Dr. Randy Lisch D.P.M. | 9012 Research Blvd Suite C-13 | Office: 512-450-0101
Dr. Harvey Lisch D.P.M. | Austin, Texas 78758 | Fax: 512-450-0086

Patient Information	Phone Numbers
Patient:	Home:( ) -
Address	Cell:( ) -
City State Zip	
Date of Birth: / /	In case of Emergency, Contact:
Sex: M or F Single Married	Name:
Widowed Separated Divorced	Relationship:
Patient S.S. #: - -	Home Phone:( ) -
	Work Phone: ( ) -
Occupation:	Cell Phone: ( ) -
Employer:	
Work Phone:( ) -	Spouse Name:
Ext:	Birthdate: / /
	S.S.#: - -
	Employer:

Insurance	
Do you need referrals to see Dr. Lisch?	Yes No
Who is responsible for this account?	
Relationship to patient:	
Insured's Name:	Birthdate: / /
Insured's S.S. #	
Insurance Co.	Group #:
Address:	Phone #:( ) -
Medicare #:	

ASSIGNMENT AND RELEASE/ CONSENT

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Randy L. Lisch, DPM, P.A., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. All outstanding accounts will be settled within 45 days ($50.00 additional charge for accounts turned over for collection). I authorize the use of this signature on all insurance submissions.

I certify that the information on these forms is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures as deemed necessary in the diagnosis and/or treatment of the above named patient's feet or foot condition.

Responsible Party signature____ Date____/____/____

** If for any reason this appointment cannot be kept, please notify us at least one day in advance. Patients who fail to notify this office of a canceled appointment within 24 hours of their scheduled visit will be charged $50.00. **

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Podiatric History

What is the chief complaint(s) for which you requesting treatment, and when did it start?

Have you had foot treatment before? No Yes :By whom?

For what?

Referring Doctor's Name: Phone #:( ) -

Ht. Weight Shoe Size Occupation:

Is there any personal or family history of Diabetes No Yes-- Who?

Do you Smoke? No Yes, PPD

Do you Drink Alcohol? No Yes, Quantity / day

Do you currently or previously had a history of Drug Abuse? No Yes

Please check the foot problems you have had or have had in the past:		Allergies	
Ankle pain	Athletes foot	Adhesive tapes	Local anesthetics
Bunions	Corns/Calluses	Codeine	
Flat feet	Foot/leg Cramps	Penicillin	Other:
Heel pain	Ingrown toenails	Sulfa	
Plantars warts	Swelling in feet	Demerol	
Tired feet		Iodine	

MEDICATIONS

MEDICAL HISTORY

Circle or check the "yes" or			"no" to indicate if you have had			any of the following:		
Aids/ HIV	Yes	No	Diabetes	Yes	No	Osteoporosis	Yes	No
Anemia	Yes	No	Ear Problems	Yes	No	Psychiatric Care	Yes	No
Angina	Yes	No	Epilepsy	Yes	No	Phlebitis	Yes	No
Arthritis	Yes	No	Fainting	Yes	No	Radiation Treatment	Yes	No
Artificial heart valves			Gout	Yes	No	Respiratory diseases	Yes	No
or joints	Yes	No	Headaches	Yes	No	Shortness of breath	Yes	No
Asthma	Yes	No	Heart disease	Yes	No	Sinus problems	Yes	No
Back Problems	Yes	No	Hemophilia	Yes	No	Sickle cell anemia/trait	Yes	No
Bleeding disorders	Yes	No	Hepatitis/ Jaundice	Yes	No	Stroke	Yes	No
Cancer	Yes	No	High blood pressure	Yes	No	Thyroid: Hyper	Hypo	Normal
Chemical Dependency	Yes	No	Kidney problems	Yes	No	Tuberculosis	Yes	No
Chest Pain	Yes	No	Liver disease	Yes	No	Ulcers – stomach	Yes	No
Chronic Diarrhea	Yes	No	Low blood pressure	Yes	No	Varicose veins	Yes	No
Circulatory Problems	Yes	No	Nervous problems	Yes	No			

OTHER

***General Childhood Diseases: (Please check):** Measles Mumps Chicken Pox

Scarlet Fever Rheumatic Fever Club Foot Polio

***Number of Childbirths:** **Are you currently pregnant?** Y or N Currently Breast Feeding? Y or N

***Are you now or have you been under any other doctor's care over the past two years?**

Y or N If yes, please explain:

*Past Surgeries and Hospitalizations:	Athletic activities in which you participate

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Office Policy on Durable Medical Equipment

Our office aims at a goal of the highest level of medical care, at times it is extremely difficult to balance your needs as a patient along with the requirements and stipulations in your health plan. We pride ourselves on doing everything possible to work within the guidelines of insurance carriers and managed health plans while providing that high level of care. Durable medical equipment costs continue to rise and subsequently insurance carriers have taken action to protect themselves from fraud and other abuses of insurance benefits. This makes it necessary for you to know your coverage. Often these products fall under exclusionary clauses and unmet deductibles. It then becomes a problem for our billing department to collect, what in some cases is a large sum of money, for equipment that cannot be returned and will not be covered by your insurance carrier.

Most times this equipment is patient specific and cannot be recycled or reused. For example, in the case of a custom molded shoe orthotics, this equipment cannot be used by anyone but that person.

Our staff will extend themselves at great lengths to help deal with these situations, but no insurance carrier will guarantee your benefits until claims are received. Most often these claims are not given attention until sometime after your office visit. As a result of the rising costs for durable medical equipment and the endless individual requirements of insurance plans regarding durable medical equipment, it has become necessary for this office to collect for these products at the time they are dispensed.

As a courtesy, our office will file the claim with your insurance carrier on your behalf. Responsibility for follow up with your insurance carrier for reconsideration of your claim will fall upon you as well.

I have read and understand the above stated office policy and agree to accept responsibility as described.

Patient Name ______________________________ Date ___________________

Social Security ______________________________

Patient Signature ____________________________

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Acknowledgement of Review of Notice of Privacy Practices

_____**Initial** – I have reviewed this office's ***Notice of Privacy Practices***, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document on request.

☐ I give permission to leave a message on my voicemail concerning my personal health information at the following number: _________________________________.

☐ I do not give permission to leave a message on my voicemail concerning my personal health information.

Disclosure to Families and Loved Ones

I authorize Randy L. Lisch, DPM, P.A. to disclose information to family and friends. (For example, you may prefer a family member or friend to be present in the exam with you, or you may prefer someone (i.e. spouse, parent, child) to be allowed to discuss your health care with us.) Without authorization, no information will be shared.

I request that my personal health information be shared with the following people:

_____________________	_____________________	_____________________
Name	Relationship	Phone Number
_____________________	_____________________	_____________________
Name	Relationship	Phone Number

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Financial Responsibility

- We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care. The following is a statement of our financial policy in order to reduce confusion and misunderstanding between our patients and practice, which we require you to read and sign prior to any treatment. If you have any questions regarding these policies, please discuss them with our office manager.
- Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept Visa, MasterCard and Discover.
- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement, and will only require you to pay the authorized co-payment, deductibles, and/or coinsurance at the time of service.
- If your insurance is one that we had an agreement with, but you do not present your insurance card at the time of service and we cannot verify your coverage, you will be required to sign a waiver of responsibility and payment in full will be expected at the time of service. You will be given a receipt to take with your insurance.
- If it is discovered, after the fact, that you did not present the current, correct insurance ID card at the time of service, you will be responsible for the charges if denied by your correct insurance company as "past the filing deadline"
- If you have insurance coverage with a plan for which we do not have a prior agreement, we will provide you with a receipt that includes all the necessary information for you to file to your insurance company. Your insurance company will send the benefit payment directly to you. Consequently, the charges for your care and treatment are due at the time of service.
- We do not file for **secondary insurance plans.** We will file only for the primary plan if we are contracted with them. The patient is responsible to file for their own secondary benefits.
- In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. If you disagree with your insurance company's determination, you must contact your insurance company directly.
- HMOs and some other insurance plans require an official referral/authorization number or form. It is your responsibility to know whether or not your insurance company requires one. If the patient presents without this authorization form and we have not received this in our office, you will be required to sign a waiver responsibility form, and full payment at the time of service will be expected.
- In the event of default on the patient's balance owed, for any reason, the patient (or guardian) will be responsible for a collection agency fee in the amount of $50. The patient will be charged $25 for each returned check, and $50 for missed appointments.
- **Minor Patients:** For all services rendered to minor patients, we will look to the adult accompanying the minor for payment. Payment arrangements must be made in advance for unaccompanied minors.

Thank you for understanding our financial policy

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

_________________________________ _____________________________________ __________________

Printed name of patient Signature of patient or responsible party Date