PLAZA DR. STE 180,

THE WOODLANDS TX, 77380

PHONE: (281) -364-9041 | FAX: (281) -364-0755

DR. ROBERT E. NEVILLE & ASSOCIATES, P.A

MEDICAL AND SURGICAL SPECIALIST OF THE FOOT AND ANKLE

2023 PATIENT INFORMATION

Date: _____/_____/_____ Whom may we thank for your referral? _____

Patient's Last Name: _____ Patient's First Name: _____ MI: _____

Age: _____ DOB: _____/_____/_____ Male ☐ Female ☐ Social Security #: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow

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

Home #: _____ Cell #: _____

Email address: _____

Ethnicity and Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Island ☐ White ☐ Other Race ☐ Decline to specify.

Patient's Employer: _____ Occupation _____

Emergency Contact Name: _____ Phone Number _____

RESPONSIBLE PARTY INFORMATION

Last Name: _____ First Name: _____ DOB: ___/____/____ Age: _____

Address: _____ City _____ State _____ Zip _____

Male ☐ Female ☐ Home Phone: _____ Work Phone_____

Social Security #: _____ Employer _____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist along with your driver's license or photo ID)

Primary Insurance Company _____ Insurance Phone # _____

Subscriber / Medicare ID # _____Group # _____ ☐ PPO ☐ POS ☐ EPO ☐ HMO

Subscriber's Last Name: _____ First Name_____ DOB ____/____/____

Employer_____ Phone Number _____

Secondary Insurance Company _____Subscriber ID # _____

ASSIGNMENT AND RELEASE

My signature below authorizes the doctor to release my medical information necessary to process my insurance claims. I authorize that any benefits due me paid directly to my physicians. I understand payment is expected at the time of service. I acknowledge that I was provided / offered a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I choose) and understand the Notice.

Responsible Person's Signature: _____ **Date:** _____/_____/_____

Printed Name: _____

Neville FOOT & ANKLE CENTERS

1120 MEDICAL PLAZA DR. STE 180,

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MEDICAL HISTORY

Patient's Name: _____

It is a pleasure to welcome you to our office! To best serve your podiatric medical / surgical needs, please take a moment to complete this medical history form.

Are you in good health? ☐

Are you now or have you been under a Physician's care during the past year? ☐

If so, for what medical problem? _____

Pharmacy Name and Location _____

Pharmacy Phone Number _____

Do you have a family physician? ☐ Yes ☐ No. If Yes, indicate the Last Seen Date: _____/_____/_____

Primary Care Physician's Name: _____ Phone Number _____

Are you currently taking any medications? ☐ Yes ☐ No. If yes, please list medication dosage below:

Name of Medication	Dosage / Strength	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Daily Vitamins_____ Daily Aspirin _____

Do you have any allergies, or have you ever had a negative reaction to (Penicillin, Sulfa, Codeine, Aspirin, Iodine, Novocain, metals, shellfish, adhesive tape, local anesthetics, pollen, mold, dust, materials, foot, topical contactant, animals, soap, clothing, jewelry, cosmetics, or anything else?_____

_____

_____

Please encircle if you have ever been treated for any of the following conditions: Heart disease, Gout, High Blood Pressure, Diabetes, Blood Clot, Rheumatic Fever, TB, Cancer, Thyroid, Ulcers, Hepatitis, Asthma, Epilepsy, Stroke, Anemia, Phlebitis, Arthritis, AIDS, Depression, Bronchitis, Anxiety, Heart Murmur, Syphilis, Gonorrhea, Sickle Cell, Broken Bones, Prolonged bleeding, Bowel, Bladder, Kidney, Liver or Lung Problems, Or any other medical concern? _____

_____

Have you ever been hospitalized for an illness, injury, or have you ever had any surgery? If yes, please list: _____

_____ .

Do you have a family history of any of the following health disorders? Heart Disease, Diabetes, High Blood Pressure, Cancer, Sickle Cell Anemia, Other: _____ .

Do you smoke? ☐ Never ☐ Current ☐ Former. If yes, how much? _____ How long? _____

Do you drink the following beverages?

Coffee: ☐ Frequently ☐ Occasionally ☐ Never

Soda: ☐ Frequently ☐ Occasionally ☐ Never

Alcohol: ☐ Frequently ☐ Occasionally ☐ Never

Do you take birth control pills? _____

Are you now or is there a possibility that you are pregnant? _____

Are you breastfeeding? _____

Do you take any recreational drugs? _____

Have you even been treated for or diagnosed with AIDS or HIV carrier? _____

Do you heal well? _____

Do you tend to bruise or scar easily? _____

Are you currently involved in a sport or exercise program on a regular basis? _____

What kind of shoes do you wear the most? _____

What is your shoe size? _____ Width? _____

What is your height? _____ Weight? _____

Were you ever treated with foot disorders as a child? _____

Were you ever treated with foot disorders as an adult? _____

Do you wear custom insoles (prescription orthotics)? _____

What is the foot or ankle problem that brought you to our office? Pease be specific. _____

_____

_____

_____

How long have you had this problem? _____

What makes it better? _____

What makes it worse? _____

Thank you for taking the time to answer these questions. Your answers will enable us to give you the kind of care that is best for your foot health needs. If you have any other medical concerns not listed above, please list them below or discuss them with the doctor.

Patient Name:	**Date of birth:**

Review of Systems: Please check all that apply

General
- ☐ General good health
- ☐ Fever Chills
- ☐ Loss of appetite
- ☐ Headache
- ☐ Dizziness

Ears, Eyes, Nose, Throat
- ☐ Vision problems/glasses
- ☐ Hearing problems/hearing aids
- ☐ Nasal Congestion
- ☐ Dental difficulties/dentures
- ☐ Neck stiffness/pain

Hematologic
- ☐ Ease of bleeding
- ☐ Ease of bruising
- ☐ Anemia

Allergic/Immunologic
- ☐ Reactions to drugs or foods
- ☐ Seasonal Allergies

Skin
- ☐ Scaling/dryness
- ☐ itching/rashes
- ☐ Open wounds
- ☐ Nail changes
- ☐ Scar easily
- ☐ Psoriasis
- ☐ Dermatitis

Endocrine
- ☐ Heat or cold intolerance
- ☐ Sweating
- ☐ Thirst
- ☐ Change in appetite
- ☐ Unusual Fatigue
- ☐ Weight Loss
- ☐ Weight gain

Genitourinary
- ☐ Painful Urination
- ☐ Frequent urination/ incontinence
- ☐ Kidney Disease/Hemodialysis
- ☐ Sexually transmitted disease

Cardiovascular
- ☐ Chest pain/Heart attack
- ☐ History of CHF
- ☐ History of heart surgery
- ☐ Palpations/fainting
- ☐ Cold feet
- ☐ Night cramps
- ☐ Intermittent Claudication
- ☐ Peripheral Edema

Respiratory
- ☐ Shortness of breath
- ☐ COPD
- ☐ Painful Breathing
- ☐ Asthma
- ☐ Cough
- ☐ Fever or night sweats
- ☐ Sleep apnea

Gastrointestinal
- ☐ Indigestion
- ☐ Ulcers
- ☐ Diarrhea
- ☐ Constipation
- ☐ GI bleeding
- ☐ Heart Burn
- ☐ Vomiting
- ☐ Liver Disease

Musculoskeletal
- ☐ Joint/muscle stiffness
- ☐ Back pain
- ☐ Redness of joints
- ☐ Swelling of joints
- ☐ Trauma
- ☐ Gout
- ☐ Arthritis
- ☐ Muscle/joint pain
- ☐ Muscle weakness
- ☐ Muscle cramps
- ☐ Limitation in motion

Neurological
- ☐ Shooting or burning pain
- ☐ Seizures
- ☐ Unsteady gait
- ☐ Tremors
- ☐ Dizziness
- ☐ Fainting
- ☐ Tingling in extremities
- ☐ Numbness in extremities
- ☐ Weakness
- ☐ Paralysis

☐ **No changes since last visit**

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Addiction
- ☐ Psychiatric care

PCP Name:	
Last Visit Date:	

IS PATIENT IN HOME HEALTHCARE		**ARE YOU DIABETIC?**	

Cardiologist Name:	
Last Visit Date:	

Last A1c:	

Smoking Status: (encircle one) Non-smoker Current Ex-Smoker

Signature:	**Date:**

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CREDIT CARD POLICY

DR. ROBERT E. NEVILLE & ASSOCIATES, P.A. MEDICAL AND SURGICAL SPECIALIST OF THE FOOT AND ANKLE

***** As of January 1, 2021, we now require a credit card or debit card on file with our office if we will be billing Insurance for you. If you do not have insurance, then payment in full is due at the time of service. *****

PLEASE INPUT YOUR CARD INFORMATION HERE:

CC# _____EXPIRATION DATE: _____

CCV: _____ CARD HOLDER'S FULL NAME ON CARD: _____

As you may have experienced when you check into a hotel or rent a car, the first thing you are asked for is a credit card which is swiped and later used to pay your bill. Due to the changes occurring in healthcare, most medical practices are implementing a similar policy.

Our office requires that a valid credit or debit card is provided at the time of service to be kept on file in a secure, encrypted system. In the even that a balance **remains after you have been notified of the outstanding balance via (2) statements sent to the address provided, payment of this balance in full will be charged to the credit / debit card. If your account should ever be turned over to a collection agency, a $50.00 fee** will be added to your account. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

Frequently Asked Questions:

Why the Change?

Many changes are occurring in healthcare as of January 1st, 2021 **due to the implementation of the Affordable Care Act**. To continue providing care and to keep medical costs as low as possible, we need to ensure that we have a guarantee of payment on file in our office. You will find that over the next year or so, most medical practices will require full payment up front or credit/debit card be on file for payment of patient balances.

But I always pay my bills, why me?

We must be fair and apply the policy to all patients. We have great patients, and we know that most of you pay your balances.

How will I know how much you are going to charge me?

You will receive two invoice before we charge your credit card. We will charge you for the balances on the invoices sent to you. **If payment is not made within 30 days, your account will incur an additional 5% finance charge for each month past 30 days.** We determine this balance by looking at the **Explanation of Benefits (EOB) that your insurance sends us that showing what the patient responsibility is.**

I'm nervous about leaving my credit card.

We store your credit card information on a secure gateway that is completely compliant as required by law – just like a hotel or rental car agency does. **We access your information only on this to process a payment.** If you absolutely do not want your credit card on file, then you can choose to pay the entire billed amount at the time of service. If your insurance then pays, we will send you a refund.

What if I need to dispute my bill?

We will always work with you to understand if there has been a mistake, and **we will refund you if we have made a billing error.**

What if I don't have insurance?

If you do not have insurance, **payment in full is due at the time of service.** In this case we do not need to have a credit card on file.

I have read and understood the above information regarding the credit card on file policy:

Signature: _____ Date: _____/_____/_____

Printed Name: _____

(For Staff Member's Use only) Staff's Name: _____Date: ____/____/____ | Credit / Debit Card Provided: ☐ Yes ☐ No.

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OFFICE AND FINANCIAL POLICIES

DR. ROBERT E. NEVILLE & ASSOCIATES, P.A. MEDICAL AND SURGICAL SPECIALIST OF THE FOOT AND ANKLE

Welcome and thank you for choosing Dr. Robert E. Neville & Associates for your foot health concern. We are committed to providing you with the highest quality medical care in an efficient, timely, and effective manner. We hope that providing you with our policies in advance, we can prevent any misunderstanding or frustration at the time of your visit.

Insurance: It is your responsibility to confirm with your insurance company that the physician is currently under contract with your plan. If your plan requires that you have a referral prior to seeing a specialist, please contact your primary physician so that you have the referral on hand prior to your appointment. We do not accept faxed referral – **if we do not have a referral at your appointment time, we will need to reschedule your visit**, unless you choose to be seen without using your insurance benefits and pay your visit in full. If your insurance should happen to change, we require that you notify our office 24 hours prior to your appointment time.

It is your responsibility to know the benefit coverage for specialist visits: We will gladly file your insurance claim on your behalf. We allow 45 days from the date the claim is filed for the insurance company to pay. **If your carrier does NOT pay within this time, you could be responsible for the entire balance.** We will not become involved in disputes between you and your insurance company regarding coverage and/or policy benefit criteria (i.e., deductibles, non-covered services, co-insurance, coordination of benefits, pre-existing conditions, or reasonable and customary changes, etc.) other than to supply factual information when necessary. **You are responsible for deductibles, co-insurance, non-covered services and any other charges insurance may not cover.** You will be sent statements on a monthly basis regarding any monies owed.

Non-Covered Services: An "**Insurance Waiver**" may be required **to acknowledge understanding of your responsibility for non-covered services.**

Check-In: Please **arrive to your appointment at least 15 minutes prior** to your scheduled time to complete all required paperwork. **Please bring your current insurance card with you to EACH VISIT as well as your valid identification card. On follow-up visits, you will be asked to verify demographic / insurance information as well as complete any necessary paperwork so that our records remain up to date. Any outstanding balances will be due at check-in to see your provider. If payment toward your outstanding balance cannot occur at that time, your appointment will need to be rescheduled and/or scheduled.**

Credit Card Policy: **Please provide a valid credit card upon check-in.** We will input your credit card information into our secure and encrypted credit card service provider. (Open Edge)

Check-Out: Please be prepared to pay for your current visit. **Payment of co-pays, deductibles, supplies or any non-covered services will be required at the time of service. Estimated patient responsibilities for surgical procedures and office care will be determined by insurance benefit coverage verification and collected at the time of service.** Paying at the time of service does not mean you will not get a bill, fees are estimated.

We only accept the following: **Check, Debit Card, MasterCard, Visa, Discover, and American Express.**

Late Arrivals: If you **arrive more than 15 minutes past your scheduled appointment time, you will be rescheduled** so that other patient are not inconvenienced.

No Shows and Late Cancellations: **We require a 24-hour notice if you must cancel your appointment.** If you cancel the same day as your appointment, you will be considered a NO SHOW for that visit. **A $50.00-fee is charged to your account for each NO SHOW.** You will be expected to pay that charge and any others that may occur at the time of your next visit.

Minors: The parent(s) or guardian(s) accompanying a minor are responsible for providing current insurance information for the minor and/or payment in full for service provided. Unaccompanied minors must have a written authorization for medical treatment signed by the parent or guardian before treatment can be released.

Statements: Statements are sent out monthly and payment is due within 30 days of statement date. **Payments not made within 30 days will be subject to a late payment penalty and may incur an additional 5% finance charge.** We offer both electronic and paper statements. **I understand if I do not choose electronic statements that I may be charged a small processing fee up to $3.00.**

I "opt in" for electronic statements. _____ (initial).

I have read, understood, and agreed to the above office and financial policies. I hereby attest that I have given and agreed to provide current demographic and insurance information, and authorize release of information necessary for insurance filing and precertification by signing this statement.

Patient's Name: _____ Date: _____/_____/_____

Responsible Person's Name: _____ Date: _____/_____/_____

Witness: _____ Date: _____/_____/_____

(For Staff Member's Use only) Staff's Name: _____Date: _____/_____/_____

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AUTHORIZATION FOR TREATMENT AND RELEASE OF MEDICAL INFORMATION

DR. ROBERT E. NEVILLE & ASSOCIATES, P.A. MEDICAL AND SURGICAL SPECIALIST OF THE FOOT AND ANKLE

AUTHORIZATION FOR TREATMENT

I, the undersigned, hereby authorize Dr. Robert E. Neville and Associates, P.A. to render treatment and/or therapy to myself that he deems medically necessary to treat the condition and/or conditions I have required from himself or his staff.

Signature of Patient or Guardian: _____ **Date:** _____/_____/_____

Relationship of Guardian to Minor Child: _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Dr. Robert E. Neville & Associates, P.A. all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator of fiduciary, insurer, and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above-named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above-named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understood this agreement.

Signature of Patient/Guardian: _____ **Date:** _____/_____/_____

Relationship of Guardian to Minor Child: _____

(For Staff Member's Use only) Staff's Name: _____Date: _____/_____/_____

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PATIENT CONSENT FORM

DR. ROBERT E. NEVILLE & ASSOCIATES, P.A. MEDICAL AND SURGICAL SPECIALIST OF THE FOOT AND ANKLE

Disclosures of Physician Ownership

Please be informed that Dr. Robert E. Neville and physicians in Neville Foot and Ankle Centers have direct and indirect financial Ownership relations, and may receive remuneration directly or indirectly from the entities of: Neville Foot and Ankle Centers, Dr. Robert E. Neville & Associates, P.A., Pinpoint Laser System, Vasomed Sensilase, Metasurg Medical Devices, Memorial Hermann Surgery Center The Woodlands, Assurance Consolidated Pharmacy, Vision Park Premier Imaging Center, Tronown Thomas Life CheckDrug, Eugene Lansangan PT, Texas Neurodiagnostic Associates Inc., Village RX Group LLC, Next Health-Select Pharma LLC, Hallux Podiatric Pathology Laboratory, Marlinz Pharma, Pharma Select-Select Pharma, PND Neurodiagnostics, and Sleep Tight Diagnostic Laboratory. Decisions regarding the admissions, referrals, or any other form of arrangement for utilization by patients of your physician of specific services or facilities are made with regard to the best interest of each individual patient. You have the right to choose the provider of your health services. **You will not b4e treated differently by your physician if you choose to obtain other health care services.** If you have any questions concerning this notice, please feel free to ask your physician.

By signing below, I certify that I have read and understood this policy.

Signature of Patient/Guardian: _____ **Date:** _____/_____/_____

Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient's Right section describing your rights under the law. You have the right to review our notice before signing the Consent. The terms of our notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice has a Notice of Privacy Practices, and the patient had the opportunity to review the Notice.
- The practice reserves the right to change the Notice of Privacy Policies.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

Occasionally, it is necessary to call our patients to remind them of an appointment, discuss medical test results, or even to return a patient's call. Often, we are greeted y an answering machine – please authorize the type of message you would like us to leave on the phone numbers provided by you on the patient demographic forms or verbally to our staff members (check all that apply):

☐ OK to leave message with call back number only

☐ OK to leave message with family member (Please specify name of individual):_____

HIPAA requires health care providers to protect the privacy of your health information. However, if you would like your provider to be able to share your health information with family member(s) or friend(s), please state his/her/their name(s) below. We will not be able to share any information with any individual not listed below.

I wish to give the following individual(s) permission to obtain information regarding my health (please list names in the box below):

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Patient's Full Name: _____ Date: _____/_____/_____

Responsible Person's Signature: _____ Date: _____/_____/_____

Witness: _____