NORTH TEXAS FOOT CARE ASSOCIATES, P.A.

John S. Sciortino, D.P.M.
NPI# 1093797532

Patient Name		Male	Female	Today's Date
Mailing Address	City		State	Zip
Physical Address				
Home Phone #	Social Security #		Birthdate	Age
Employer	Occupation		Business Phone / Ext.	
Cell Phone #	E-mail Address			
Marital Status	Spouse Name		Spouse Social Security #	
Spouse Employer	Spouse Birthdate		Spouse Business Phone / Ext.	
If a Minor, Parent / Guardian Name	Address, if Different From Above		Phone	
Parent / Guardian Employer	Birthdate		Business Phone / Ext.	

Primary Insurance Carrier / Medicare	Employee (Covered Person)	Group #	Ins. I.D. #
Place of Employment (Covered Person)	Employee Birthdate	Phone #	
Secondary Insurance Carrier	Employee (Cover Person)	Group #	Emp. I.D. #
Mailing Address	Employee Birthdate	Phone #	

Family Physician	**Height:**	**Weight:**
Referred By	**Shoe Size:**	**Blood Pressure:**

NORTH TEXAS FOOT CARE ASSOCIATES, P.A.
John S. Sciortino, D.P.M.
3415 Loy Lake Road
Sherman, Texas 75090
Telephone: (903) 893-9661
Fax: (903) 868-2975

MEDICAL INFORMATION RELEASE

I authorize North Texas Foot Care associates, P.A. and staff to review my medical history, prescriptions, and insurance information for the purpose of providing medical and/or surgical treatment. I authorize the physicians and their staff to release any information needed to determine these benefits payable for related services. I also authorize North Texas Foot Care Associates, P.A. and staff to furnish a copy of my medical records to any entity that provides my written consent.

INSURANCE ASSIGNMENT

I hereby authorize the staff of North Texas Foot Care Associates, P.A. to bill my insurance company(ies) for any services, materials, and supplies which are furnished to me in conjunction with my medical and/or surgical treatment. I authorize payment directly to North Texas Foot Care Associates, P.A. of the surgical and/or medical benefits, if any, otherwise payable to me. I understand I am responsible to the physicians for charges not covered by this agreement.

FOR OUR PATIENTS INFORMATION

Some insurance companies now require a referral number or form to see anyone but your primary care physician (PCP). Please check your policy or call your company prior to your visit with us. If a valid referral is not on file, you will be responsible for the charges at the time of the visit.

PERMISSION TO EXAMINE & TREAT

I hereby give John S. Sciortino, D.P.M. permission to examine and treat my feet.

_____ _____

Signature of Patient **Date**

_____

Signature of Parent or Guardian (if patient is a minor)

_____

Relationship to Minor

NORTH TEXAS FOOT CARE ASSOCIATES, P.A.

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MEDICAL HISTORY

NAME OF PATIENT: **DOB:**

DATE:

What brings you to our office today?

Describe problem:

Duration of problem?

Injury: Yes / No If Yes, Date of Injury: Work Related: Yes / No

List any surgeries you have had:

Alcoholic beverages? (circle one) None Rarely Moderately Daily Quit

Recreational Drugs? (circle one) None Rarely Moderately Daily Quit

Do you smoke now? ❑ No ❑ Yes Packs/day _____ years _____ If you quit, when did you do so? _____

DO YOU HAVE OR HAVE YOU EVERY BEEN TREATED FOR:

- ❑ Diabetes
- ❑ Poor Circulation
- ❑ High Blood Pressure
- ❑ Heart Disease / ❑ Heart Attack
- ❑ Osteoporosis
- ❑ Thyroid Problems
- ❑ Stroke
- ❑ Lung Disease / ❑ Asthma / ❑ COPD
- ❑ Gout
- ❑ Liver Disease / ❑ Hepatitis
- ❑ Stomach Ulcers / ❑ Acid Reflux
- ❑ Kidney Disease
- ❑ Arthritis
- ❑ Nerve Disorders / ❑ Neuropathy
- ❑ Other _____

Medications Allergies:	
Medications:	

OFFICE USE ONLY	
Height:	**Weight:**
Shoe Size:	**Blood Pressure:**

_____ **D.P.M.**

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on 4/14/03 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by calling our office at (903) 893-9661.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

North Texas Foot Care A[redacted]es, P.A. 3415 Loy Lake Rd., Sherma[redacted]5090, (903) 893-9661
John S. Sciortino, DPM UPIN TI5803

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice of Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Please print your name here

Signature

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

☐ The patient refused to sign.
☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
☐ We weren't able to communicate with the patient.
☐ Other *(Please provide specific details)*

Employee Signature *Date*

HIPPA Acknowledgement of Receipt of the Notice of Privacy Practices
This form does not constitute legal advice and covers only federal, not state, law.

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John S. Sciortino, D.P.M.*

*Diplomat of the American Board of Podiatric Surgery

OUR FINANCIAL POLICY

Thank you for choosing North Texas Foot Care Associates for your Podiatric services. We are committed to providing the best treatment possible. Please understand that payment of your bill is considered part of your care. The following is our **Financial Policy,** which we require you to read and sign prior to any treatment.

You must provide an accurate address, home/work phone numbers and insurance coverage information before seeing the doctor. **If this information changes during the course of your care, it is your responsibility to inform us of those changes.** If you do not have the required insurance information at the time of your visit, payment in full will be required at the time of service. Our fees are usual and customary for our area. We accept personal checks, cash, and credit cards for services rendered.

It is your responsibility to know and abide by your insurance plan's policies. Fees for care are always your responsibility, whether or not your insurance company pays for your services. Your insurance policy is a contract between you and the insurance company; we are not a part of that contract. However, we make every effort to work with your insurance carrier. If we are a participating provider in your plan, we require full payment of any remaining balance after your insurance processes the claims, which is due upon receipt of the first statement. It is your responsibility to be aware of any non-covered services/items in your policy.

Co-pays, co-insurance and deductibles are due in full at the time of your visit. We cannot discount nor waive deductible, co-pay or co-insurance amounts. We will inform you of your financial obligation for any scheduled surgical procedures outside of our office prior to treatment. Payment will be due at the pre-operative visit. Durable medical items, including orthotics, must be paid in full prior to dispensing. If your insurance company subsequently pays for these items we will mail a refund directly to you.

A $25 service fee will be assessed to account balances over 60 days old. We reserve the right to prohibit further appointments until overdue balances are paid in full.

A parent or guardian who accompanies a minor will carry full financial responsibility for the minor's account regardless of any court ordered divorce decree and/or verbal consent unless prior financial arrangements have been made with this office.

I AGREE TO THE NORTH TEXAS FOOT CARE FINANCIAL POLICY:

_____ _____

PRINTED NAME **SIGNATURE**

DATE:_____

Patient Cancellation & No Show Policy

"No-shows" or last minute cancellations/reschedules leave empty appointment times that would otherwise have been used to help others waiting to receive medical care. It is a disservice to patients and physicians.

Patients who do not keep their appointments or provide 24 hour notice of cancellation or the need to reschedule will be subject to a charge of $25.00 for first cancellation/reschedule or no-show without proper notice. The rate will increase to $75.00 for subsequent occurrences.

This fee will be applied after the second missed appointment or second failure to provide 24 hour notice of cancellation. Payment of cancellation/no show fees are the patient's responsibility and will not be billed to your insurance company.

We realize that on a rare occasion, emergencies may arise and we will address these situations with you at that time.

We reserve the right to terminate our relationship with you after five (5) or more occurrences. Good medical care and a positive doctor-patient relationship are dependent upon consistent consultation and treatment. This cannot be accomplished with frequent missed appointments.

Your signature on this document indicates your understanding and acceptance of our policy regarding cancellation and/or missed appointments. If you should have any questions regarding this policy, we will be happy to discuss them with you.

Acknowledgement of Cancellation & No Show Policy

I understand that I am personally financially responsible for charges incurred due to appointment cancellation or no show.

Name: _____ **Date:** _____

Signature: _____

Witness: _____