

Dr. Ali Kareem, DPM, AACFAS
South Texas Foot & Ankle Doctors
4413 N. McColl Rd, McAllen, TX 78504



Name

LAST NAME

FIRST NAME

INITIAL

Address

Phone #:

City

State

Zip

Sex: M F

Age: Birthdate:

Soc. Sec. #

Patient Employed by

Occupation

Business Address

Email Address:

Name of primary care physician:

Marital Status:

In case of an emergency who should be notified?

Phone

PRIMARY INSURANCE

Policy Holder:

Last Name

First Name

Initial

Relation to Patient:

Birthdate:

Soc. Sec. #

Policy Holder Employed by:

Occupation:

Business Address:

Business Phone:

Insurance Company:

ADDITIONAL INSURANCE

Policy Holder Name:

Relation to Patient:

Birthdate:

Policy Holder Employed by:

Business Phone:

Insurance Company:

Soc. Sec. #

PLEASE COMPLETE OTHER SIDE OF FORM

CONSENT TO CARE

I authorize Dr. Ali Kareem, to perform upon me injections, draw blood and/or any other procedure/treatment he may judge or determine advisable for my well-being in his office. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the outcome of the procedures/treatments.

Date _____ Patient's Signature _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have received a copy of the Privacy Notice and was given an opportunity to object to disclosures of my protected health information.

Date _____ Patient's Signature _____

ASSIGNMENT OF BENEFITS

I hereby assign payment of authorized Medicare benefits and any other medical and/or surgical benefits, to include major medical benefits to which I am entitled, to be made either to me or on my behalf to Dr. Ali Kareem for any services furnished me by him. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as its original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Date _____ Patient's Signature _____ Witness _____

SAMPLE MEDICATIONS

This clinic gives many kinds of sample medication to its patients. Should you be one of these patients, please be sure you are not allergic to any one of the samples given before you accept such samples.

ANTIBIOTIC MEDICATION / PAIN MEDICATION / ANTI-INFLAMMATORY MEDICATION

Should you receive a sample of medication that is used to treat an infection, anti-inflammatory medication to treat arthritis and joint pain with swelling and stiffness, and/or pain medication to relieve pain AND you develop a rash, drowsiness, light-headedness, dizziness or any type of stomach disorder, please notify the physician; as with any medication be sure to follow the directions given.

I have read and understand the above, I also understand these samples are given to me free of charge and for my sole use only.

Date _____ Patient's Signature _____

ADVANCE DIRECTIVE

Designate a person as agent to make health care decisions for you if you are unable to make your own decisions.

1. _____ Phone: _____

Dr. Ali Kareem, DPM, AACFAS

South Texas Foot & Ankle Doctors

Name _____ Date _____

Chief Complaint

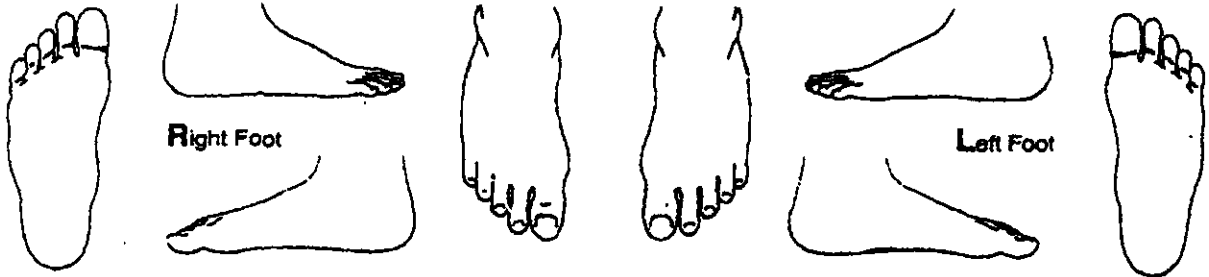
Age _____

What is your main foot problem today? _____

Do you have any other foot problems that need attention? _____

History of Present Illness

Mark on the diagram below the areas where each problem is located.



When did your main problem begin? _____ [] Days [] Weeks [] Months [] Years ago.

Is the pain: [] Burning, [] Throbbing, [] Sharp, [] Dull, [] Aching, [] Tingling, [] Numbness, [] Itching, [] Other _____

How severe is your pain? 0 1 2 3 4 5 6 7 8 9 10
(No Pain) PLEASE CIRCLE (Extreme pain)

Is the pain worse after rest or after activity? [] Rest [] Activity

What causes the problem or makes it worse? _____

Was it caused by an injury? [] No [] Yes (if yes, explain) _____

What previous treatments have been used?: _____

Self: _____

Professional: _____

Past/Family/Social History

Name _____

Past History

Injuries

- No injuries of consequence
- List serious injuries and approximate age:

Major Past Illnesses

- No serious past illnesses
- List serious illness and approximate age:

Surgeries or Hospitalizations

- None
- List any surgeries or hospitalizations:

Had surgery/ hospitalization for:	On date of:	With complications:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have vascular grafts? Yes No Where? _____

Do you have joint implants? Yes No Where? _____

Do you have replacement heart valves? Yes No Where? _____

Are you under active chemotherapy? Yes No Where? _____

FAMILY HISTORY

Is there a family history of any of the following: (Please indicate parent affected)

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Gout	<input type="checkbox"/> Mother <input type="checkbox"/> Father
<input type="checkbox"/> Birth Defects	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Mother <input type="checkbox"/> Father
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Foot Problems	<input type="checkbox"/> Mother <input type="checkbox"/> Father
<input type="checkbox"/> Cancer	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Stroke	<input type="checkbox"/> Mother <input type="checkbox"/> Father
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Other	<input type="checkbox"/> Mother <input type="checkbox"/> Father

Mother Alive Died Age of Death _____ Cause of Death _____

Father Alive Died Age of Death _____ Cause of Death _____

Social History

Occupation: _____

Activity Level: Sedentary Moderately Active Athletic

Do you smoke now? Yes No Packs/day _____ Years _____

Did you ever smoke? Yes No Packs/day _____ Years _____

Alcoholic beverages? None Rarely Moderately Daily Quit



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Are you allergic or have you ever had a reaction to any of the following?

(Please circle all that apply)

Anesthesia	Iodine	Penicillin
Aspirin	Latex	Radiographic Contrast/Dye
Band Aids/Tape	Lidocaine	Sulfa Drugs
Codaine	Novocaine	

Other _____

Do you have or have YOU ever been treated for any of the following?

(Please circle all that apply)

Amputation	Epilepsy	Lung Disease
Anemia	Gout	Neuropathy
Arthritis	Gerd	Osteoporosis
Asthma	Heart Attack	Psychiatric Disorder
Back Pain	Hepatitis	Seasonal Allergies
Blood Clot	High Cholesterol	Stomach Ulcer
Bunion	HIV/AIDS	Stroke
Cancer	Hypertension	Thyroid Disease
Circulation Problems	Kidney Problems	Ulcer/Wound
Type I Diabetes (Juvenile)	Liver Disease	Vision Problems
Type II Diabetes	Chronic Kidney Disease	Retinopathy

Do you have any FAMILY HISTORY (mom, dad, aunt, uncle) of any of the following?

(Please circle all that apply)

Arthritis	Diabetes	Hypertension
Bleeding Disorders	Foot Deformities	Osteoporosis
Cancer	Heart Disease	Stroke

Do you use any of the following assistive devices?

Walker	Cane	Crutches
Wheelchair	Braces	

Have you ever had foot surgery? Yes No

If yes, please list type and date of surgery _____

Please list all other surgeries and dates _____

Financial Information

Traditional Medicare Insurance: Our office participates with Medicare. This means that we will send your claim to Medicare and we will adhere to Medicare's allowable fee schedule. Medicare sets an allowable fee for each service that they cover. Once you have met your annual deductible Medicare will pay us 80% of the allowable fee and you will be responsible for the remaining 20%. If you have a secondary insurance this amount will then be sent on to them and you will be billed for any remaining balance after their payment.

Medicare has strict guidelines concerning their coverage of routine foot care such as trimming nails, or paring corns and calluses. The doctor will be able to determine if your routine foot care is or is NOT covered by Medicare. Should you have a non-covered service such as this performed, you will be asked to pay for that service at the time of your appointment. We will also ask you to sign Medicare's Advanced Beneficiary Notice (ABN) indicating you were informed that Medicare will not be paying for that particular service. The ABN will be provided at the time of visit.

If you have any other service such as a new patient office visit or a visit for a new problem performed on the same day such as routine nail care or another non-covered service, Medicare will be billed for the covered service and we will collect the uncovered service fee from you that day. **South Texas Foot and Ankle Doctors** will submit your claims to all other insurance companies providing:

- At each visit we receive a copy of all current insurance identification cards.
- Our Patient Information form is current and correctly completed.
- Our Financial Policy is signed.

If we have not heard from your secondary insurance within 60 days, you will be billed directly. In that event you must contact the insurance company directly to find out why your claim has not been paid. **It's** the patient's responsibility to give us their current insurance information? If we do not have a copy of your current insurance card, or have received incorrect or old insurance information, all charges will become the patient's responsibility. **All** uncollected co-pays and co-insurances from prior visits will be due at the time of your next appointment, as specified in your insurance contract and mandated by your carrier in our participating provider agreement.

For your convenience South Texas Foot and Ankle Doctors accepts cash, all major credit cards, debit cards, and personal checks. Payment is expected at each visit. You will receive a billing statement for all personal balances due. If we have not received a response from you by phone or received a payment or letter regarding your unpaid balance within 90 days, your Account will be sent to our collections department.

No Insurance:

If you do not have health insurance, charges for the day's medical service are due at the time of service unless other arrangements have been made with the office in advance. In many cases a cash payment Discount may be given to patients without health insurance.

Care Credit:

This is offered as a payment option for patients who qualify. Please speak to the office staff if you would like more information.

There is a \$35.00 fee assessed for returned checks. South Texas Foot and Ankle Doctors know that unexpected financial problems do arise. We encourage you to contact the office at (956) 682-8391 immediately for assistance in managing your account.

Referrals/Authorizations:

It is the patient's responsibility to obtain all referrals if your insurance requires one. We will do all we can to assist you, but it is ultimately your responsibility. If a required referral is NOT in place PRIOR to your appointment, we may reschedule the appointment until it is received.

FMLA/Disability Forms:

The doctor at South Texas Foot and Ankle Doctors will complete your first insurance disability form for you at no charge. You will be charged a fee of \$25.00 for every disability form to be completed thereafter. The fee is payable upon presentation of the forms. The forms will not be completed until the \$25.00 fee is received.

I understand that there is a \$10.00 fee for copies of medical records. Please call office to request medical records if necessary.

Missed Appointment Policy:

South Texas Foot and Ankle Doctors reserve the right to charge a patient for a missed appointment. If you cannot make your scheduled appointment, you should give us 24 hours' notice. A charge for a missed appointment is NOT a charge for the service itself. One missed appointment, or severe weather problems will NOT result in a patient being charged. Consecutive missed appointments or repeated missed appointments will be assessed at a fee of \$30.00 for each missed appointment. Habitually missed appointments could lead to a patient being discharged from the practice.

Collections:

South Texas Foot and Ankle Doctors will attempt to make payment terms that meet your needs. If we do not hear from you by phone, mail or partial payment within 90 days of a statement being sent, you may be referred to a collection agency. In the event your account is assigned to collection, the patient agrees to be responsible for a 25% collection fee, as well as all court costs and attorney fees.

I understand that if a custom DME product is ordered for me, such as orthotics or special shoes, or I receive an air cast, night splint, surgical shoe, and ankle brace, Dyna-Flex Plate or Power steps, that they are non-refundable and non-returnable. If my insurance denies them for any reason, I understand it is ultimately my responsibility and I will pay for the product(s) I have received.

I understand that South Texas Foot and Ankle Doctors financial policy is in effect for the entire time I am a patient not just for the date that I sign the policy. If there are any changes, our office will have you fill out a new form at that time.

I authorize South Texas Foot and Ankle Doctor Ali Kareem, to release information regarding my medical history and treatments to my insurance company in order for them to be paid. I also authorize payments for services to be paid directly to South Texas Foot and Ankle Doctor Ali Kareem from my insurance company.

I understand that unpaid balances have to be paid prior to making a follow up appointment. I understand that I will speak with an office staff to initiate a payment plan if my balance is unmanageable.

I acknowledge by signing my name below, as the patient or guardian of the patient, that I have read and initialed all of the above financial disclosures and understand and will comply. I have asked questions, if necessary, and I have had those questions answered and I understand.

Print: _____

Date: _____

Signature: _____

Date: _____

Patient Responsibility

I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes any medical service or visit, routine examination, refraction, testing, and any other screening ordered by the doctor or staff.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

I understand and agree that it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full.

I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

If I am a Medicare patient, I understand that I need to provide the office both my Medicare ID card and my secondary ID card. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations, and/or as required by law. I have the right to revoke this consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior consent. **STEAD** provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Printed Patient Name (and Guardian Name if applicable)

Patient or Guardian Signature

Date

ULCEA/PS Witness

I give permission to communicate my Private Healthcare Information to:

Name

Relationship

Name

Relationship

Name

Relationship

Our office does not make the rules. They are determined by your specific medical insurance or vision plan.



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Ali A. Kareem DPM

Medical Records Request

Name: _____ DOB: _____

Reason for request: _____

From: _____

Medical Data/Information

- _____ Demographic Information on Record
- _____ Recent Progress Notes
- _____ Diagnosis
- _____ Finding of Physical Examination
- _____ Laboratory Data
- _____ Reports of Diagnostic Tests (X-ray/Ultrasound) _____
- _____ Imaging Reports _____
- _____ Reports of Surgical Procedure _____
- _____ List of Medications
- _____ List of Treatments
- _____ Information from Physician H&P
- _____ All Healthcare Information
- _____ Other _____

Signature of Patient: _____ Date: _____

Signature of Witness: _____ Date: _____

Fax: 956-682-0018