Pete O'Donald, DPM PLLC
2234 Nederland Ave.
Port Neches, TX 77651

Name _____ _____/_____/_____ _____
First Middle Last Date of Birth Age

SSN: _____--_____--_____ Marital Status: S M W D Gender: M F

Address: _____
Street City State Zip

Hm Phone (____) _____-_____ WK (____) _____-_____ Cell (____) _____-_____

I consent to be contacted by: (circle all that apply) Phone Text Email: _____

Employer: _____ Occupation: _____

SPOUSE / Parent Name _____ Birth Date _____/_____/_____

Address (if different from above) _____
Street City State Zip

Hm Phone (____) _____-_____ Cell (____) _____-_____ WK (____) _____-_____

Primary Physician's Name _____ Phone # (____) _____-_____

Date Last Seen by Primary Physician _____

*EMERGENCY CONTACT _____/_____ Phone # (____) _____-_____
(Relationship)

How did you hear about the practice? (circle one)

Internet/Google_____ Friend/Family_____ Doctor Referral (who?)_____

Insurance Company_____ Facebook_____ Other_____

Insurance Information:

1. _____
Primary Insurance Company Policyholder Policy holder DOB Relation to Patient

_____
Member ID # Group #

2. _____
Secondary Insurance Company Policyholder Policy holder DOB Relation to Patient

_____
Member ID # Group #

Medicare Number _____ Are you working? Yes No

I hereby authorize payment directly to Dr. Pete O' Donald for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

SIGNATURE of Responsible Party X _____ Date: _____

Patient Name: **DOB:** / /

COMPREHENSIVE PATIENT MEDICAL HISTORY

Do you have or ever been treated for:

___ AIDS / HIV
___ Alzheimer's
___ Anemia
___ Ankle Sprain
___ Anxiety
___ Arch Pain
___ Arthritis
___ Artificial Heart Valve
___ Artificial Joint
___ Asthma
___ Back Problems
___ Bleeding Disorder
___ Bipolar Disorder
___ Blood Clot/DVT
___ Broken Ankle / Foot
___ Bunions
___ Cancer
___ Chemical Dependency
___ Chest Pain
___ Childhood Foot Problems
___ Corns / Calluses
___ Cramps in Feet / Legs
___ Depression
___ Diabetes – How long _____
___ Emphysema
___ Eye Problems
___ Fibromyalgia
___ Flat Feet
___ Fungal Nails
___ Gastric Reflux
___ Gout
___ Hearing / Ear Disorder
___ Heart Attack
___ Heart Failure
___ Heart Murmur
___ Heel Pain
___ Hemophilia
___ Hepatitis
___ High Arch Feet
___ High Blood Pressure
___ High Cholesterol
___ Intestinal Disorder
___ Ingrown Nails
___ Keloid / Thick Scar
___ Kidney Disorder
___ Knee Pain
___ Liver Disease
___ Low Blood Pressure
___ Neuroma
___ Neuropathy
___ Pain Management
___ Pacemaker
___ Paralysis
___ Psoriasis
___ Raynaud's
___ Rheumatic Fever
___ Schizophrenia
___ Seizures / Epilepsy
___ Swelling of Feet / Legs
___ Stroke
___ Thyroid Problems
___ Toe Walking
___ Tuberculosis
___ Ulcers of Foot / Leg
___ Ulcers (Stomach)
___ Varicose Veins
___ Warts
___ Other(s)_____

Height:_____

Are you pregnant? Yes No

Are you slow to heal? Yes No

Any abnormal bruising, bleeding,or Scarring? Yes No

Does foot pain limit Daily activity? Yes No

Do you have difficulty Walking? Yes No

Weight:_____ **Shoe Size:**_____

Any pain in calves/buttocks When walking? Yes No

Is the pain relieved by Standing still? Yes No

Do you get leg cramps? When _____ Yes No

Do you have any vascular Grafts? Yes No

Do you have joint implants? Yes No

Do you have a replacement Heart valve? Yes No

Currently under Chemotherapy? Yes No

Do you smoke? Yes No
Pack(s) per day? _____

Do you drink alcohol? Yes No
Rarely Occasionally Frequently

Any illicit drug use? Yes No

___Appendectomy ___Hysterectomy ___Gall Bladder ___Foot Surgery **R** **L**

___Bypass Surgery ___Tonsillectomy ___Hernia Surgery ___Other

Previous Surgeries/Hospitalization: _____

_____

Family History:

___ Alzheimer's
___ Anemia
___ Arthritis
___ Asthma
___ Bunions
___ Cancer
___ Diabetes
___ Epilepsy
___ Flat Feet
___ Gait (walking problems)
___ Glaucoma
___ Gout
___ Hardening of the Arteries
___ Heart Condition
___ High Arches
___ High Blood Pressure
___ Low Back Pain
___ Neuroma
___ Other

Current Medications:

_____ _____
_____ _____
_____ _____
_____ _____

Drug Allergies:_____

Pharmacy: _____ **Phone:** _____

Reason for Office Visit: _____

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

SIGNATURE of Responsible Party: X _____ Date: _____

Cancellation / No Show Policy

Cancellation / No Show Policy for Doctor Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit.

If an appointment is not cancelled by 2:00 pm the day before your appointment, you will be charged a thirty dollar ($30) fee; this will not be covered by your insurance company.

Late for Scheduled Appointments

We understand that delays can happen, however we must try to keep the other patients and doctor on time. If you know you will be late for your appointment, please contact the office as soon as possible to inform us that you will be late. Our office will work diligently with you to get you seen the same day.

Account Balances

We will require that patients with self-pay balances pay their account balances to zero ($0) prior to receiving further services by our office. Patients who have questions about their bills or who would like to discuss a payment plan option may speak to the Office Manager to make arrangements.

Thank you so much for your consideration of Dr. O'Donald's office policies.

_____ _____

Patient Print Name **Patient/Guardian Signature**

_____

Date

Consent for Disclosure of Protected Health Information

With this consent, representatives of Pete O'Donald, D.P.M. may call or mail my home or other alternative location, or leave a message on voicemail in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointments, discussion of lab, radiology, or procedure results, or to ask to call regarding an issue or concern.

I authorize Pete O'Donald, D.P.M., and his staff to release laboratory/radiology results and reports to the following individuals listed below. At no time will a representative of Pete O'Donald, D.P.M., discuss your medical circumstances or condition without your consent

1. _____ Relation to Patient: _____

2. _____ Relation to Patient: _____

This authorization shall be in force and effect for one year from the date of signature.
I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to 2234 Nederland Ave., Port Neches, TX 77651.

____ **NO, I do not wish my information to be released to anyone but myself.**

By signing this form I acknowledge that the Notice of Privacy Practices was available and that I have read (or had the opportunity to read if I choose) and understand the notice.

By signing this form, I am consenting to allow Pete O'Donald, D.P.M., and his office staff to use and disclose my personal health information to carry out treatment, payment, and health care operations. I also accept full financial responsibilities for any services not covered by my insurance policy/policies.

_____
Patient Name

_____ _____
Signature of Responsible party Date

OFFICE AND FINANCIAL POLICIES

We are dedicated to providing the best possible care and service to you. An essential element of your care and treatment is understanding your financial responsibilities. If you have any questions about the policies, please discuss them with our office staff.

Health Insurance

We are contracted with most insurance plans to accept assignment of benefits. Our office will file your visit with the insurance company and will only collect your copay, deductible, and/or coinsurance when it applies. **Please note: Our contract with your insurance carrier requires us to collect your co-pay at each visit.**
If you have insurance coverage with a plan that we do not have a prior agreement with, the charge for your care and treatment are due at the time of service.

Patient Payments

In the event your health plan determines a service to be "non-covered", you will be responsible for the complete charge. Payment is due upon receipt of statement from this office unless prior arrangements have been made. I understand that there will be a **$35.00 NSF fee** for any returned checks.

Referrals

It is your responsibility to obtain a valid referral from your primary care physician when required by your insurance company.

Disability and Insurance Forms

There is a $25.00 fee to fill out disability and insurance forms. Please mail or leave them at the front desk along with your payment. Forms will not be completed until payment is received. Please allow at least 5-7 working days for processing. We will call you once we have completed your request.

Medication History Authority

I grant Dr. O'Donald and his staff the authority to download my medication history automatically from benefit managers (PBMs). This medication history may include prescriptions from all of my treating physicians within the last 12 month period.

I have read and understand the office policies, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice. I hereby assign my insurance benefits to be paid directly to the healthcare provider, Dr. Pete O'Donald.

_____ _____

Signature of Responsible party Date

MEDICAL RECORDS RELEASE

I, _____, hereby authorize

_____ to release copies of my medical

records to the office of Pete O'Donald, DPM PLLC.

Signed:_____

Witness:_____

Date:_____

Please send copies of the above mentioned patient's medical records to the following address:

Pete O'Donald, DPM

2234 Nederland Ave.

Port Neches, TX 77651

Ph: 409-727-1122

Fax: 409-727-1114

Thank you for your assistance.