

## Next Step Foot & Ankle Clinic

**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 you also provide us with a current list of medications and any recent lab work. You can 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](mailto: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 \$10.00 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. You will receive your user name and password for the Patient Portal when you come to the clinic for your first visit.

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 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:** We participate in most insurance plans. If we do not participate with your insurance plan, payment in full is expected at each visit. If you are insured by a plan we participate in, but you do not have an up to date insurance card and we are unable to verify benefits, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

**MEDICARE:** We are a participating Medicare provider. We will bill Medicare and any secondary policy you have. 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 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 tertiary insurance plans.

**COPAYS & DEDUCTIBLES:** The co-pay and deductible arrangement is part of your agreement with your insurance company. All co-pays and unmet deductibles must be paid at time of service. Failure on our part to collect copayments 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 and Care Credit. A \$35 NSF 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 auth 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/auth requirements.

**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.

**PATIENT BILLING:** Insured patients will be sent up to three "remainder" statements, showing 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. The third statement for self-pay and insured patients is considered a Final Notice, and if no payment is received on your account, you may be sent to collections. If your insurance pays after you have paid on your account, a refund will be mailed to you within 30 days.



### 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](http://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 Registration Form										<input type="checkbox"/> Pleasanton <input type="checkbox"/> Floresville <input type="checkbox"/> Universal City	
Last Name		Legal First Name		Middle							
DOB		Age		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Weight		Height		Shoe Size	
Address:		Apt:		City:		State:		Zip:			
Home Phone ( )		Work Phone ( )		Cell Phone ( )		Email:					
Circle Preferred Method of Call/Voicemail (In addition to NSFAC's Secure Portal) Email US Mail											
Emergency Contact Name		Relationship		Home Phone		Cell Phone					
Name 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	
Primary Language:		Ethnicity: Hispanic/Latino		Not Hispanic/Latino		Patient Declined					
PCP or Referring Physician (Full Name)		Phone									
If Diabetic, full name of Diabetic Doctor		When did you see them last?									
How did you hear about our office?		Friend/Family		Internet Search		Website		Facebook		Mailing Book Offer	
Physician		Other:									
Reason for Visit with Us:											
Date Occurred:											
Is your injury/condition (Circle) Work-Related Car Accident Related Other Liability Being Paid By Employer Self-Pay/Cash											
Secondary Insurance -- Copy of Card Required											
Insurance Name		Eligibility Phone		Insurance Name		Eligibility Phone					
Member ID#		Group#		Member ID #		Group #					
Policyholder Name		Patient's Relationship to Policyholder		Policyholder Name		Patient's Relationship to Policyholder					
Policyholder Date of Birth		Policyholder SS#		Policyholder Date of Birth		Policyholder SS#					
CURRENT PROBLEM (Please Check all that Apply)											
Location: (where)		<input type="checkbox"/> Top Of		<input type="checkbox"/> Bottom of		<input type="checkbox"/> Inside of		<input type="checkbox"/> Outside of		<input type="checkbox"/> In between	
Site: (what)		<input type="checkbox"/> Ankle		<input type="checkbox"/> Arch		<input type="checkbox"/> Ball of foot		<input type="checkbox"/> Calf		<input type="checkbox"/> Foot / Feet	
Quality: (Type of pain)		<input type="checkbox"/> Aching		<input type="checkbox"/> Bruised		<input type="checkbox"/> Burning / Itchy		<input type="checkbox"/> Cramping		<input type="checkbox"/> Deep	
		<input type="checkbox"/> Numb		<input type="checkbox"/> Pressure		<input type="checkbox"/> Sharp		<input type="checkbox"/> Swollen		<input type="checkbox"/> Tender	
How long has it bothered you?		<input type="checkbox"/> Today		<input type="checkbox"/> # of days		<input type="checkbox"/> # of weeks		<input type="checkbox"/> # of months		<input type="checkbox"/> # of years	
When does it bother you?		<input type="checkbox"/> At Night		<input type="checkbox"/> After Exercise		<input type="checkbox"/> Constant		<input type="checkbox"/> In Morning		<input type="checkbox"/> Off and on	
What caused it?		<input type="checkbox"/> Fell		<input type="checkbox"/> Foot type		<input type="checkbox"/> Increased Activity		<input type="checkbox"/> Injury		<input type="checkbox"/> Running	
What makes it better?		<input type="checkbox"/> Ice / Heat		<input type="checkbox"/> Elevation		<input type="checkbox"/> Medication		<input type="checkbox"/> Compression		<input type="checkbox"/> Orthotics	
What makes it worse?		<input type="checkbox"/> Barefoot		<input type="checkbox"/> Pressure		<input type="checkbox"/> In Shoes		<input type="checkbox"/> Increase Activity		<input type="checkbox"/> Running	
Also have:		<input type="checkbox"/> Back Pain		<input type="checkbox"/> Dementia		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Overweight		<input type="checkbox"/> Headaches	
		<input type="checkbox"/> Fatigue		<input type="checkbox"/> Swelling		<input type="checkbox"/> OTC Inserts		<input type="checkbox"/> Weakness		<input type="checkbox"/> Osteoporosis	
TODAY's Pain Scale: (Circle)		0		1		2		3		4	
		5		6		7		8		9	
		10		Worst		Mild		Moderate		Severe	



PAST MEDICAL HISTORY (Please Check All that Apply)									
<input type="checkbox"/> No Known Problems	<input type="checkbox"/> CAD	<input type="checkbox"/> COPD/Lung Issue	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Gout	<input type="checkbox"/> Injury Legs/Feet	<input type="checkbox"/> MRSA	<input type="checkbox"/> RSD / CRPS	<input type="checkbox"/> TB	
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Cancer	<input type="checkbox"/> DVT, Blood Clot	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Seizures	<input type="checkbox"/> Thyroid	
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Depression	<input type="checkbox"/> GI, Ulcer	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Stroke		
<input type="checkbox"/> Asthma	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Dementia	<input type="checkbox"/> GERD, Acid Reflux	<input type="checkbox"/> HIV	<input type="checkbox"/> MI, myocardial	<input type="checkbox"/> Pain in legs/feet	<input type="checkbox"/> Swelling of		
PREVIOUS PROCEDURES OR SURGERIES (Please Check All that Apply)									
<input type="checkbox"/> No Surgical History	<input type="checkbox"/> Bunion	<input type="checkbox"/> Hip Surgery	<input type="checkbox"/> Lower Extremity Bypass						
<input type="checkbox"/> Amputation of _____	<input type="checkbox"/> Coronary Bypass	<input type="checkbox"/> Kidney Transplant	<input type="checkbox"/> Lower Extremity Stent						
<input type="checkbox"/> Angioplasty / Stent	<input type="checkbox"/> Foot or Ankle Surgery (Type _____)		<input type="checkbox"/> Pacemaker						
<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Gallbladder Surgery	<input type="checkbox"/> Knee Surgery	<input type="checkbox"/> Steroid Injection						
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Gastric Bypass	<input type="checkbox"/> Liver Transplant	<input type="checkbox"/> Other _____						
FAMILY HISTORY (Check in box if present in family member's history)									
Unknown History	Alive & Well	Arthritis	Cancer (Type _____)	Kidney Disease	Hypertension	Stroke	Diabetes	Other	
Father <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mother <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Son <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Daughter <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SOCIAL HISTORY (Please Circle Response)									
Do you drink alcohol? Y N									
Do you smoke? Y N									
Are you a former smoker? Y N									
Recreational Drug Use (Circle) Never Used Currently Use Treated for Addiction (Year _____)									
PHARMACY AND MEDICATIONS – A Typed List of Medications, Dosage, & Frequency Would Be Greatly Appreciated									
Pharmacy: _____	Medication	Dose	Frequency	Medication	Dose	Frequency			
Street: _____	1			6					
City / Zip: _____	2			7					
Phone: _____	3			8					
Fax: _____	4			9					
	5			10					
ALLERGIES (Please Check all that Apply)									
<input type="checkbox"/> No Known Allergies	<input type="checkbox"/> Egg	<input type="checkbox"/> Adhesive (tape)	<input type="checkbox"/> Local Anesthetic	<input type="checkbox"/> General Anesthetic	<input type="checkbox"/> Sulfas	<input type="checkbox"/> Codeine	<input type="checkbox"/> Shellfish		
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Iodine	<input type="checkbox"/> Latex	<input type="checkbox"/> Milk	<input type="checkbox"/> Oak	<input type="checkbox"/> Penicillins	<input type="checkbox"/> Heparin	<input type="checkbox"/> Other:		
VACCINES (Indicate month and year last given)									
Flu ( _____ ) Pneumonia ( _____ ) Tetanus ( _____ )									
ATTESTATION									

Print Name of Patient or Legally Authorized Representative

### Relationship to Patient

Signature of Patient or Legally Authorized Representative

Date \_\_\_\_\_

NSFAC 6 2015 MS

I DO HEREBY 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.

Print Name of Patient or Legally Authorized Representative

### Relationship to Patient

Signature of Patient or Legally Authorized Representative

Date \_\_\_\_\_

NSFAC 6 2015 MS



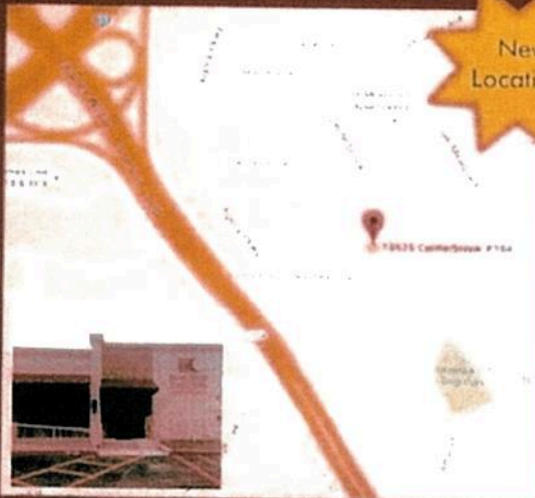
## Now Serving San Antonio and South Texas

### Next Step Foot & Ankle Clinic - Universal City

13525 Centerbrook, Suite 104

Universal City, TX 78148

Ph: 210.375.3318 Fx: 210.257.6931



### Next Step Foot & Ankle Clinic - Pleasanton

409 N. Bryant Street

Pleasanton, TX 78064

Ph: 830.569.FEET(3338) Fx: 830.569.6833



[www.NextStepFoot.com](http://www.NextStepFoot.com)

#### Directions to Our Universal City Office

We are located just off Pat Booker Road. Turn left on Athenian Drive, then left on Centerbrook. Between Kohl's and the Universal City Dog Park.

#### Directions to Our Pleasanton Office

##### Directions From the North (via I-37 S)

- Take I-37 S to Exit 109 toward TX-97/Pleasanton/Floresville
- Turn right onto E State Highway 97/TX-97
- Take slight right onto Commerce Street, which becomes E Bensdale Road
- Turn left onto North Bryant Street
- Our office is on the right between Stadium Drive and W Adams Street

##### Directions From the Northeast (Floresville Area)

- Take State Highway 97 W/TX-97 toward Pleasanton
- Take slight right onto Commerce Street, which becomes E Bensdale Road
- Turn left onto North Bryant Street
- Our office is on the right between Stadium Drive and W Adams Street
- Turn left on South Bryant Street
- Our office is on the left between W Adams Street and Stadium Drive