Welcome to
High Desert Foot & Ankle Specialists
Tommy G. Roe, DPM, FACFAS

Patient Intake Form - Please fill out this form carefully and completely.

Today's Date _____

Patient Information

Last Name_____First_____Middle Initial_____
Other Names Used _____ SSN_____ Date of Birth_____
Spouse's Name_____ If patient is minor child, parent(s) name_____

Gender: ☐Male ☐Female ☐Transgender
Language: ☐English ☐Spanish ☐Indian ☐Other _____ ☐Refused to Report
Ethnicity: ☐Asian ☐Black/African American ☐Hispanic ☐Pacific Islander
☐White ☐Other Race _____ ☐Refused to Report
Marital Status: ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced ☐Partnered ☐Minor Child

I wish to be contacted in the following manner:

Current Mailing Address _____City_____State_____Zip_____
Street Address (if different from mailing) _____
Home Phone (_____) _____ Cell (_____) _____ Work (_____) _____ ext._____

Would you like to be web enabled? ☐Yes ☐No If yes, please provide your Email Address_____

I hereby authorize Dr. Tommy Roe, and any staff member in the office of High Desert Foot & Ankle Specialists to discuss my personal health information and services with the individuals I have listed below:

1. _____, _____ (_____) - _____ - _____
Emergency Contact Name | Relationship to Patient | Contact Number

2. _____, _____ (_____) - _____ - _____
Contact Name | Relationship to Patient | Contact Number

Whom may we thank for your referral?_____

Who is your Primary Care Physician?_____Date of last visit?_____

Insurance & Responsible Party Information

Primary Insurance Company Name _____
Identification Number _____ Group Number_____
Subscriber's Last Name_____First_____Middle Initial_____
Subscriber's Date of Birth_____ Relationship to Patient_____
Home Phone (_____)_____ Cell (_____)_____ Work (_____)_____ ext._____
Secondary Insurance Company Name _____
Identification Number _____ Group Number_____
Tertiary Insurance Company Name _____
Identification Number _____ Group Number_____

Insurance Assignment and Release

I certify that I have insurance coverage with _____ and assign directly to High Desert Foot & Ankle Specialists and Tommy G. Roe, DPM all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all assigned charges not paid by my insurance. I authorize the use of my signature on all insurance submissions. High Desert Foot & Ankle Specialists and Tommy G. Roe, DPM may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Medicare Authorization

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made on my behalf to High Desert Foot & Ankle Specialists and Tommy G. Roe, DPM for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits related services. I authorize the use of my signature on all insurance submissions. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Signature of Patient (Beneficiary), Guardian, or Responsible Party | Date

_____ _____
Print Name of Above Signature | Relationship to Patient (Beneficiary)

Financial Policy

1. We will gladly file your insurance claim if our office participates with your individual insurance plan. At the time of service, you will be responsible for any co-pays, deductibles, and any co-insurance amounts unapplied. You may verify our participation with your plan by calling the insurance number on the back of your insurance identification card.
2. We *must* have a copy of your insurance card to file any insurance claims for you or your family member(s). We will ask for a photo ID to verify the name of the insured individual.
3. Due to time restrictions for claim filing, we must be notified of all insurance changes at the time of service. If your insurance coverage changes and we are not notified at the time of your visit you may be responsible for all charges incurred. Once the time limit has expired, we will not be able to bill your insurance company and you will be financially responsible for all charges.
4. For those patients who are members of an HMO or managed care plan (e.g. Centennial Plans, Indian Health Services), please verify with the receptionist before your visit to ensure that you do have a current referral/authorization to be seen. If you do not have a referral/authorization you will be responsible for all charges incurred during your visit.
5. The responsibility for payment of services rendered to any dependent children whose parents are divorced rests with the parent who seeks treatment. Any court-ordered responsibility judgment must be worked out between the individuals involved without the inclusion of our office.
6. If your insurance plan denies payment for non-covered services or supplies (boots, cast and post-op shoes, orthotics, crutches, etc.) received from our office, the patient or guardian will be financially responsible for the charges incurred.
7. If you have any questions regarding your podiatry coverage, please call the number on the back of your insurance card *prior* to receiving services or supplies. Once supply items have left the building they *cannot* be returned or resold, even if they show no wear or made no improvement to your condition.
8. All charges incurred during your visit(s) are subject to correction and verification from our billing department for both insurance and self-pay claims.
9. Our office will make our very best effort to help guide you through the billing process. However, we are *not* responsible for misquotes by your insurance company. Information obtained from your insurance company by our office is done as a courtesy and *cannot* be guaranteed. We encourage you or a knowledgeable family member to contact your insurance company directly for price quotes or amounts applied to patient responsibility.
10. A $35.00 service charge will be applied to your account for all returned checks. Your account will be handled on a cash only basis for future visits.
11. Any patient balances will be billed to you after claim finalization from your insurance company. Three statements will be mailed to the address you report; please make sure we are aware of any address changes. After three statements, your account will be turned over to collections. You will then be responsible for your debt and any collection fees added to your account by our collection agency, including all Attorney fees encountered in the collection of this debt. No further appointments will be scheduled until your account is paid in full.
12. Once a surgical procedure has been scheduled with a surgical facility, a $75.00 service charge will be applied to your account for surgery cancellations that are unrelated to a medical condition.
13. A 24-hour cancellation notice is required for scheduled appointments. A $50.00 service charge will be applied to your account for chronic No-Show appointments; Medicaid patients will be terminated from the practice.
14. Refunds will be issued to the patient or guardian listed on the account.
15. All patient complaints will be handled in the same manner that has been established for Medicare beneficiaries.
    PROTOCOL FOR RESOLVING COMPLAINTS FROM MEDICARE BENEFICIARIES - The patient has the right to freely voice grievances and recommend changes in care or services without fear of reprisal or unreasonable interruption of services. Service, equipment, and billing complaints will be communicated to management and upper management. These complaints will be documented in the *Medicare Beneficiaries Complaint Log*, and completed forms will include the patient's name, address, telephone number, and health insurance claim number, a summary of the complaint, the date it was received, the name of the person receiving the complaint, and a summary of actions taken to resolve the complaint. All complaints will be handled in a professional manner. All logged complaints will be investigated, acted upon, and responded to in writing or by telephone by a manager within a reasonable amount of time after the receipt of the complaint. If there is no satisfactory resolution of the complaint, the next level of management will be notified progressively and up to the owner of the practice, Dr. Tommy Roe. The patient will be informed of this complaint resolution protocol at the time of set-up of service.

I have read, understand, and agree to High Desert Foot & Ankle Specialists and Tommy G. Roe, DPM financial policy which is stated above and I agree to be responsible for any insurance assigned medical expenses and/or those that are not covered by my insurance company.

_____ _____

Signature of Patient (Beneficiary), Guardian, or Responsible Party | Date

_____ _____

Please Print Name of Above Signature | Relationship to Patient (Beneficiary)

Heath Questionnaire

The following information will help your physician in reviewing your personal health, family history, and your current health habits. This will be kept in strict confidence and made part of your medical record.

Podiatric History

Chief Complaint

Briefly List Current Symptoms/Complaints_____

_____

How long has your problem been bothering you? _____Days _____Weeks _____Years

Have you ever seen a Podiatrist before? □ Yes □ No If yes, Condition you were treated for_____

Any past problems with your feet and/or ankles?_____

_____

Any past surgical procedures on your feet and/or ankles?_____

_____

What is your shoe size?_____Current Weight? _____Current Height? _____

Accident/Injury Information

Was your condition due to an auto accident? □ Yes □ No

Will this claim be covered by Workman's Compensation? □ Yes □ No

Date of Injury _____

Place of Injury _____

Insurance Company Name _____

Adjustors Name_____

Case Number _____

Contact Number _____

Hospice Election

Is the patient enrolled in Hospice Care? □ Yes □ No If yes, Date of Enrollment _____

Current or Past Foot Problems

Please check (√) all that apply

□ Ankle Sprain
□ Athlete's Foot
□ Bunions
□ Change in Nail Color or Thickness
□ Corns and Calluses
□ Cramps in Feet or Legs
□ Eczema-Foot
□ Flat Feet
□ Foot Sprain
□ Foot Ulcers
□ Fracture/Broken-Foot or Ankle
□ Gout
□ Hammertoes
□ Ingrown Toenails
□ Joint Pain or Swelling
□ Numbness in Feet or Legs
□ Pain-Ankle, Heel, Foot, or Toe (Circle)
□ Pain-Burning or Tingling
□ Plantar Warts
□ Plantar Fasciitis
□ Skin Rashes
□ Skin Fissures
□ Sprained Ankles or Feet
□ Swelling in Ankles or Feet
□ Tendonitis

Personal Medical History

Please check (√) all that apply

□ Anemia
□ Arthritis
□ Asthma
□ Bleeding Disorders
□ Blood Disease
□ Broken Bones
□ Cancer
□ Chemical Dependency
□ Chills
□ Changes in Moles
□ Depression
□ Emphysema
□ Epilepsy
□ Fever
□ Gout
□ Hardening of Arteries
□ Heart Disease
□ Hepatitis
□ High Blood Pressure
□ HIV Positive
□ Kidney Trouble
□ Liver Trouble
□ Loss of Sleep
□ Loss of weight
□ Polio
□ Poor Circulation
□ Raynaud's Disease
□ Recurrent Infections
□ Sore that won't heal
□ Stomach Ulcers
□ Stroke
□ Thyroid Disease
□ Varicose Veins

□ Diabetes Date of Last Blood Sugar_____ Date of Last A1C_____ Date Last Seen by PCP for Diabetes_____

List All Surgeries & Hospitalizations

_____

_____

_____

_____

Social History & Health Habits

Place of Birth_____Education (Highest Level)_____
Occupation_____ How Long?_____
If student, school attending _____
Employed by_____
Job Involve Heavy Lifting? □ Yes □ No How much?_____ How often?_____
Spouse Employed by_____ Occupation?_____

Cigarette Smoking? □ Yes □ No Number of packs per day? _____ Number of Years?_____
Electronic Cigarette? □ Yes □ No How much/often?_____ Number of Years?_____
Smokeless Tobacco? □ Yes □ No How much/often?_____ Number of Years?_____
Quit Nicotine Use? □ Yes □ No When?_____
Alcohol Use? □ Yes □ No How much/often?_____ Number of Years?_____
Quit Alcohol Use? □ Yes □ No When?_____
Street Drug Use? □ Yes □ No Type?_____ How much/often?_____

Do you live alone? □ Yes □ No
Exercise? □ Yes □ No Type?_____ How often?_____

Medication & Pharmacy Information

Pharmacy Name _____ Pharmacy Address/Phone_____

Medication Name	Dose & How Often	Reason for Taking	Prescribing Physician

Allergies & Sensitivities

□ Betadine? □ Antibiotics (Penicillin, Sulfa Drugs)? _____ _____
□ Latex? □ Anesthetics (Lidocaine, Marcaine)? _____ _____
□ Tape? □ Other? _____ _____

Family History

Does anyone in your family have a history of any of the following conditions, list family member(s)

High Blood Pressure □ Yes □ No _____
Diabetes □ Yes □ No _____
Heart Disease □ Yes □ No _____
Stroke □ Yes □ No _____
Cancer □ Yes □ No _____
Thyroid Disease □ Yes □ No _____
Overweight □ Yes □ No _____
Similar Foot Problems □ Yes □ No _____

Is your father □ Living □ Deceased Cause of Death_____
Is your mother □ Living □ Deceased Cause of Death_____

Patient/Guardian Signature and Consents

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, the beneficiary, or my minor child, have a change in health. I hereby give my permission to administer treatment, and to perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my, the beneficiary, or my minor child's podiatric condition.

I agree that High Desert Foot & Ankle Specialists and Dr. Tommy Roe may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payers for treatment purposes.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read and understand the Notice and agree to its terms.

_____ _____
Signature of Patient (Beneficiary), Guardian, or Responsible Party Date

_____ _____
Please Print Name of Signature Above Relationship to Patient (Beneficiary)