Dr. Joseph L. Yeargain, DPM
3801 Gaston Avenue, Suite 330
Dallas, Texas 75246
214.824.3851
dryeargain.com

YF&A

PATIENT NAME: _____ _____ ____ DOB : ___/___/_____ AGE: ___ SEX: M / F
LAST FIRST MI

HOME ADDRESS: _____ CITY/STATE: _____ ZIP: _____

HOME PHONE #: (____) _____-_____ WORK PHONE #: (____) _____-_____ SSN#: _____ -_____- _____

CELL PHONE #: (____) _____- _____ E-MAIL: _____

EMPLOYER: _____ OCCUPATION: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (____) _____- _____

PRIMARY CARE DOCTOR: _____ PHONE #: (____) _____- _____

PHARMACY: _____ LOCATION: _____ PHONE #: (____) _____- _____

WHO REFERRED YOU TO US? _____

PRIMARY INSURANCE: _____ SECONDARY INSURANCE: _____

ID#:_____ GROUP #:_____ ID#:_____ GROUP#:_____

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

_____

SHOE SIZE: _____ HEIGHT: _____ WEIGHT: _____

PLEASE LIST ALL **MEDICATIONS** YOU ARE CURRENTLY TAKING: _____

_____

_____

PLEASE LIST ALL PRIOR **SURGERIES:**

TYPE OF SURGERY YEAR

_____

_____

_____

SOCIAL HISTORY:

USE OF ALCOHOL: ☐ NEVER ☐ OCCASIONAL ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT/HOW LONG AGO? _____ ☐ SMOKE ____ PACKS/DAY FOR _____ YEARS

RECREATIONAL DRUGS: ☐ NEVER ☐ OCCASIONAL ☐ DAILY___

FAMILY MEDICAL HISTORY- PLEASE LIST ANY MEDICAL ISSUES THAT RUN IN YOUR FAMILY

MOTHER: _____ FATHER: _____

ALLERGIES: ☐ MEDICATIONS _____

☐ ANESTHESIA _____ ☐ FOODS _____

☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ METAL _____

☐ NONE ☐ OTHER _____

HAVE **YOU EVER** BEEN TREATED FOR ANY OF THE FOLLOWING CONDITIONS BELOW? IF NOT LISTED PLEASE LIST IN **OTHER.**

__ANEMIA	__GOUT	___HIV	__SEIZURES	__ARTHRITIS	__GLAUCOMA
__KIDNEY DZ	__STROKE	__ASTHMA	__HEART DZ	__BLEEDING DISORDER	__TB
__CANCER	__LIVER DZ	__ULCERS	__HIGH CHOLESTEROL	__DIABETES	__HIGH BP

OTHER: _____

I AUTHORIZE DR. YEARGAIN TO RELEASE ANY MEDICAL INFORMATION FOR PURPOSES OF DISABILITY, OR PROCESSING INSURANCE CLAIMS RELATED TO SERVICE. I AUTHORIZE PAYMENT OF INSURANCE BENEFITS TO DR. YEARGAIN FOR THE PERFORMANCE OF SERVICES. I ACKNOWLEDGE THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A HARD COPY OF TO DR. YEARGAIN'S NOTICE OF PRIVACY PRACTICES.

SIGNATURE: _____ DATE: _____

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Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- **Please initial on the lines below after reading**

_____ **There is a service fee of $25.00 for all returned checks**. Your insurance company does not cover this fee.

_____ **We do require that you give us 24 hours notice to cancel or change an appointment**. Your insurance company does not cover this fee. Fee must be paid prior to making your next appointment. (See appointment cancellation/no show policy, next page)

_____ **The fee for FMLA paperwork is $50.00**, and we reserve the right to take up to 5 business days to complete it. If FMLA paperwork is needed for surgery, please provide the FMLA paperwork prior to pre-op appointment.

Signature of Patient/Responsible Party: _____

Print Name of Patient/Responsible Party: _____ Date: _____

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Appointment Cancellation / No Show Policy

As a courtesy to our patients, we email confirmation of the appointment two days in advance, and we call to confirm each appointment at least day one in advance. This policy allows us to schedule patients that need immediate attention and to minimize loss from patients that do not show up to their scheduled appointments. However, it is the patient's responsibility to properly record and maintain all appointments at Yeargain Foot & Ankle, or to cancel in accordance with our cancellation policy.

Please be aware that a fee will be assessed for any appointments missed or cancelled with less than a **24 hour** notice. Failure to maintain an appointment or to cancel an appointment within an appropriate time frame denies our practice the ability to serve other patients. We understand that occasions might arise that will prevent you from coming to your appointment; we just ask that you let us know in advance, so that we can accommodate other patients.

This fee will be applied based on the amount of time that has been reserved for your care and will be assessed at the rates detailed below.

New patient appointment	**$100**
Follow up/Established appointment	**$50**

Note: If you arrive later than your recommended time of arrival, we will attempt to "work you in" to our schedule, without delaying other patients who were on time for their appointments. You will be seen as soon as possible, depending on the current patient flow.

If you are later than 15 minutes, or we cannot accommodate you on the same day, you will be rescheduled and will be subject to the fee mentioned above.

_____ _____/_____/_____

Signature of Patient/Legal Representative Date