2681 Gattis School Rd Ste 220
Round Rock, TX 78664
P: 512-843-0770
F: 512-843-0648

Patient Demographics

Name (First Middle Last): ____

Home Address: __________________________City: ___________ State: ____ Zip: ______

DOB: _________ Age: _____ Gender: _______ Relationship to Patient: ___________________

Primary Care Provider

Primary Care Physician: ____________________________ Phone: ____________________

Address: ____________________________City: _____________ State: ____ Zip: _______

Contact Information

Home: __________________ Cell: _________________ Work: __________________

Email: ____

Pharmacy Information

Pharmacy: ____

Address: ____________________________City: _____________ State: ____ Zip: _______

Insurance Information

Self-Pay: Yes or No *** If Yes, skip section ***

Primary Insured Name: _____________________________________ DOB: ____________

*** Please skip section below if you have provided us with a copy of your insurance card ***

Primary Insurance Company Name: ____

Type: ☐ HMO ☐ PPO ☐ Other: ____

Policy Number: _____________________ Group Number: __________________________

Secondary Insurance Company Name (If Applicable): _________________________________

Type: ☐ HMO ☐ PPO ☐ Other: ____

Policy Number: _____________________ Group Number: __________________________

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Emergency Contact Information

Name: ________________________ Relationship: _____________ Phone: ______________

Release of Personal Health Information:

Name: ________________________ Relationship: _____________ Phone: ______________

I authorize the above-named individual to receive and discuss personal health information from the provider and other staff members at Varni Foot and Ankle Care, PLLC. You may remove the name of this individual at any time with a written request.

_____________________________ ______________________________ _____________

Patient Name Signature Date

How Did You Hear About Us? ____

VARNI
FOOT & ANKLE CARE

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Current Problem:

What brings you in today? ____

Current Weight: _______ lbs. Height: ____ft. ____ in. Shoe Size: ___________

Medical History

Select all that apply

Alzheimer's	COPD	Kidney Disease
Anxiety/ Depression	Dementia	Migraines/ Headaches
Arthritis	Diabetes Type 1 or 2	Multiple Sclerosis
Asthma	Fibromyalgia	Neuropathy
Autoimmune Disorders	GERD	Osteoporosis
Back Trouble	Gout	Rheumatoid
Bleeding Disorder	Heart Attack	Sickle Cell Disease
Blindness	Heart Disease	Stomach Ulcers
Blood Clots/ DVT	Hepatitis	Stroke
Bronchitis/ Emphysema	High Blood Pressure	Thyroid Disease
Cancer: Type__________________	High Cholesterol	Use of Steroids past 6 months
Chronic Pain	HIV/AIDS	Valvular Dysfunction

Other: ____

Allergies

Select all that apply

Penicillin Latex Sulfa Codeine Gluten Shellfish

Other: ____

Surgical History

Please indicate year

___________________________ ____________________________ __________________________

___________________________ ____________________________ __________________________

___________________________ ____________________________ __________________________

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Social History

Current Occupation: ____

Marital Status: ☐Single ☐Married ☐Widow ☐Divorced ☐Other ______________________

Smoking: ☐ Never ☐Former: ____ Years; Quit Year: ____ ☐Active: Start Year: _____ Quantity: ____

Alcohol: ☐Never ☐Once a week ☐2-3 Times a week ☐Greater than 3 Times a week

Family History

Medical Conditions/Relationship: ____

____

Medications

Please indicate name and dosage. You may provide a separate list, if available

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

Review of Systems

(Circle all that apply)

System	Symptoms
General	Fever Chills Weight Loss Weight Gain Fatigue
Eyes	Blurry vision Visual disturbances Headaches
Ears, Nose, Throat	Ringing Hearing Problems Difficulty Swallowing Sore Throat
Cardiovascular	Chest Pain Palpitations Leg Swelling
Respiratory	Wheezing Shortness of Breath Cough
Gastrointestinal	Heartburn Abdominal Pain Diarrhea Constipation Nausea Vomitting
Urinary	Painful Urination Bladder Leakage
Musculoskeletal	Joint Pain Swelling Stiffness Back Pain Arthritis Muscle Weakness
Skin	Rash Lesions Itching Redness Wounds Dryness
Neurological	Numbness of hands/feet Seizures Tremors Paralysis Dizziness
Psychiatric	Depression Anxiety Trouble Sleeping Memory Loss
Hematology	Easy bruising Abnormal bruising

Other ongoing issues: ____

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Financial Policy for Varni Foot and Ankle Care, PLLC

Thank you for choosing **Varni Foot and Ankle Care** as your health care provider. Please carefully read each statement and sign below. This policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care for our patients. It is important that we work together to ensure that payment for services is as simple and straightforward as possible. Our practice manager or billing department will be glad to discuss these policies with you.

1. I understand that if I do not have my insurance card, referral, and/or copayments, my appointment may be rescheduled until such time that I can provide the required documents or payments.

2. I understand that **Varni Foot and Ankle Care** will collect all copayments at the time of visit and any procedure deductibles and coinsurance up to an amount equal to payment in full for the planned procedure code. Payment in full and expected coinsurance payment responsibility are determined by the anticipated billing code(s), details of your Insurance policy, and agreement between your insurance company and **Varni Foot and Ankle Care.**

Any overpayment to your account will be refunded to you at your request after payment and/or remittance has been received from your insurance company.

3. I understand that a $25 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds (cashier's check, money order, or cash.)

4. I understand that if I am unable to make a scheduled appointment, I need to contact **Varni Foot and Ankle Care** at least 24 hours before my scheduled appointment time. Due to a high demand for appointments, missed appointments prevent us from scheduling appropriately and keep others in need of urgent care from being seen. A $25 FEE MAYBE BE ASSESSED FOR ALL MISSED APPOINTMENTS NOT CANCELLED WITH AT LEAST 24-HOUR ADVANCED NOTICE.

5. I understand that if my accounts are not paid for in full within 90 days of the statement date, a 35% collection agency processing fee will be added to the outstanding balance and will be turned over to collections for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

6. **Varni Foot and Ankle Care** will allow 60 days from the date of filing for my Insurance company to process or pay a claim. It is my responsibility to provide my insurance company with requested

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Information needed to process a claim for services. It is also my responsibility to notify **Varni Foot and Ankle Care** if there is any change in my insurance coverage, residence, or phone number. ULTIMATELY, IT IS UP TO ME TO KNOW MY INSURANCE BENEFITS.

I have read and agree to all the provisions of the above financial policy. I understand that I am ultimately responsible for all professional fees incurred for professional services performed by the attending physician.

____	_________________________	___________
Full Name of Patient or Authorized Representative	**Signature**	**Date**

____
Relationship to Patient

Assignment of Benefits

We require insured patients to complete assignment of benefits authorizing insurance to remit payment to physician's office.

I hereby assign all medical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plans to: **Varni Foot and Ankle Care**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges where or not paid by said insurance. I hereby authorize said assignee to release all medical information necessary to secure the payment.

____	_________________________	___________
Full Name of Patient or Authorized Representative	**Signature**	**Date**

____
Relationship to Patient

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Acknowledgement of Receipt of Notice of Varni Foot and Ankle Care PLLC's Notice of Privacy Practices and Consent For Use And Disclosure Of Health Information

By signing this form, you acknowledge you were advised of the HIPPA Notice of Privacy Practices of Varni Foot and Ankle Care, PLLC. Our HIPAA Notice of Privacy provides information about how we may use and disclose your protected information. We encourage you to read it in full. Our Notice of Privacy Practices is subject to change. You may request a copy of the Notice of Privacy. This consent is voluntary, and you may refuse to sign it, the provider may refuse to treat me.

____ ___________________________ ____________
Full Name of Patient or Authorized Representative **Signature** **Date**

____ (**Relationship to Patient)**