Ulla Britt Larka, DPM

Patient Information Sheet

Attention: Please fill out this form COMPLETELY, write N/A where applicable and sign it. Thank you.

Social Security#

Welcome to our Office…

2041 West Alabama
Houston, TX 7708

First Name: **Last Name**: **Middle Initial:**

Date of Birth: (MM/DD/YYYY) **Age:** **Gender:** ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Other
Language: _____ **Ethnicity:**_____
Race: _____

E-Mail Address:

Address: **Apt.#:** **City:** **State:** **Zip:**

Home Phone: **Work Phone:** **Mobile Phone:**

Emergency Contact: **Emergency Telephone#:** **Relationship to patient:**

Employer Name: **Employer's Address / City / State / Zip**

Contact Preference: Home/ Work/ Mobile/ Portal/ Email

Referred by: **Referred Person's Address / City / State / Zip** **Phone: ( )**

Primary Care Physician: **Primary Care Physician's NPI:** **Phone: ( )**

Pharmacy Information
Name:
Phone:
Crossroads:

PRIMARY Insurance Company Information:

Policy Holder First Name & Last Name:

Policy Holders SS# **Policy Holders Date of Birth:**

Gender: ☐ Male ☐ Female **Relationship to Policy Holder:** ☐Self ☐Spouse ☐Child ☐Other

Policy Holder's Address: ☐ **Same as patient**

City: **State:** **Zip:**

Insurance's Name:

Policy ID: **Group #:**

Claim Submission Address:

Effective Date: _____ / _____ / _____

Do you have a Co-pay? ☐ No ☐ Yes, Amt $_____

Referral Required: ☐ **Yes** ☐ **No**

SECONDARY Insurance Company Information:

Policy First Name & Last Name:

Policy Holders SS# **Policy Holders Date of Birth:**

Gender: ☐ Male ☐ Female **Relationship to Policy Holder:** ☐Self ☐Spouse ☐Child ☐Other

Policy Holder's Address: ☐ **Same as patient**

City: **State:** **Zip:**

Insurance's Name:

Policy ID: **Group #:**

Claim Submission Address:

Effective Date: _____ / _____ / _____

Do you have a Co-pay? ☐ No ☐ Yes, Amt $_____

Referral Required: ☐ **Yes** ☐ **No**

Responsible Party Information – *Please complete if the responsible for payment is not the Patient or the Policy Holder.*

Responsible Party's Name (Last / First): **Responsible Party's SSN:** **Relationship to Responsible Party:** ☐Self ☐Spouse ☐Child ☐Other

Responsible Party's Address / City / State / Zip:

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENDENTS OR MYSELF. I UNDERSTAND THAT IT IS AS A COURTESY THAT THE DOCTOR ACCEPTS MY INSURANCE FOR PAYMENT AND THAT IF FOR ANY REASON THEY DO NOT PAY MY BILL THAT I AM RESPONSIBLE.

☐ **I have received the Confidentially Agreement (HIPAA) and agree to comply with all its terms.**
☐ **To the best of my knowledge, the above information is complete and accurate.**
Today's Date:_____ Patient's Signature: _____

Ulla Britt Larka, DPM

Podiatry History

What is the chief concern for which you came to be treated?

_____

_____

When did you notice the problem?_____

Any Other Concerns? _____

_____

Have you ever been to a Podiatrist before? ☐Yes ☐No

If yes, please list:

Name _____Last Visit _____

Is there any personal or family history of diabetes? ☐Yes ☐No

Your occupation _____

Activities in which you participate (frequency):

_____

_____

Please indicate which foot problem you now have or have

Ankle Pain ……....	☐Yes	☐No
Arthritis ……..	☐Yes	☐No
Athlete's Foot ……	☐Yes	☐No
Corns and Calluses ……	☐Yes	☐No
Cramps or Numbness in Feet or Legs …	☐Yes	☐No
Arch Problems..……..	☐Yes	☐No
Foot or Leg Cramps ……..	☐Yes	☐No
Gout ……...	☐Yes	☐No
Heel Pain ……	☐Yes	☐No
Ingrown Toenails ……...	☐Yes	☐No
Plantar Warts ……	☐Yes	☐No
Swelling in Ankles or Feet ……	☐Yes	☐No
Tired Feet ……...	☐Yes	☐No

What makes it better? _____

_____

What makes it worse? _____

_____

Medical History

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐Yes	☐No	Circulatory Problems	☐Yes	☐No	Phlebitis	☐Yes	☐No
Allergies to Anesthetics	☐Yes	☐No	Diabetes	☐Yes	☐No	Psychiatric Care	☐Yes	☐No
Allergies to Medicine or Drugs	☐Yes	☐No	Ear Problem	☐Yes	☐No	Radiation Treatment	☐Yes	☐No
Allergies to Latex	☐Yes	☐No	Epilepsy	☐Yes	☐No	Rash	☐Yes	☐No
Allergies to Penicillin	☐Yes	☐No	Eye Problem	☐Yes	☐No	Respiratory Disease	☐Yes	☐No
Anemia	☐Yes	☐No	Fainting	☐Yes	☐No	Rheumatic Fever	☐Yes	☐No
Angina	☐Yes	☐No	Foot or Leg Cramps	☐Yes	☐No	Shortness of Breath	☐Yes	☐No
Arthritis	☐Yes	☐No	Gout	☐Yes	☐No	Sinus Problem	☐Yes	☐No
Artificial Heart Valves or Joints	☐Yes	☐No	Headaches	☐Yes	☐No	Special Diet	☐Yes	☐No
Asthma	☐Yes	☐No	Heart Disease	☐Yes	☐No	Stroke	☐Yes	☐No
Back Problems	☐Yes	☐No	Hemophilia	☐Yes	☐No	Swelling in Ankle, Feet	☐Yes	☐No
Bleeding Disorders	☐Yes	☐No	Hepatitis or Jaundice	☐Yes	☐No	Swollen Neck Glands	☐Yes	☐No
Cancer	☐Yes	☐No	High Blood Pressure	☐Yes	☐No	Tired Feet	☐Yes	☐No
Chemical Dependency	☐Yes	☐No	Kidney Problems	☐Yes	☐No	Tuberculosis	☐Yes	☐No
Chest Pain	☐Yes	☐No	Liver Disease	☐Yes	☐No	Ulcers	☐Yes	☐No
Chronic Diarrhea	☐Yes	☐No	Low Blood Pressure	☐Yes	☐No	Varicose Veins	☐Yes	☐No
Cigarette/Tobacco Use	☐Yes	☐No	Neuropathy	☐Yes	☐No	Venereal Disease	☐Yes	☐No

Surgeries/Hospitalization you have had _____

_____

_____

Family Physician _____ Last Visit Date _____

Are you now, or have been, under any other doctor's care for any reason over the past two years? ☐Yes ☐No

If yes, please explain _____

Medications

Include prescriptions, over-the-counter medications and vitamins: _____

_____

_____

Pharmacy Name(s) _____

Pharmacy Phone(s) _____

Allergies

☐ Adhesive/Tape
☐ Anticoagulant Therapy
☐ Aspirin
☐ Demerol
☐ Iodine
☐ Other: _____
☐ Local Anesthetics
☐ Novocaine
☐ Seafoods
☐ Sulfa

Payments: Patients are responsible for all fees including missed visits and returned checks. Interest and late fees may apply on past due balances. Payment is expected at the time services are rendered. Payments exceptions must be arranged before treatment.

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to provide podiatric services, and medicines, submit my insurance form, consider my signature "on file" for payment, and to release any & all records needed. I understand the privacy policy, and have read and understand the above and agree to be personally responsible for all charges & fees.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

****Please sign and date each item below****

ACKNOWLEDGEMENT AND AUTHORIZATION:

1. **I have read and understand the HIPAA/Privacy Policy for Ulla-Britt Larka, DPM PA**

   Signed:_____ Date:_____

2. **I hereby assign my insurance benefits to be paid directly to the healthcare provider**

   Signed:_____ Date:_____

3. **I authorize Ulla-Britt Larka DPM PA to release medical information required to process my claim**

   Signed:_____ Date:_____

4. **I have read and understand the Financial Policy for Ulla-Britt Larka DPM PA**

   Signed:_____ Date:_____

5. **I authorize Ulla-Britt Larka DPM PA to obtain/have access to my medication history**

   Signed:_____ Date:_____

6. **I authorize my provider's office to contact me by mobile phone**

   Signed:_____ Date:_____

Ulla-Britt Larka, DPM
PODIATRIST

Medical & Surgical Specialist of the Foot

Assignment and Release/Financial Responsibility

Payment is due at the time of visit including copay unless otherwise arranged. A $10 fee will be assessed for all copays that are billed and not paid at the time of visit.

What is a copay?
A copay is the small amount you have to pay to access medical care according to your insurance contract. In some cases, it might range from $5-$50 or with some insurances, it would be a percentage of your bill (10% is common). This is supposed to provide a slight incentive for you to visit the doctor less and thereby avoid overuse of medical services. Medicare patients don't pay a copay "upfront", but they are responsible for a small portion of the bill.

What is a deductible?
A deductible is the amount of money that a patient must pay out of pocket before the insurance carrier is responsible for any charges. The average deductible ranges from $100-$1500 and once this has been met, the insurance company will begin to pay for covered services. Medicare patients are responsible for a small deductible at the beginning of each year.

Why do I have to pay my copay and/or deductible?
When you sign up with an insurance carrier, you basically sign a contract which stipulates that you are obligated to pay your copay and/or deductible in certain instances. That usually means that you are required to pay a copay and/or deducible for all office visits, including follow-up examinations and outpatient surgical procedures done in our office, etc.…

Why do you collect the copay instead of billing me like my last doctor?
It is much more efficient to collect the copay at the time of service. Otherwise, it becomes more difficult and expensive to deal with administratively. It needs to be entered in the computer, bills must be mailed, and our billing person will need to track the account for payment, etc.… Higher administrative costs in the office ultimately result in higher medical costs for the patient. This policy is not something we can negotiate or change.

Why can't you just "write off" my copay and/or deducible?
There are several reasons why this is not a good idea. First, since your insurance "contract" stipulates that you must pay a copay and/or deductible, waiving this fee violates your contract. Second, when we sign up with your insurance company, we also sign a contract that says we will collect copays and /or deductibles as stipulated in the contract. Third, if the doctor gives you a discount by waiving your copay and/or deductible and then bills the insurance company without giving them the same "discount", it could be considered insurance fraud. Thus, many medical billing consultants say that if you waive the copay, you cannot bill the insurance company. This rule has effectively eliminated "professional courtesy" which existed when I was a kid. Doctors used to routinely treat each other and their families "for free", but since everyone is insured these days, everyone must pay a copay.

I, the undersigned certify that I (or my dependent) have insurance with_____
Name of Insurance(s) Company (ies)

and assign directly to Ulla-Britt Larka, DPM, PA, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am personally responsible to pay all charges that are not covered by my insurance, including but not limited to, copays, deductibles, and non-covered services such as Orthotics or any other materials dispensed in the office. I am responsible if I do not have a referral for my visit if I am an HMO patient. This applies even if a verbal referral has been given. I further understand that I am responsible for any collection and/or legal fees incurred in the collection of any past due charges. I hereby authorize the doctors to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____	_____	_____
Responsible Party Signature	**Relationship**	**Date**

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you
have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare
operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health
Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous
usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not
be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____