Dr. Douglas E. Webb Jr. D.P.M.

Thank you for choosing our office! Please take a few minutes to fill out this form as completely as you can. Please print clearly. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your health.

Last name: _____ First name: _____ MI: _____

Birthdate: _____ Sex: (M or F): _____ Age: _____ Marital Status: S M W D

Race:
- ☐ Black/African American
- ☐ White
- ☐ Asian
- ☐ American Indian/Alaska Native
- ☐ Native Hawaiian/Pacific Islander
- ☐ Other
- ☐ Declined

Ethnicity:
- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Other
- ☐ Declined

Social Security #: _____-_____-_____ Home Phone: _____

Mobile/Cell Phone: _____ Work Phone: _____

E-Mail Address _____ Street Address: _____

Apt. # _____ City/State: _____ Zip: _____

Patient's Family Doctor: _____

Date Last Seen: _____ Phone #: _____

Preferred Pharmacy: _____ Location: _____

Phone #: _____

Whom may we thank for referring you? _____

Employer/School (if student): _____ Occupation: _____

Spouse/Parent's Name: _____Phone #: _____

In Case of Emergency Contact (not living in same household):

Name: _____ Relationship: _____

Phone #: _____

**********Responsible Party**********

Name of person responsible for this account: _____

Relationship to patient: _____ Phone #: _____

Address: _____ City/State: _____ Zip: _____

Employer of Responsible Party: _____

Employer's Phone: _____ Social Security Number: _____-____-_____

**********AUTHORIZTION AND CONSENT FOR HEALTH CARE**********

I HEREBY AUTHORIZE Douglas E. Webb, DPM & Associates, P.A. or other providers to release any information acquired in the course of my treatment to my insurance company, employer, or third party payer as required for claims filed, quality assurance, health plan administration, or complaints/grievances. I understand that the specific information to be released may include, but is limited to history, diagnosis and/or treatment of all related illnesses including HIV virus and Acquired Immune Deficiency Syndrome (AIDS). I authorize direct payment to be made to Douglas E. Webb, DPM & Associates, P.A. or other providers for any and all medical or surgical services/supplies rendered. I understand that if any services or charges are not covered, or if Douglas E. Webb, DPM & Associates, P.A. is unable to verify eligibility; I am responsible for all charges incurred for services rendered.

Signature of Responsible Party: _____

Relationship to patient: _____ Date: _____

PATIENT NAME _____ DATE_____

MEDICAL HISTORY

PLEASE CIRCLE ANY CONDTION THAT YOU HAVE OR HAVE HAD IN THE PAST

Alcoholism	Diabetes Type I or II	Hormone Problems	Prone to infection
Allergies	Insulin Yes No	Kidney Problems	Rheumatic Fever
Anemia	Dizziness	Leg Cramps	Shortness of Breath
Anxiety/Depression	Epilepsy	Migraines/Headaches	SkinProblems/Ulcers
Asthma	Fainting Spells	Multiple Sclerosis	Stomach Ulcer
Arthritis	Gout	Nerve Disorder/Pain	Stroke
Bleeder	Hearing Difficulty	Neurological Problems	Thyroid Problems
Blood Disorder	Heart Disease	Pacemaker	Tuberculosis
Breast Lumps	Hepatitis	Phlebitis	Weight Gain/Loss
Cancer	High Blood Pressure	Pneumonia	
Chest Pain	HIV (AIDS)	Poor Circulation	

SURGICAL HISTORY

PLEASE LIST PAST SURGICAL PROCEDURES OR HOSPITALIZATIONS WITH DATES

_____ Date _____

_____ _____

_____ _____

Any Complications with Surgery? ☐ Yes ☐ No

MEDICATION

CURRENT MEDICATIONS: PLEASE LIST ALL INCLUDING VITATMINS & SUPPLEMENTS

_____

_____

_____

FAMILY HISTORY

CIRCLE TO REPORT YOUR FAMILY HISTORY (BLOOD RELATIVES)

	RELATIVE		RELATIVE
DIABETES	_____	TUBERCULOSIS	_____
CANCER	_____	HIGH BLOOD PRESSURE	_____
HEPATITIS	_____	HIV (AIDS)	_____
BUNIONS	_____	HEART PROBLEMS/STROKE	_____
HAMMERTOES	_____	CIRCULATION PROBLEM LEG/FOOT	_____

SOCIAL HISTORY

SOCIAL HISTORY (CIRCLE & COMPLETE)

ALCOHOL	YES	NO	AMOUNT_____
SMOKE	YES	NO	AMOUNT_____
ILLEGAL DRUGS	YES	NO	AMOUNT_____

ALLERGIES

PLEASE CIRCLE OR LIST ANY ALLERGIC REACTIONS FROM THE FOLLOWING:

PENICILLIN	DEMORAL	ADHESIVE TAPE	ANTIBIOTICS	LIDOCAINE
CODEINE	MORPHINE	LATEX	CORTISONE	OTHER LOCAL ANESTHETICS
ASPIRIN	SEAFOOD	VICODIN	SULFA	OTHER _____

**DO YOU HAVE ANY PROBLEMS TAKING ASPIRIN OR IBUPROFEN (ADVIL/MOTRIN) YES NO

Patient Name: _____ Age:_____

Height: _____ Weight:_____ Shoe Size:_____

*If female- could you be pregnant YES NO

	CHIEF COMPLAINT			
	RIGHT	LEFT	DURATION	PREVIOUS TREATMENT
ANKLE PAIN				
ARCH PAIN				
BALL OF FOOT				
BUNION				
CONTRACTED TOE				
FOOT PAIN				
FOREIGN BODY				
FRACTURE				
FRACTURE FOLLOW UP				
HEEL PAIN				
INFECTION				
INGROWN TOENAIL				
INJURY				
JOINT PAIN				
LESIONS/CALLUS				
GROWTH				
OPEN WOUND				
PAIN				
RASH				
SPURS				
TAILORS BUNION				
THICK PAINFUL TOENAILS				
ULCER				
WARTS				
WOUND CARE				
DIABETIC FOOT CARE				
ROUTINE FOOT CARE				
OTHER				

ADDITIONAL MEDICAL HISTORY

	NONE
HEAD AND EYES	☐
EAR/NOSE/THROAT	☐
RESPIRATORY	☐
CARDIOVASCULAR	☐
GASTROINTESTINAL	☐
URINARY PROBLEMS	☐
MUSCULOSKELETAL	☐
DERMATOLOGIC	☐
NEUROLOGIC	☐

PLEASE LIST ANY ISSUES WITH THE FOLLOWING

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Financial Policy

Thank you for choosing us as your Health Care Provider. Our goal is to provide you with highest quality medical and surgical care at affordable cost. 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 CO-INSURANCE) 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, AND AMERICAN EXPRESS**
- **PATIENT REQUESTS FOR COPIES OF RECORDS MAY TAKE 2-4 WEEKS OR LONGER TO RECEIVE AND REQUIRES A CURRENT SIGNED PATIENT HIPAA RELEASE FORM ON THE DATE OF THE REQUEST. CHARGES OF $25 OR MORE MAY APPLY TO ALL RECORD REQUESTS. IN ORDER TO PROTECT YOUR SECURITY, FAXED REQUESTS FOR RECORDS ARE NOT ACCEPTABLE.**
- **X-RAYS ARE NOT ALLOWED TO BE RELEASED FROM THE OFFICE PER OUR MEDICAL LIABILITY INSURANCE CARRIER.**
- **PLEASE ALLOW A MINUMUM OF 48 HOURS FOR COMPLETION OF ANY FMLA/DISABILITY FORMS AND THERE IS A $25.00 CHARGE DUE AT THE TIME WE RECEIVE THE FORMS.**
  Dishonored checks will be charged back to the patient's account with a service fee of $25.00.

Regarding 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 insurance will be filed by our office. However, you will be personally responsible for your account balance regardless of whether or not your insurance will pay for the total balance of your claims, unless you're eligible for discounts under our indigency 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 pre-approved 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 services and 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 Corporate Indigency 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 indigency discount assistance by asking our staff to determine if you're eligible.

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 in the hospital we will bill your health plan. Any balance due is your responsibility.

While we don't 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.

Surgical procedures will require pre-payment. You will be informed in advance if your procedure is one of those and payment will be due one week prior to the surgery.

Regarding PPO and HMO Network Participation

As you may know, you may have the choice to choose a surgeon or surgical facility with or without PPO or HMO participation under different insurance coverage and benefits levels. We are dedicated to providing highest quality care to every patient, however we have no power to change your insurance coverage or network limitations. Most health care plan or insurance policies may provide surgical coverage to non-PPO providers and facilities, but at lower percentage of insurance reimbursement. Although it is your responsibility to verify your insurance coverage for non-PPO/HMO providers, we will always disclose to you as to our participation status to your insurance plan. We also provide every patient with financial assistance or discount with high deductibles and coinsurance for our Corporate Indigency Policy in accordance with federal and state laws.

We will verify your insurance coverage and obtain pre-certification if applicable for all services as a courtesy to you before your surgery. Please understand that all insurance verification is not a guarantee of insurance payment.

Compliance & Disclosure under Texas Occupations Code – Section 102.006

In compliance with Section 102.006 of Texas Occupations Code in connection with my informed consent and personal choice of doctors and facility solely based on the quality and safety of care, reputation of patient satisfaction, and my knowledge in my decision-making in exercising my rights with respect to the in-network or out-of-network coverage and cost sharing, my attending doctor(s) and/or clinic (facility) have disclosed to me at the time of initial contact and at the time of referral with respect to the choice of a doctor or facility solely in the interest of my healthcare quality and safety, as a result of my informed consent and personal choice of doctor(s) and /or facility: (A) his/her affiliation, if any, with the doctor or facility for whom the patient is referred and (B) that he/she will receive, directly or indirectly, remuneration for referring upon my such request and excising my rights of freedom of choice for the provider(s) and facility under the in-network or out-of-network coverage as provided by my health plan, in compliance with all applicable federal and state laws, Medicare, ERISA, PPACA and the Section 102.006 of Texas Occupations Code.
Specifically, Dr. Douglas E. Webb/Douglas E. Webb, DPM and Associates, P.A. has a financial interest(s) and/or serves in capacities for consultation (i.e. medical director/consultant) and may receive renumeration from any and all of the following entities: Abbvie Incorporated (pharmaceutical company), Abbott laboratories, Aetna US Healthcare, Houston Physicians Hospital and Outpatient Surgery Center, Becton Dickinson and Company, HCA Holdings-Clear Lake Regional Hospital, Bay Area Surgicenter, Mainland Hospital, Kimberly-Clark corporation, One Step Diagnostics (Medical Director/Consultant), Stryker Corporation, also various Mutual Fund investments that may or may not include various Health Care related entities/interests.

Your Responsibility for Cooperation

If we accept your insurance assignment as a payment from your insurance reimbursement, you agree to timely cooperation with your insurance company or health plan in the course of insurance claim processing, such as insurance inquiries, requests for additional information, claims status verification or any inquiries for the purpose of your claim processing. If you fail to provide the information to your insurance company and in turn your insurance company denies or fails to pay our claim(s), you will be responsible for the bill in its entirety without any discounts, as well as, any fees required to collect money due this office, which may include attorney fees, court fees or any other fees required to collect for our services. You also agree to notify us immediately of any insurance inquiry or request for additional information and provide us with a copy of any documentation received from the insurance company or submitted to insurance company from you.

In an event that you do receive insurance payment checks for your surgeries rendered by this doctor, you agree to submit such insurance reimburse check to our office within five (5) business days after your receipt of insurance checks. In a failure or refusal to forward or send us the insurance reimbursement checks for the medical services from this provider, all of your discount arrangements will be voided, and the total balance is due immediately, as there is no justification for you to keep the insurance payment for our services as you promised to pay for our services. You further agree to compensate us for any legal fees if we have to retain any legal services to collect past dues.

We are committed to serving you with highest quality care at an affordable cost. Every staff member at our office is ready to help you, answer questions and offer any assistance concerning your insurance needs. If you have any questions regarding our financial policies, please do not hesitate to ask us at any time. We thank you for your co-operation.

I have read the Financial Policy. I understand and agree to this Financial Policy.

X _____ _____ _____

Signature of Patient or Responsible Party | Patient Name (print) | Date

X _____ _____ _____

Signature of Co-Responsible Party | Your Name (print) | Date

Dr. Douglas E. Webb Jr. D.P.M.

Receipt of Notice of Privacy Practices Written and Acknowledgement Form

**A full copy of our Written Privacy Practices is located in our waiting area. If you would like to take a copy to take with you to review please speak with the front desk and we would be happy to assist you.

I, _____, have read a copy of DOUGLAS E. WEBB JR. D.P.M. & ASSOCIATES, P.A'S Notice of Privacy Practices and I have been offered an opportunity to review it.

Signature of patient: _____ Date: _____