Casteel
FOOT & ANKLE CENTER.

Catherine A. Casteel, DPM
7501 Lakeview Parkway, Ste. 135 Rowlett, TX 75088
Phone 972-412-4449
Fax 972-412-6460

Welcome to Casteel Foot & Ankle Center!

Attached is our Patient Registration Package. Please complete these forms to help us maintain accurate contact and medical records. If you printed these forms from our website (coming soon), you may fax them to us at (972) 412-6460 prior to your appointment, or bring the completed original forms with you to your appointment along with the other items requested below.

We realize that you have a choice of where to be treated. We also understand and respect the great deal of trust in your physician. We want to provide you with the most up to date information and treatment options regarding your skin care health. We do appreciate and value the trust you have placed in us.

Casteel Foot & Ankle Center specializes in treatment of all foot and ankle disorders. Our doctor and trained office staff work together to meet your podiatric needs five days a week. We desire to assist you in receiving the best of what today's medicine has to offer. We are highly committed to quality patient care with an emphasis on individual attention for each patient. Providing the best services, in a comfortable, private atmosphere is extremely important to us. We assure you we will do our best to give you total satisfaction.

We value highly the relationship with our patients. We especially value patient feedback. Therefore, we will ask you to communicate to us your experiences at our practice. Your feedback matters because it helps us continue to serve you and our other patients with the highest level of care possible. If you have any questions or concerns, please do not hesitate to ask any member of our team.

Warmest Regards,

Dr. Casteel and Staff!!!

REMINDERS OF REQUIRED ITEMS FOR YOUR VISIT

- **Insurance Cards** if you have health insurance, we cannot see you without making a copy of your insurance card.
- **Written Referral** from your primary Care Physician if required by your insurance plan.
- **Co-Pay** or **Deductible** is collected at the time of service.
- **Cosmetic Procedure fees** are due at time of visit.
- **Completed Patient Registration Package**
- **Driver's license or State Issued Photo ID**

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Financial Policy

Payment is required for all services at the time they are rendered unless the patient is in an insurance plan with which we participate. For those patients, applicable co-payments and deductibles will be collected for services rendered. Once our office has received payment from your insurance, if for some reason insurance decides to pay your charges at a higher benefit level they what was quoted to our office at the time of service; we will then issue the patient a refund for the over payment amount or apply a credit on the account. In an effort to endure the most accurate refund amount please be advised that our office cannot issue any refunds until all line items have been finalized by your insurance.

We accept payment in the form of cash, check, and all major credit cards.

Missed Appointments

For appointments which are missed or cancelled with less than 24 hours notification, there may be a $25.00 missed appointment fee added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Returned Checks

All NSF checks will be charged a $35.00 processing fee. We will only accept cash or money orders to replace and NSF check. Your signature below signifies your understanding and willingness to comply with this policy.

Privacy Practices (HIPPA)

Acknowledgement of Practice's *Notice of Privacy Practices*: By signing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

_____ _____

Signature Date

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Additional Fees:

- X-rays are property of Casteel Foot & Ankle Center, If you wish to receive copies of digital X-rays there will be a fee assessed of $15.00.
- Disability forms that need to be completed by our staff will incur a $35.00 fee.
- Any self-pay items returned are subject to a $5.00 restocking fee.
- For copies if medical records, our office requires a 10 day notice. There is a fee of $20.00 for up to 25 pages and $35.00 any pages after that.
- If your account is sent to collections you will be charged 33% of balance due to Casteel foot & Ankle Center. This will be added to your bill.
- Statements are sent each month. There will be a $12.00 charge for each additional statement sent after the first, if there is no payment made.

❖ I have read and understand the financial policy statement. I agree to make in-full prompt payment to Casteel Foot & Ankle Center when billed for any and all charges not covered or paid by valid insurance benefits for and in consideration of services rendered. Further, I authorize payment directly to Castell Foot & Ankle Center or medical insurance benefits payable to me under the terms of my policy but not to exceed the balance due for services performed for my treatments.

❖ In addition to the above, if I am a Medicare patient, I authorize the holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical benefits either to myself or to the party who accepts assignment. Regulation pertaining to Medicare assignment of benefits apply.

_____ _____

Signature Date

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First Name: _____ MI: _____ Last Name: _____

Previous Name: _____ Generation: _____ Gender: Female ☐ Male ☐

Social Security Number: _____ DOB: _____ Email: _____

Home Address: _____ City: _____ State: TX

Home #: _____ Cell #: _____ Work#: _____

Preferred language: English ☐ Spanish ☐ French ☐ Italian ☐

Race: Native American ☐ African American ☐ Asian ☐ White ☐ Hispanic ☐ Pacific Islander ☐

Other: _____ Unreported/Refused ☐

Referral Source: Family/Friend ☐ Insurance Provider ☐ Internet Search ☐ Newspaper Ad ☐

Physician ☐ Top Doc ☐ Zoc Doc ☐ Yellow Pages ☐ Other: _____

Primary Physician: _____ Date Last Seen: _____ Referring Provider: _____

Emergency Contact: _____ Phone Number: _____ Relation: _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner ☐

Insurance Information (It is the patient's responsibility to get any referrals. Failure to do so may result in denied and the patient will be responsible for all services rendered).

Primary Insurance: _____ Policy #: _____ Group#: _____

Primary Insurance Policy Holder: _____ Referral Required: Yes ☐ No ☐
(PT responsible to obtain referrals)

Secondary Insurance: _____ Policy #: _____ Group #: _____

Responsible Party, if different from patient information: Name: _____

Social Security No: _____ DOB: _____

Address: _____ City: _____ State: TX Zip code: _____

Phone #: _____ Email: _____ Relationship to Patient: _____

Pharmacy Information: Name: _____ Location: _____ Phone: _____

Fax: _____

Patient or Responsible Party Signature of Agreement _____ Date _____

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Patient History Form

(Please fill out the confidential information)

Patient Name: _____ Age: _____ Height: _____ Weight: _____ Shoe Size _____
Current Foot or Ankle problem: _____

_____

When did the problem start? _____
What has been done to treat the problem? _____
Are you now or have you ever been under a physician's care in the past two years? _____
If yes, please explain: _____

_____

_____

Name of Family Physician: _____ Date last seen: _____
Name of Former Podiatrist: _____ Date last seen: _____
What conditions were you treated for: _____

_____

_____

MEDICAL HISTORY

- ☐ Diabetes
- ☐ Gout
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Stroke or Heart Attack
- ☐ Stomach Ulcer / Reflux
- ☐ Thyroid Disease
- ☐ Liver Disease
- ☐ Kidney or Bladder
- ☐ Bleeding Disorders (sickle cell)
- ☐ Anemia / Blood
- ☐ Asthma / Bronchitis
- ☐ Rheumatic Fever
- ☐ Accident / Injuries
- ☐ Immune Disease (HIV, AIDS)
- ☐ Cancer
- ☐ Epilepsy / Seizures
- ☐ Depression or Anxiety
- ☐ Vascular / Circulatory Disease
- ☐ Arthritis
- ☐ Foot Problems
- ☐ Other

Please explain any positive responses above: (ie. hepatitis for liver disease.)

_____

_____

_____

_____

MEDICATIONS. (please include dosage of each)

1) _____ 5) _____
2) _____ 6) _____
3) _____ 7) _____
4) _____ 8) _____

ALLERGIES. (penicillin, novocaine, tape, foods, etc.)

1) _____ 3) _____
2) _____ 4) _____

SURGERIES and HOSPITALIZATIONS (describe procedure, year and any complications)

1) _____
2) _____
3) _____
4) _____

SOCIAL HISTORY

Occupation: _____ Tobacco: If yes, how much? No
Alcohol: If yes, how much? No Illicit drugs: If yes, how much? No

FAMILY HISTORY (diabetes, heart disease, gout, cancer, foot problems or other):

_____

_____

_____

_____

Whom may we thank for referring you to our office? _____

I hereby give Casteel Foot & Ankle Center, permission to diagnose and administer treatment for my foot condition and authorize any release of information obtained in the course of my treatment.

Signed: _____ Date: _____

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Authorization to Leave a Voicemail

Please provide number(s) **ONLY IF** you approve us to leave **DETAILED** information related to appointments, billing, test results, diagnosis, and procedures on your voicemail.
Primary Phone _____ Secondary Phone _____

Authorization to Send an Email Message

Please provide an email address below **ONLY IF** you approve us to send **DETAILED** information regarding your appointments and billing in an email.
Email address: _____

Personal Representative Authorization for Medical Release Form

Under HIPPA requirements, we are not allowed to discuss any of your health information with anyone else without consent.
I authorize this facility to speak to the following family members or my personal representative regarding

☐ All medical information, including but not limited to: appointments, billing, test results, diagnosis, and procedures.
☐ Only the following types of information: _____

The above medical information shall only be released to the following person(s):

1. _____ Relationship: _____ Phone number: _____
2. _____ Relationship: _____ Phone number: _____
3. _____ Relationship: _____ Phone number: _____

Authorization to Send a Text Message

Please provide a number **ONLY IF** you approve us to leave **DETAILED** information related to appointments. _____

By signing below I understand and agree to all starred and filled in above; I also understand my rights are protected by the Privacy Act (HIPPA) and that I may request a copy of this Act at any time.

Name (**PRINTED**) _____

Signature _____

Date _____

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Authorization to Treat

By signing below, I authorize Casteel Foot & Ankle Center, and whoever may be employed or assistant in administration to administer care as is deemed necessary.

_____
Patient Name

_____ _____
Signature (Patient or Guardian) Date

Parents, or legal guardians of patients under the age of eighteen (18), MUST sign and date before medical care can be rendered.

Release of Medical Information

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications, and prescriptions electronically to you pharmacy.

_____ _____
Signature **Date**

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Surgery Cancellation Policy Effective 09/16/13

Patients, or legal guardians of patients under the age of eighteen (18), MUST sign and date below before medical care can be rendered.

At the Casteel Foot & Ankle Center we strive to provide the best and most complete patient care. In an attempt to preserve patient care, we have a Surgery Cancellation Policy that allows us to schedule appointments for all patients. When a surgery is scheduled, that extended period of time has been set aside for you. When it is missed, that time cannot be used for surgery for another patient, or filled with appointments for patients that urgently need the care.

We request that you please give our office 24 hours' notice in the event that you need to reschedule or cancel your surgery with the physician assistant. This allows other patients in need of care to be schedules in that appointment time. It also makes it possible to reschedule your appointment more efficiently. Patients failing to provide 24 hours' notice that they cannot make their surgery as scheduled will have a charge of 100.00 added to their account. Please note that this charge is the financial responsibility of you, the patient, and will not be paid by your insurance company. We thank you for cooperation in this manner so that each patient can receive the treatment and medical attention that they need and deserve.

I have read and understand the Medical Appointment Cancellation Policy of the practice 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, ____ (print name), have read, understand, and will comply with the Casteel Foot & Ankle Surgery Cancellation Policy.

____________________________________ ____________________________________

Signature Date

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DISCLAIMER

We have verified your insurance coverage. At this time it is a quote of medical benefit coverage and not a guarantee of payment until the claim submitted has been reviewed. In the event your insurance denies payment you are responsible for the balance in full. At the time of your visit you are responsible for the co-payment where applicable and/or percentage and/or the deductible (if not satisfied this year), according to information obtained from your insurance company.

_____ _____

Signature Date