Casteel
FOOT & ANKLE CENTER

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Phone 972-412-4449
Fax 972-412-6460

Welcome to Casteel Foot & Ankle Center, Part of Stride Healthcare

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, 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 you want to be treated. We want to provide you with the most up to date information and treatment options regarding your foot care. 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(s) 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 in a comfortable, private atmosphere. We assure you that we will do our best to give you total satisfaction.

We value highly the relationship with our patients, as well as value patient feedback. Therefore, we will ask you to communicate to us your experiences at our practice. Your feedback 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.
- **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 that 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.

Disclaimer

We have verified your insurance coverage and at this time this is a quote of medical benefit coverage and not a guarantee of payment until the claim submitted has been reviewed. In the event that your insurance company denies payment, you are responsible for the balance in full. You are also responsible for the deductible, co-payment, and or percentages where applicable.

_____ _____

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.

1. 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.

2. 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. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____

Signature Date

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First Name: _____ MI: _____ Last Name: _____

Gender: Female_____ Male_____ DOB: _____ Email: _____

Home Address: _____ City:_____ State: _____

Home PH: _____ Mobile PH: _____ Work PH:_____

Social Security Number: _____ Preferred Language: _____

Race: Native Amer. _____ African Amer. _____ Pacific Island _____ Asian _____ White
_____ Other

Primary Care Doctor: _____ Referring Doctor: _____Date Last Seen: _____

Emergency Contact:_____ PH. Number: _____ Relationship: _____

Marital Status: _____ Single _____ Married _____Divorced _____ Widowed _____ Separated

Insurance Policy Information

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

Policy Holder Name: _____ DOB: _____

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

Policy Holder Name: _____ DOB: _____

Pharmacy Information: Name _____ Location: _____

Pharmacy PH. Number: _____ Pharmacy Fax: _____

_____ _____
Signature Date

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Patient History Form

Patient Name: _____ DOB:_____ HT: _____ WT: _____ Shoe Size: _____
Current foot or ankle problem:_____

_____

When did the problem start and what has been done to treat it:_____

_____

Have you been under a physicians care in the past two years for this problem? If so, explain:_____

_____

Name of former Podiatrist:_____ Last seen:_____
What condition(s) did they treat you for:_____

Medical History

____ Diabetes	____ Kidney or Bladder	____ Cancer
____ Gout	____ Bleeding Disorders(sickle cell)	____ Epilepsy/Seizures
____ Heart Disease	____ Anemia/Blood	____ Depression or Anxiety
____ High Blood Pressure	____ Asthma/Bronchitis	____ PTSD
____ Stroke or Heart Attack	____ Rheumatic Fever	____ Vascular/Circulatory Disease
____ Stomach Ulcer/Reflex	____ Accident/Injuries	
____ Thyriod Disease	____ Immune Disease (AIDS or HIV)	____ Arthritis
		____ Hepatitis A,B,C
____ Liver Disease	____ Tuberculosis	____ Other (explain below)

**Please briefly explain "Positive" responses to the above condition(s): _____

_____

Medications: (Please include dosage and frequency taken)

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

Allergies: (Penicillin, Novocaine, tape, food, seasonal, etc)

1. _____ 3. _____
2. _____ 4. _____

Surgeries and Hospitalization: (Describe procedure/complications and year conducted)

1. _____ 3. _____
2. _____ 4. _____

Social History:

Occupation:_____ Tobacco: How much/how long?_____
Alcohol use:_____ Illicit Narcotics: What kind/how long?_____

Family History: (Diabetes, Heart disease, Cancer, Gout, Foot disorders)

_____

_____ _____

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

_____ _____
Patient Name Date

_____
Signature

Release of Medical Information

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

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

_____ _____
Signature Date

Disclaimer

We have verified your insurance coverage and at this time this is a quote of medical benefit coverage and not a guarantee of payment until the claim submitted has been reviewed. In the event that your insurance company denies payment, you are responsible for the balance in full. You are also responsible for the deductible, co-payment, and or percentages where applicable.

_____ _____
Signature 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/Text Message

Please provide an email address and or mobile number below **ONLY IF** you approve of us to send **DETAILED** information regarding your appointment and or billing information .
Email address/Mobile number: _____

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 with the following family members or the individual(s) listed below about:

_____ All medical information, to include 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: _____

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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HIPAA ACKNOWLEDGEMENT/CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Pratices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name: _____

Signature: _____

Signature Date: _____

Relationship to Patient (if patient unable to sign):_____