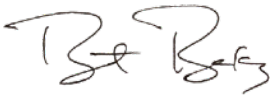
Fort Worth
FOOT & ANKLE

Thank you for taking the time to visit us at Fort Worth Foot & Ankle. Please fill out the attached pages. I know that this process can be burdensome, but any information that we get regarding your health can greatly assist us in giving you the best possible care. Please don't hesitate to reach out if you have any additional questions or concerns!



Brent Banks, DPM

800 8th Ave, Suite 440 Fort Worth, Tx 76104 p: 817.776.5533 f: 817.380.2428 fwfoot.com

Fort Worth
FOOT & ANKLE

Last Name **First Name** **Middle Initial**

Date of Birth **Social Security Number** **Gender:**

Race (Optional) ☐ Black-Non Hispanic ☐ American Indian/Alaskan Native ☐ Hispanic ☐ Asian/Pacific Islander ☐ White-Non Hispanic

Home Address **Apt #** **City** **State** **Zip Code**

Home Phone **Cell Phone** **Email Address**

Employer **Work Phone**

Emergency Contact Name **Emergency Contact Phone**

Primary Care Physician **Referring Physician**

How did you hear about us? ☐ Physician ☐ Insurance ☐ Google ☐ Yelp ☐ Internet ☐ Website ☐ Insurance ☐ Other:_____

Primary Insurance **Policy Number** **Group Number**

Secondary Insurance (If Any) **Policy Number** **Group Number**

Guarantor (Policy Holder) ☐ Self (If self, skip to the next page) ☐ Spouse ☐Parent ☐ Other

Guarantor Last Name **Guarantor First Name** **Middle Initial**

Guarantor Date of Birth **Guarantor Social Security Number**

Guarantor Telephone **Guarantor Employer**

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Medical History

Patient Name:_____ **Date of Birth**:_____

Thank you for choosing our clinic for your healthcare needs! We appreciate your assistance with completing this form as it will help us better care for you. This is confidential information, and will be kept in your electronic medical record.

Please describe the reason for today's visit:

Left Right

_____

_____

Allergies: (Food or Drug)
Please indicate type of reaction to next to each.

_____

Medications:

Medication	Medication

Surgical History:

Type	Year

Vitals: Height:_____ Weight:_____

Social History:

Marital Status: **Single** **Married** **Divorced** **Widowed**

Occupation:_____

Tobacco: **Yes** **No** Type/Frequency:_____

Alcohol Use: **Yes** **No** Type/Frequency:_____

Drug Use: **Yes** **No** Type/Frequency:_____

Females Only:

Are you or could you be pregnant? **Yes** **No**

Review Of Systems: Have you recently experienced any of the following?

Constitutional: Fever, Weight Gain/Loss, Weakness, Fatigue, Anemia
Eyes: Double Vision, Blurring, Difficulty Seeing
ENT: Ringing Ears, Hearing Loss, Vertigo, Sinus Infection, Sore Throat, Problems Swallowing
Respiratory: Shortness of Breath, Wheezing, Coughing
Digestive: Abdominal Pain, Constipation, Diarrhea, Loss of Appetite, Nausea, Vomiting, Black Stool
Cardiovascular: Chest Pains, Palpitations, Irregular/Rapid Heartbeat, Murmur, Shortness of Breath, Leg Swelling, Pain in Legs When Walking
Neurologic: Seizures, Loss of Balance, Paralysis, Loss of Memory, Headaches, Fainting, Tremors, Numbness
Musculoskeletal: Stiffness, Joint Swelling, Joint Pain,
Psychiatric: Depression, Anxiety, Hallucinations, Sleep Disturbances
Urologic: Pain When Urinating, Increased Frequency/Urgency of Urination, Loss of Bladder Control, Bleeding
Skin: Itching, Rashes, Eczema, Hives, Redness
Endocrine: Excessive Thirst, Heat/Cold Intolerance, Increased Appetite
Gynecologic: Breast Masses, Pain, Discharge

Past Medical History / Family History:

Please **check** any medical conditions **you** have had or currently have.
Additionally, please **check** any medical conditions a **family member** has had or currently has.

	Patient	Family			Patient	Family
Anemia	____	____		High Blood Pressure	____	____
Anxiety	____	____		High Cholesterol	____	____
Asthma	____	____		HIV/ AIDS	____	____
Atrial Fibrillation	____	____		Kidney Failure	____	____
Autoimmune	____	____		Liver Disease	____	____
Blood Clots	____	____		Lung Disease	____	____
Cancer:_____ _	____	____		Migraine	____	____
COPD/ Emphysemia	____	____		Osteoporosis	____	____
Degenerative Arthritis	____	____		Pacemaker	____	____
Depression	____	____		Panic Attacks	____	____
Diabetes	____	____		Pulmonary Embolism	____	____
Fibromyalgia	____	____		Psoriasis	____	____
Gout	____	____		Rheumatoid Arthrits	____	____
Heart Attack	____	____		Seizures	____	____
Heart Burn/ Reflux	____	____		Stroke	____	____
Heart Disease	____	____		Thyroid Disorder	____	____
Hepatitis A B C	____	____		Other		

Pharmacy:_____ **Phone**:_____

Street:_____ **City**:_____

Patient Signature: _____ **Date:** _____

Consent to Treat Form

1. I _____ (patient name) give permission for **Fort Worth Foot and Ankle** to give me medical treatment.

2. I allow **Fort Worth Foot and Ankle** to file for insurance benefits to pay for the care I receive.

   I understand that:
   - **Fort Worth Foot and Ankle** will have to send my medical record information to my insurance company.
   - I must pay my share of the costs.
   - I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

3. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my clinician.

_____ _____

Patient's Signature Date

_____ _____

Parent or Guardian Signature Date
(for children under 18)

_____

Print name

Fort Worth
FOOT & ANKLE

PATIENT CONSENT FORM

I understand that as part of my healthcare, Dr. Brent Banks ("PHYSICIAN") originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

The PHYSICIAN's *Notice of Privacy Practices* provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the *Notice of Privacy Practices* and understand that I have the right to review the notice prior to signing this consent. I understand that the PHYSICIAN reserves the right to change the *Notice of Privacy Practices*. Prior to implementation of the revised *Notice of Privacy Practices*, the revised *Notice* will be mailed to me if I provide my address below. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment or healthcare operations and that the PHYSICIAN is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that the PHYSICIAN has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

I request the following restrictions on the use and/or disclosure of my personal health information.

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I have been provided and have reviewed the PHYSICIAN'S *Notice of Privacy Practices* dated 08/01/2018.

Signature of Patient or Legal Representative _____

Date _____

Print Name of Patient or Legal Representative _____

*I request that changes to the *Notice of Privacy Practices* be sent to me at this address:

Name:
Address:
City:
State:
Zip Code:

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FOOT & ANKLE

NOTICE OF PRIVACY PRACTICES

Effective Date: 08/01/2018

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

YOUR PRIVATE HEALTH INFORMATION (PHI)

Each time you have contact with a healthcare provider for delivery of healthcare, a record of your contact/visit is prepared. This record, maintained in written, oral or electronic format, contains presenting signs/symptoms, results of examination and tests, diagnoses, treatment and future care. Your medical record is the physical property of the PRACTICE, but you have certain rights to restrict some of the uses or disclosures of the information in your medical record. The PRACTICE, however, has the right to use and disclose the information contained in your medical record in the process of providing treatment, receiving payment and performing other regular healthcare operations such as:

Documenting and describing the care you received for legal purposes

Communicating with other healthcare providers who may be involved in your care

Educating health care professionals

Medical research

Providing information for government and public health entities responsible for improving public health and welfare

Evaluating and improving the care you receive and the outcomes achieved Billing and verification of services provided to you

Conducting other routine healthcare operations such as quality improvement studies and assessing healthcare provider competence

Protecting your privacy and maintaining the security of your health information is one of the most important responsibilities of the PRACTICE. The PRACTICE is required by law to maintain privacy and confidentiality of your health information, provide you with this Notice of Privacy Practices, notify you of your rights to restrict use of this information, notify you if the PRACTICE is unable to agree to a requested restriction, and allow you to review the Notice of Privacy Practices prior to granting consent and notifying you of changes/revisions to this Notice.

EXAMPLES OF DISCLOSURE OF YOUR PHI

Healthcare delivery and treatment:
Information obtained from you by a physician, nurse or other healthcare professional is documented in

your record and used for the assessment, evaluation, diagnosis and treatment of your medical condition(s). This information is provided to other healthcare professionals, such as other physicians, specialists, physical therapists, hospital based providers and/or other healthcare providers following your treatment by PRACTICE.

Billing and payment:
Your PHI is utilized to justify the level of care delivered to you and the charges incurred for the services. This information generally accompanies the bill and is sent to our payers and other third party administrators.

Other healthcare operations:
The PRACTICE may disclose your PHI to other individuals and businesses in order for the PRACTICE to perform its day-to-day operations. These other individuals and businesses include business associates such as vendors and/or contractors used for credentialing and peer review, patient satisfaction surveys, utilization review/utilization management, billing and claims management, medical research, disease management, and quality improvement initiatives, as well as management services organizations, laboratories, free standing diagnostic facilities and legal counsel. The PRACTICE requires all its business associates to agree to appropriately protect the confidentiality of your PHI.

Reminders and Treatment:
The PRACTICE may contact you to provide you with information that we feel is useful or helpful to you, based on your PHI. For example, the PRACTICE may contact you (or instruct a specialist physician to whom you have been referred to contact you) to schedule an appointment or as an appointment reminder, to suggest alternative treatments, or to provide you with information on treatments you are already receiving.

Other Uses and Disclosures:
The PRACTICE may also utilize or disclose your PHI in order to communicate with or notify family members, relatives and others responsible for your health, and funeral directors. In addition, the PRACTICE may disclose your PHI through other communications and reports required to be made by healthcare professionals such as the public health department, law enforcement, the Food and Drug Administration, organ procurement organizations, correctional institutions, and workers compensation, where applicable.

Other uses and disclosures of PHI not permitted or required by law will be made only with your written authorization. You may revoke your authorization at any time provided that the revocation is in writing, except to the extent that the PRACTICE has already taken action in reliance on your prior authorization.

YOUR RIGHTS CONCERNING PHI

Except as otherwise provided by law, you have the right to: receive a paper copy of this Notice of Privacy Practices if you have agreed to receive it electronically, receive confidential communications of PHI if a request is submitted to the PRACTICE in writing; inspect and copy PHI or records about you in a designated record set as long as the PHI is maintained in the record set;

ask the PRACTICE to amend PHI or records about you in a designated record set as long as the PHI or record is maintained in the record set (the PRACTICE is not required to change the information if it deems it to be accurate);

receive an accounting of disclosures of PHI (a list of the disclosures made by the PRACTICE about you for reasons other than for treatment, payment or health care operations); and

request that the PRACTICE restrict uses or disclosures of your PHI. Though the PRACTICE is not required to agree to a restriction, to the extent that it does agree with your request, the PRACTICE may not use or disclose the protected PHI in violation of the restriction unless the information is needed to provide emergency treatment, or is otherwise permitted or required by law.

The PRACTICE is required by law to abide by the terms of this Notice of Privacy Practices, allow you to review this Notice prior to granting consent, and notify you of changes/revisions to this Notice. If you believe your privacy rights have been violated, you may submit a written complaint to the PRACTICE or the Secretary of Health and Human Services describing in detail the manner in which you feel your privacy rights have been violated. The PRACTICE will not retaliate against you in any way for filing a complaint with the PRACTICE, or with the Secretary.

For further information regarding PHI, please contact Brent Banks, Privacy Officer of PRACTICE, at 817-776-5533.