Brazos Foot & Ankle Clinic
Shannon R. Mueller, DPM
Diplomate, American Board of Podiatric Surgery
Fellow, American Board of Foot and Ankle Surgeons

1201 Medical Plaza Court
Granbury, Texas 76048
817-578-8555
brazosfootandankle.com

Dear Patient:

Thank you for placing your trust in us to provide your foot and ankle care needs. Your appointment is scheduled for _____ at _____. The following is a list of instructions that will make your visit with us go more smoothly.

It is very important that we have an up-to-date list **of all prescription and non-prescription medications or supplements** that you take for your medical record. We also need to know what **medical conditions you are being treated for and any surgical procedures you have had**. Please bring this information to every appointment. Please also bring your **completed patient registration forms**. This will speed up your appointment time significantly.

We also need to know about all of your insurance plan information prior to your visit. We will verify your coverage and benefits prior to your visit. Please understand that information we obtain is just an estimate provided to us by your insurance company and is subject to change. **All co-pay, co-insurance and deductible amounts are due at the time of service.**

We always appreciate your feedback about your visit to our office. Please feel free to share any compliments or concerns with any of our staff or myself.

We look forward to meeting you.

Thank you,

Dr. Shannon Mueller and Staff at Brazos Foot & Ankle Clinic

Brazos Foot & Ankle Clinic
Shannon R. Mueller, DPM

Name _____ Date _____

How do you describe your foot/ankle problems? _____

How long have you had this problem? _____

What treatments, both home and professional have you tried? _____

_____

Have any of the above treatments helped at all? _____

List all medications (including strength) that you take on a daily basis:_____

_____

List all past medical history::_____

_____

List all previous surgeries:_____

_____

List all medication allergies:_____

_____

Social History: Marital status:_____ Occupation:_____

Tobacco Use: Y/N (circle all that apply) Current / Previous, Cigarettes Cigars Chew Dip
Quantity: _____ per day/week
Alcohol Use: : Y/N (circle all that apply) Current / Previous, Beer Wine Liquor
Quantity: _____ per day/week
Drug History: _____

Family Medical History:

Condition	**Relationship to Patient**	**Circle one please**
Arthritis	_____	Deceased or Living
Cancer	_____	Deceased or Living
Diabetes	_____	Deceased or Living
Hypertension	_____	Deceased or Living
Heart Disease	_____	Deceased or Living

Referring physician: _____

Primary physician: _____

Brazos Foot & Ankle Clinic
Shannon R. Mueller, DPM

MEDICAL HISTORY REVIEW OF SYSTEMS

Name_____Date_____

Please check any of the following that **currently** apply to you:

Constitutional:
□ Fever □ Weight loss □ No symptoms

Eyes:
□ Loss of vision or side vision □ Double vision □ Dryness □ Mucous discharge □Redness □ Itching
□ Sandy/Gritty feeling □ Burning □ Excess tearing/ watering
□ Glare/Light sensitivity □ Eye pain or soreness □ No symptoms

Ear/Nose/Mouth/Throat:
□ Ringing in ears □ Poor hearing □ Nasal surgery □ Mouth sores
□ Dry mouth □ Sinus congestion □ Difficulty swallowing □ No symptoms

Cardiovascular:
□ Shortness of breath □ Varicose veins □ Chest pain □ Palpitations
□ Irregular heartbeat □ Peripheral vascular disease □ No symptoms

Respiratory:
□ Shortness of breath □ Cough up blood □ productive, prolonged cough □ No symptoms

Gastrointestinal:
□ Nausea □ Vomiting □ Heartburn □ Diarrhea □ Constipation □ Ulcer □ No symptoms

Genitourinary:
□ Incontinence □ Kidney disease □ Kidney infections □ Reduced urine flow □ Bladder infections □ Burning during urination □ Sexually transmitted disease □ No symptoms

Bones/Muscles:
□ Arthritis □ Muscle weakness □ Unsteady on your feet
□ Difficulty walking/standing/sitting □ No symptoms

Skin:
□ Rash □ Unexplained bruises □ Open sores, If so, where? _____ □ No symptoms
□Change to nails □Skin color change

Neurologic:
□ Seizures □ Loss of sensation □ Tingling □ Numbness
□ Tremors □ Paralysis □ Headache □ No symptoms

Psychological:
□ Unusually stressed □ Depressed □ Memory Loss □ Anxiety □ No symptoms

Endocrine:
□ Recent hair loss □ Unusual hunger or thirst □ Cold or heat intolerance □ No symptoms

Hematologic/Immunologic:
□ Anemia □ Blood clots □ Inability to clot □ Environmental allergies □ No symptoms

Brazos Foot & Ankle Clinic
Shannon R. Mueller, DPM

Patient And Guarantor Information Sheet

Part A: Patient Information

Patient Name:	Sex:	Birth Date:
Address:		
City, State, Zip:		
Preferred Phone Number:	Alternate Phone:	
Email Address:		
Patient & Guarantor The Same? Yes Or No If no, please explain:		

Part B: Policy Holder/Guarantor Information
(If Other Than Self)

Name:	Sex:	Birth Date:
Address:		
City, State, Zip:	Work #:	
Phone Number:	Work #:	

Please make sure that you've given your current insurance card and a photo ID to the Receptionist for your record.

Brazos Foot & Ankle Clinic
Shannon R. Mueller, DPM

Financial Policy

Attention Patients:

Our Physicians share your concern about the cost of medical care. We strongly believe that the best medical service is based on a friendly, mutual understanding between the doctor and the patient. With all the changes to medical Insurance and the healthcare field, our office is asking patients to be in charge of confirming with your insurance carrier if our providers are preferred or participating providers for your insurance plan. If your insurance requires a referral or authorization for you to see a specialist, you are responsible for obtaining a referral from your primary care provider **before** being seen in our office. If you anticipate problems with your insurance coverage or personal payment, you are encouraged to contact our office. The earlier we know about a possible problem, the better we can develop suitable options for you.

Agreement

This is an agreement between Dr. Shannon Mueller / Dr. Nicole Mueller and the patient named on this form. By executing this agreement, you the patient, are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. All balances are expected to be paid in full upon receipt of this statement. A fee of $10.00 will be added each time we have to send more than one statement to collect a balance.

Insurance: Insurance is a contract between you and your insurance company.

- The Insurance company makes the final determination of your eligibility.
- You agree to pay any portion of the charges not covered by your insurance.
- Insurance filing is done as a courtesy to you. It does not dismiss your responsibility to pay for services.
- If the insurance does not pay 45 days from the time of services are rendered, the balance may be billed to you.
- You may choose to pay for services in full and file yourself with your insurance company.

Required Co-Payments: Any co-payment required by an insurance company must be paid at the time of service.

Returned Checks: There is a fee of $25.00 for checks returned by the bank. If a returned check is received on your account, you will be required to pay all fees associated with this check. All future visits will need to be paid in cash prior to being seen.

Past Due Accounts: If your account becomes past due, we will take steps to collect this debt. If we are forced to, we will refer your account to an outside collection agency.

Disputes: You should notify us of discrepancies with your balance immediately. We will investigate and resolve your dispute within 30 days.

Missed Appointments with Dr. Mueller: When a patient does not show for an appointment or cancels with less than 24-hour notice, the patient may be subject to a $25.00 fee. This fee would be due prior to rescheduling.

_____ _____

Patient Name Date of Birth

_____ _____

Signature Date

Brazos Foot & Ankle Clinic
Shannon R. Mueller, DPM

Insurance authorization and assignment:

I request that payment of medical benefits be made on my behalf to Brazos Foot & Ankle Clinic for any services furnished to me.

I authorize Brazos Foot & Ankle Clinic to release any medical or other information needed to process my claims.

In the case of a Medicare claim, my signature authorizes Brazos Foot & Ankle Clinic to release to Medicare, medical and non-medical information, including employment status, and whether I have employer group health insurance, liability, no-fault, or other insurance which is responsible to pay for the services for which the Medicare claim is made.

Private pay patients:

By signing below I acknowledge my financial responsibility for services rendered by Brazos Foot & Ankle Clinic. I understand that payment is due at the time of service unless prior arrangements have been made.

Financial policy:

I have reviewed a copy of the financial policy from Brazos Foot & Ankle Clinic.

By signing below, I acknowledge that I have read, understood and agree to the Insurance Authorization and Assignment, the Private Pay (if applicable), and Financial Policy:

_____ _____

Patient/parent/guardian signature **Date**

Brazos Foot & Ankle Clinic
Shannon R. Mueller, DPM

HIPAA ACKNOWLEDGMENT

Due to the **HIPAA Compliance Privacy Laws of the Federal Government**, it is mandatory that we ask you to review and answer the following questions.

In the event a family member or caregiver attends my office visit and is in the exam room at the time of any evaluation and/or treatment, I give Brazos Foot & Ankle Clinic and its physician or employees my permission to discuss freely my condition, treatment, or diagnosis with that person. *(please circle your answer*)**YES / NO**

HOME PHONE: _____ MAY WE LEAVE A MESSAGE **YES / NO**

WORK PHONE: _____ MAY WE LEAVE A MESSAGE **YES / NO**

CELL PHONE: _____ MAY WE LEAVE A MESSAGE **YES / NO**

***(please circle your answers to the above statements/questions*)**

With whom may we discuss or release information about your care, treatment or diagnosis?

_____Relationship _____Phone Number _____

_____Relationship _____Phone Number _____

Are either of these people your Power of Attorney for medical or financial purposes?

_____

I authorize Brazos Foot & Ankle Clinic to obtain or release my medical or insurance information as necessary to assist with my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions or to process my medical claims.

I understand that I may revoke or amend this authorization by requesting so in writing.

_____
Signature of Patient or Legal Guardian of Power of Attorney

_____
Printed name

_____
Date