**Next Step Foot & Ankle Clinic – New Patient Packet**

**Welcome to our practice!** Our goal is to provide the best possible foot care for you. Please fill out this paperwork and **immediately return it to our office**. We ask that your also provide us with a current list of medications and any recent lab work. **We prefer you securely e-mail these documents to us with your patient portal account when complete**, but you may also send it to our **Universal City** Office fax at 210.257.6931 or **Pleasanton** Office fax at 830.569.6833, email to: contactus@silvesterfc.com or drop it by during normal business hours. We appreciate your trust in us and we appreciate the opportunity to serve you.

**Payment Policy:** Payment for services is due at the time service is given. We accept cash, checks, and credit cards. Care Credit© may be available. If you have specific financial concerns, we will be happy to discuss payment options with you.

**Assignment of Insurance Benefits:** We will bill your insurance for you. Rarely does an insurance company cover an entire bill. We will do our best to estimate your deductible and the portion that will be covered by your insurer. **Co-payments and deductibles are due by you on the date you are seen.** In addition, any balance remaining after your insurance pays is your direct responsibility. This includes any non-covered services. While we make every effort to determine your benefits ahead of time, it is ultimately your responsibility to know what your insurance plan covers.

**Referrals:** If your insurance requires a referral, please help us by making sure that referrals are sent by your primary care doctor prior to your visit. **Please call our office to check on your referral status before coming for your appointment. If you show up and a referral is not in place, we will ask you to reschedule or you can choose to pay for your visit.**

**Appointments:** Your time is valuable, and we strive to keep as close to your scheduled appointment time as possible. As with any medical setting, situations may occur that keep the doctor from seeing you at the scheduled time. If we are running late, we will inform you and give you the option of waiting, or rescheduling. Please call us if you are running late to see if accommodation can be made. If you are more than 15 minutes late, we may ask you to reschedule your appointment.

**If you will miss an appointment, kindly let us know. A $25.00 fee will be assessed for no-shows. Please provide a current list of medications at each visit.**

**Please read and initial your consent to the following:**

___ **X-rays and photos of your feet may be taken during your visit.** X-rays or photos of individual feet or portions of feet may be used for medical records to document wound healing, for educational or marketing purposes. If used for educational or marketing purposes, your identity will be kept confidential.

__ **E-Prescribing.** We participate in the governmentally mandated practice of e-prescribing, which means we electronically submit prescription requests to your choice of pharmacy. This process checks for potential adverse reactions by creating a history of medications prescribed.

__ **Electronic Communication.** With your provided email address, we will subscribe you to our Patient Portal. The Patient Portal will provide a secure method of communication between our clinic and you. **Your Patient Portal Account Information is mentioned later in this packet.**

If you have questions about our office procedures, please do not hesitate to ask us. We are here to help and look forward to being your first choice in foot care.

Signature _____ Date_____

## Next Step Foot & Ankle Clinic Patient Portal

Next Step Foot & Ankle Clinic has established an internet-based patient portal to help effectively and securely manage your healthcare information as required by Medicare.

Use Next Step Foot & Ankle Clinic Patient Portal for:

- Returning your New Patient Paperwork before your 1st Appointment
- Non-Urgent Secure E-mail Communication with Medical Assistants and Doctor
- Non-Urgent Prescription Refill Requests
- Updated insurance information
- Access Clinic Visit Summaries
- Work / School Note Requests
- Any Questions or Concerns

Your Patient Portal Account Information

**User Name:** First Initial First Name, Full Last Name, Year of Birth
ex. JSmith1949 (initial letter of first and last name in caps)
**Password:** password1

To log in to the Patient Portal, visit our website at
www.NextStepFoot.com


Look for the red Patient Portal button
on the right-hand side of the screen.

If you have trouble logging in, please call the office.
Universal City 210.375.3318
Pleasanton 830.569.3338

Next Step Foot & Ankle Clinic

**Darren J. Silvester, DPM, PA**
Fellow, American College of Foot and Ankle Surgeons
Diplomate, American Board of Foot & Ankle Surgery
Fellow, Association of Extremity Nerve Surgeons

## Financial Policy and Privacy Policy

Thank you for choosing our office to provide your foot and ankle care. We are committed to serving you with skill and compassion. We strive to make our payment policy as clear as possible for our patients. The medical services provided by our offices are services you have elected to receive, which implies a financial responsibility on your part.

**INSURANCE:** Next Step Foot & Ankle Clinic (NSFAC) does not participant in all insurance networks; our in-network list is available on our web site. Claims will be submitted electronically to your insurance provider. All locations will reiterate the benefits to you that were disclosed by your insurance plan. We will collect payment for copays, deductibles, coinsurances, and balances that apply at the time of service.

**MEDICARE:** We are a participating Medicare provider. We will bill Medicare and any secondary policy. However, that does not mean that all services are covered. Non-covered services will be identified as such, and you will have the choice to receive or not receive these services. You are responsible for paying your annual Medicare deductible. You are also responsible for any coinsurance, which is 20% of the Medicare allowed amount for an item or service. We do not participate in all Medicare replacement plans.

**SECONDARY & TERTIARY INSURANCE:** Your medical claim will be forwarded to your secondary insurance after payment or explanation of benefits (EOB) is received from your primary insurance. We do not bill your tertiary insurance.

**COPAYS & DEDUCTIBLES:** The co-pay, coinsurances, and deductible arrangement is part of your agreement with your insurance company. ALL CO-PAYS, COINSURANCES, AND UNMET DEDUCTIBLES MUST BE PAID AT TIME OF SERVICE. Failure on our part to collect copayments, coinsurances, and deductibles from patients can be considered fraud.

**SELF-PAY:** Payment in full is due at the time of service if you do not have health insurance, and for items not covered by insurance. We accept cash, money orders, check, Visa, MasterCard, Discover, American Express and Care Credit. A **$35 fee** will be assessed for all bad checks.

**NON-COVERED SERVICES:** Please be aware that some of the services you receive may not be covered or may not be considered reasonable/customary/necessary by Medicare or other insurers. You are responsible for payment for those services.

**REFERRALS/AUTHORIZATIONS:** Our practice does not require a referral to be seen UNLESS required by your insurance plan. If you arrive for an appointment and the necessary referral or authorization is not in place, you will be given the option to reschedule or pay for those services at the time they are given. We will do all we can to help you get these in place, but ultimately it is your responsibility to understand your plan's referral/authorization requirements. NSFAC may refer patients to other providers, facilities and labs. We are not responsible for these entities. The patient should contact these outside service providers, facilities or labs directly regarding any billing questions.

**CLAIMS SUBMISSION:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. *Your insurance company may need you to supply certain information to them directly. It is your responsibility to get this information to them in a timely manner. Claim balances become patient responsibility if insurance requests are ignored.* Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays on your claim. Your insurance benefit is a contract between you and your insurance company.

**BILLING:** Patients will be sent statements at the end of the month, showing any charges, payments you have made, what your insurance company has paid on your behalf, any amounts that we have adjusted off due to our contract with your insurance company, and what your remaining financial responsibility is. Please contact our billing office immediately upon discovering any error or if you are unable to make payment. ***We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in managing your account.*** Payment arrangements will be agreed upon in writing. The third billing statement for all patients is considered **Final Notice**, and if no payment is received on your account, you will receive a letter requesting immediate payment and/or asked to set up a payment plan with us. A **rebilling charge of $25.00 per month** will be assessed all accounts after the second statement. Please be aware that if a balance remains unpaid after the fourth billing statement, we may refer your account to collections and/or small claims court and you may be discharged from this practice. In case of defaulted Payment Plan Contracts, you agree to pay any fees and costs incurred while collecting the balance on the amount owed. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative podiatric care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

**REFUNDS/RETURNS:** Only unworn and non-custom items are returnable within **14 days** of receipt, if no visible signs of wear, tear, or odor. Custom items are tailored to meet individual needs; custom items are non-returnable, non-refundable. NSFAC issues patient refunds in the original tender within **30 days** of a completed investigation of the potential overpayment, as long as other outstanding accounts are resolved.

**MEDICAL RECORDS:** You may access your medical records at no charge by using our secure patient portal. There will be a **$25 fee** for completion of disability / FMLA forms.

**MISSED APPOINTMENTS:** A **$25 fee** will apply for appointments broken or cancelled without 24 hours advanced notice.

**Patient Signature or Legal Authorized Representative:** _____ **Date:** _____

13525 Centerbrook, Suite 104, Universal City, TX 78148, 210.375.3318, Fax 210.257.6931
409 N. Bryant Street, Pleasanton, TX 78064, 830.569.FEET (830.569.3338), Fax 830.569.6833
**www.NextStepFoot.com**

Next Step
Foot & Ankle
CLINIC

**Darren J. Silvester, DPM, PA**
Fellow, American College of Foot and Ankle Surgeons
Diplomate, American Board of Foot & Ankle Surgery
Fellow, Association of Extremity Nerve Surgeons

## ASSIGNMENT OF BENEFITS

I, the undersigned patient or authorized representative, certify that I have coverage as presented, and assign directly to DJ Silvester, DPM, PA/Next Step Foot & Ankle Clinic all insurance benefits payable to me for services rendered. I understand that I am liable for payment of deductibles, copayments, and/or non-covered services. I authorize the release of medical information to my insurance carrier or requested physician to provide continuity of care. I authorize the use of my signature on all insurance submissions.

I understand that it is my responsibility to notify the doctor's office if there is any change to my insurance coverage.

I have read the above policy regarding My Financial Responsibility to Next Step Foot & Ankle Clinic/DJ Silvester DPM PA for medical services and products provided. I agree to pay Next Step Foot & Ankle Clinic/DJ Silvester DPM PA any balance unpaid by my insurance carrier for myself or the patient named below.

**Print Patient Name** _____ **Signature** _____

**Date** _____

**If signature above is not Patient, relationship to Patient** _____

## PATIENT ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been given the opportunity to read a copy of Notice of Privacy Practices. This Notice of Privacy Practices is available in our office, and on our website: www.nextstepfoot.com.

Protected Health Information (PHI) may consist of items such as diagnoses, treatments, labs, prescriptions and appointments. **Who may we discuss your Protected Health Information with?**

___Spouse: Name and phone number_____

___ Child: Name and phone number_____

___ Other: Name and phone number_____

Print Patient Name _____ Signature _____

Date _____

If signature above is not Patient, relationship to Patient _____

**----OR----**

**DOCUMENTATION of FAILURE TO OBTAIN SIGNED ACKNOWLEDGMENT:**

On (date) _____NSFAC presented this Acknowledgment of Receipt of Privacy Practices form to _____. Patient or agent refused to provide a signature.

Employee Signature _____ Date_____

## NEXT STEP FOOT AND ANKLE CLINIC — NEW PATIENT REGISTRATION FORM

| LAST NAME: | LEGAL FIRST NAME: | MIDDLE: | |
|---|---|---|---|
| DOB: | AGE: | SHOE SIZE: GENDER: M / F | WEIGHT: | HEIGHT: |
| ADDRESS: | APT: | CITY: | STATE: | ZIP: |
| HOME PHONE: | WORK PHONE: | CELL PHONE: | EMAIL: |

**CIRCLE PREFERRED NUMBER TO CALL**
HOME PHONE WORK PHONE CELL PHONE

**CIRCLE PREFERRED METHOD OF WRITTEN CORRESPONDANCE**
PATIENT PORTAL EMAIL MAIL

### EMERGENCY CONTACT INFORMATION

| E.C. NAME: | RELATIONSHIP: | HOME: | CELL: | |
|---|---|---|---|---|

NAME OF PERSON(S) WHO CAN ACCESS YOUR RECORDS / PHI OR PICK UP ITEMS FOR YOU:

**RACE:** AMERICAN INDIAN/ALASKA NATIVE ASIAN BLACK / AFRICAN AMERICAN HISPANIC NATIVE HAWAIIAN WHITE

**ETHNICITY:** HISPANIC/LATINO NOT HISPANIC/LATINO PATIENT DECLINED

**PRIMARY LANGUAGE:**

**PCP OR REFERRING PHYSICIAN (FULL NAME):**

**PHONE:**

**IF DIABETIC, FULL NAME OF DIABETIC DR:**

**DATE LAST SEEN:** **A1C Score:**

**HOW DID YOU HEAR ABOUT OUR OFFICE?** FRIEND/FAMILY INTERNET WEBSITE FACEBOOK MAILING PHYSICIAN OTHER:

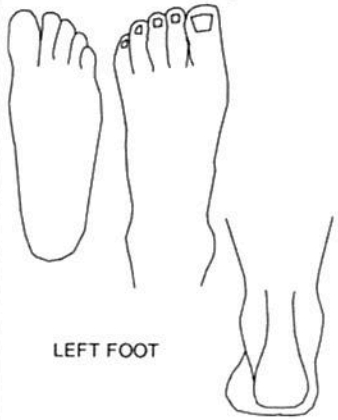
**REASON FOR VISIT WITH US?**

**DATE OCCURRED:**

**IS YOUR INJURY/CONDITION:** (CIRCLE ONE) WORK-RELATED CAR ACCIDENT RELATED OTHER LIABTILITY BEING PAID BY EMPLOYER CASH

### CURRENT PROBLEMS

**Circle Area(s) where pain is:**




**Left Foot Issues**

**Pain Scale:** 1 2 3 4 5 6 7 8 9 10 **(ten is worst)**

**Severity:** Mild Moderate Severe

How long has the pain hurt?_____

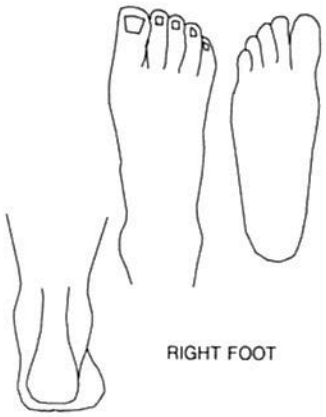
What time of day is it most painful?_____

Do you have pain at rest?_____

What caused the pain?_____

What have you done for it?_____

**Circle Area(s) where pain is:**




**Right Foot Issues**

**Pain Scale:** 1 2 3 4 5 6 7 8 9 10 **(ten is worst)**

**Severity:** Mild Moderate Severe

How long has the pain hurt?_____

What time of day is it most painful?_____

Do you have pain at rest?_____

What caused the pain?_____

What have you done for it?_____

**Other Concerns: (Please Circle)**

**Falling**

**Poor Circulation**

**Fungus**

**Ingrown Toenail**

**Diabetic Shoes**

**Replace Orthotics**

### PAST MEDICAL HISTORY (PLEASE CIRCLE ALL THAT APPLY)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| NONE | CAD | COPD/LUNG | DIABETES | GOUT | INJURY LEGS/FEET | MRSA | RSD / CRPS | TB |
| ANXIETY | CANCER | DVT, BLOOD CLOT | FIRBOMYALGIA | HEPATITIS | KIDNEY DISEASE | NEUROPATHY | SEIZURES | THYROID |
| ARTHRITIS | CHOLESTEROL | DEPRESSION | GI, ULCER | HYPERTENSION | LIVER DISEASE | OSTEOPOROSIS | STROKE | ASTHMA |
| H EART FAILURE | DEMENTIA | GERD,ACID REFLUX | | HIV | MYOCARDIAL | PAIN IN LEGS/FEET | SWELLING OF_____ | |

| VACCINATIONS | FLU MONTH | YEAR | PNEUMONIA MONTH | YEAR | TETANUS MONTH | YEAR | |
|---|---|---|---|---|---|---|---|

## PREVIOUS PROCEDURES OR SURGERIES (PLEASE CIRCLE ALL THAT APPLY)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| NONE | BUNION | HIP SURGERY | LOWER EXTREM BYPASS | AMPUTATION OF _____ | CORONARY BYPASS | KIDNEY TRANSPLANT | LOWER EXTREM STENT | ANGIOPLASTY / STENT |
| FOOT OR ANKLE SURGERY TYPE | PACEMAKER | APPENDECTOMY | GALL BLADDER SURGERY | STEROID INJECTION | BLOOD TRANSFUSION | GASTRIC BANDING | LIVER TRANSPLANT | OTHER:_____ |

## FAMILY HISTORY (CHECK IN BOX IF PRESENT IN FAMILY MEMBER'S HISTORY)

| FAMILY | UNKNOWN | ALIVE &WELL | ARTHRITIS | CANCER (TYPE) | KIDNEY DISEASE | HYPERTENSION | STROKE | DIABETES | OTHER |
|---|---|---|---|---|---|---|---|---|---|
| Father | | | | | | | | | |
| Mother | | | | | | | | | |
| Son | | | | | | | | | |
| Daughter | | | | | | | | | |

## SOCIAL HISTORY (PLEASE CIRCLE RESPONSE)

**DO YOU DRINK ALCOHOL?** YES / NO **IF YES, DO YOU DRINK** EVERY DAY SOCIAL ONLY

**DO YOU SMOKE?** YES / NO **IF YES, HOW MANY YEARS HAVE YOU SMOKED?**

**ARE YOU A FORMER SMOKER?** YES / NO **IF YES, HOW MANY YEARS DID YOU SMOKE?** **WHAT YEAR DID YOU QUIT?**

**RECREATIONAL DRUG USE** NEVER USED HAVE USED CURRENTLY USE TREATED FOR ADDICTION (YEAR - )

## PHARMACY INFORMATION & MEDICATIONS (PLEASE PROVIDE A LIST OF MEDICATIONS, DOSAGE & FREQUENCY AT FIRST APPOINTMENT)

**PHARMACY:**

**STREET**

**CITY / ZIP:**

**PHONE:**

**FAX:**

**ALLERGIES (PLEASE CIRCLE ALL THAT APPLY)**

| | | | | | |
|---|---|---|---|---|---|
| NONE | EGG | ADHESIVE TAPE | SULFA | OAK | PENICILLINS |
| CODEINE | LATEX | LOCAL ANESTHETIC | SHELLFISH | MILK | HEPARIN |
| ASPIRIN | IODINE | GENERAL ANESTHETIC | | | |

**OTHER ALLERGIES:**

**DO YOU HAVE: (PLEASE CIRCLE)**
**PACEMAKER YES OR NO**
**BACK STIMULATOR YES OR NO**

## PRIMARY INSURANCE INFORMATION – REQUIRED TO SHOW INSURANCE CARD AT FIRST APPOINTMENT

| | | |
|---|---|---|
| **INSURANCE NAME:** | **PATIENT SS#:** | **ELIGIBILITY PHONE #:** |
| **MEMBER ID:** | **SPOUSE SS#:** | **GROUP #** |

## SECONDARY INSURANCE INFORMATION – REQUIRED TO SHOW INSURANCE CARD AT FIRST APPOINTMENT

| | | |
|---|---|---|
| **INSURANCE NAME:** | **PATIENT SS#:** | **ELIGIBILITY PHONE #:** |
| **MEMBER ID:** | **SPOUSE SS#:** | **GROUP #** |

## ATTESTATION

I DO HEARBY ATTEST THAT THIS INFORMATION IS TRUE, ACCURATE, AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT ANY FALSIFICATIONS, OMISSIONS, OR CONCEALMENT OF ANY MATERIAL FACT MAY SUBJECT ME TO ALL FEES FOR SERVICES AND/OR OTHER LIABILITY. I ALSO UNDERSTAND THAT I AM TO NOTIFY NSFAC IMMEDIATELY OF ANY CHANGES TO THE ABOVE INFORMATION, AND I WILL BE ASKED TO DO AN ANNUAL UPDATE TO THIS REGISTRATION FORM ANNUALLY.

| | |
|---|---|
| **PRINTED PATIENT NAME OR LEGALLY AUTHORIZED REPRESENTATIVE:** | **DATE:** |
| **SIGNATURE OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE:** | **RELATIONSHIP TO PATIENT:** |