PATIENT REGISTRATION FORM

Metroplex Foot & Ankle Center

Patient information *(please use full legal name, no nicknames, check all that apply*

First Name _____ MI _____ Last name _____

SSN___-___-___ Birth date _____ Gender ☐M ☐F Nickname _____

Address_____ City _____ State_____ Zip _____

Home Phone:_____ Work Phone_____ Cell Phone_____

Preferred Phone:_____ E-mail: _____ Mailing Address:_____

Race (check one): ☐ American Indian/Alaskan Native ☐Asian ☐Black/African American ☐More than one race

☐ Hawaiian ☐ Pacific Islander ☐ White/Caucasian **Preferred Language:** ☐English ☐ Spanish ☐ Other ____

Ethnicity: ☐Non-Hispanic/Latino ☐Cuban ☐Mexican/Mexican American ☐Other Hispanic/Latino ☐ Puerto Rican

Marital Status ☐S ☐M ☐D ☐W **Employer name and address:** _____

Referring Physician _____ Phone _____

Primary Physician (if different from referring) _____ Phone _____

Pharmacy (general location and phone): _____

☐ Albertsons ☐CVS ☐Kroger ☐Savon ☐TomThumb ☐Walgreens ☐Wal-mart ☐Other_____

Primary Insured Information

Relationship to Patient: ☐Self ☐Spouse ☐Parent ☐Other:_____

Last name _____ First Name _____ MI _____

Address_____ City _____ State_____ Zip _____

Phone: _____ Social Security_____-_____-_____ Birth date _____

Insurance information *(please allow receptionist to photocopy your insurance ID card)*

Primary insurance: _____ HMO PPO POS

Policy ID number: _____ Group number _____

Secondary insurance: _____ HMO PPO POS

Policy ID number:_____ Group number _____

Medicare/Secure Horizons Patients

Are you a resident of a ☐ Skilled Nursing Facility or ☐ Rehab Facility? Admit Date: _____

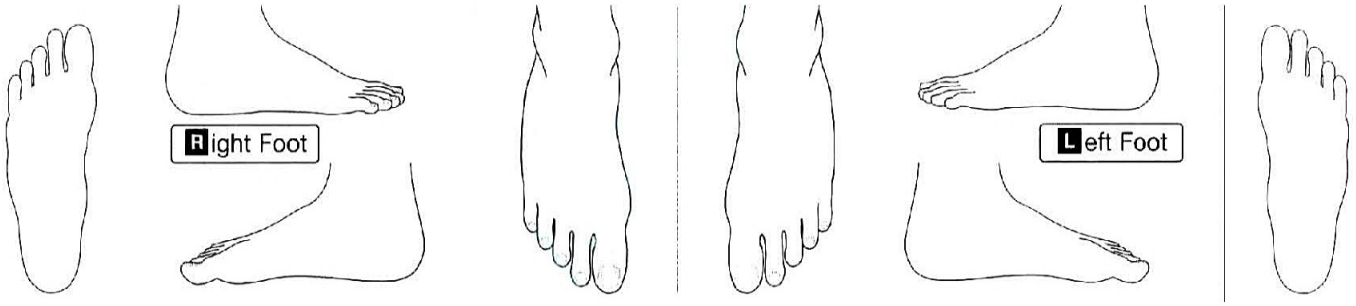
Name of Facility: _____ Phone# _____

Patient name: _____ DOB: _____ DOS: _____

What is the main reason for your visit: ☐ Diabetic Exam ☐ Nail Problem ☐ Numbness ☐ Pain ☐ Skin Problem
☐ Stiffness ☐ Swelling ☐ Weakness ☐ Other

Did you bring x-rays? ☐ Yes ☐ No

Please indicate below where your problem is:



In this section, check the ONE BOX which best describes how your problem started. Then answer the questions below the box you checked. Use as much space to the right as needed.

☐ **NO INJURY (Onset was:** ☐ Gradual or ☐ Sudden
Why do you think it started?

☐ **INJURY (☐ Sport ☐ Accident – NOT Auto or Work)**
Date _____ Where and how did it happen?
What sport? _____

☐ **INJURY AT WORK** Date _____
Briefly describe _____

☐ **AUTO ACCIDENT** Date _____

COMMENTS
_____
_____
_____
_____
_____
_____
_____

On a scale of 0-10 (10 is the worst), how severe is your pain?
(circle) 0 1 2 3 4 5 6 7 8 9 10

How long ago did it start? _____ Days _____ Weeks _____ Months _____ Years

Have you had a problem like this before? ☐ Yes ☐ No

What is the **quality** of the pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning
☐ Numb ☐ Other _____

This pain is ☐ Constant ☐ Comes and goes. **Does your pain wake you from sleep?** ☐ Y ☐ N

Since my problem started, it is: ☐ Getting better ☐ Getting worse ☐Unchanged

What makes your symptoms **worse**? ☐ 1st step in morning ☐ Standing ☐ Walking ☐ Lifting ☐ Exercise
☐ Stairs ☐ Sitting ☐ Twisting ☐ Other _____

What makes your symptoms **better**? ☐ Rest ☐ Elevation ☐ Ice ☐ Heat ☐ Other _____

What have you done to treat this? _____

Height: _____ **Weight:** _____ **Shoe Size** _____

ALLERGIES

Do you have any ALLERGIES to any medications? ☐Yes ☐No If yes, list below:

Which Medication?	**REACTION:**

Patient name: _____ DOB: _____

PAST MEDICAL HISTORY:

WHAT MEDICATIONS DO YOU TAKE? ☐ None ☐ See list

MEDICATION	DOSE	HOW OFTEN

PAST SURGICAL HISTORY: (List complications if any)

Surgery/ Year

FAMILY HISTORY: List relationship of family member with the following:

☐ Reaction of Anesthesia _____ ☐ Heart Disease _____ ☐ Diabetes _____

☐ Lung Disease _____ ☐ Kidney Disease _____ ☐ Rheumatoid arthritis _____

☐ Bleeding Disorder _____ ☐ Cancer _____ ☐ Liver Disease _____

Social History:

☐ Single ☐ Married ☐ Live alone ☐ Assisted living ☐ Other _____

Smoking ☐ Never # packs per day _____How long _____ When quit _____

Other Tobacco Products: ☐ Never Type _____

Alcohol ☐ Never ☐Social ☐ Daily ☐ Frequently

Illicit Drugs ☐ Yes ☐ No Type? _____

Occupation: _____ ☐ Student

PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS

☐ Anemia
☐ Anxiety
☐ Asthma
☐ Atrial Fibrillation
☐ Blood Clots in Veins
☐ Broken Bones
☐ Bronchitis
☐ Cancer
☐ Cataracts
☐ Change in skin
☐ Chest Pain
☐ Chills
☐ Chronic Back Pain
☐ Chronic Neck Pain
☐ Colon Polyps
☐ Congestive Heart Failure
☐ COPD
☐ Coughing Blood
☐ Covid - When _____
☐ Degenerative Arthritis
☐ Depression
☐ Diabetes _____
☐ Diarrhea
☐ Double Vision
☐ Eczema
☐ Emphysema
☐ Eye Pain
☐ Fever
☐ Fibromyalgia
☐ Frequent Urinary Infection
☐ Gallstones
☐ Glaucoma
☐ Gout
☐ Heart Attack
☐ Heart Murmur
☐ Heart Valve Disease
☐ Hemorrhoids
☐ Hepatitis
☐ Hernia
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV infection
☐ Incontinence
☐ Irritable Bowel Syndrome
☐ Joint Pain
☐ Joint Swelling
☐ Kidney Disease
☐ Kidney Stones
☐ Liver Disease
☐ Lupus
☐ Memory Loss
☐ Migraine Headache
☐ Multiple Sclerosis
☐ Muscle Weakness
☐ Nausea/Vomiting
☐ Neuropathy _____
☐ Night Sweats
☐ Numbness Tingling
☐ Osteoporosis
☐ Pneumonia
☐ Previous Ankle Surgery
☐ Previous Foot Surgery
☐ Psoriatic Arthritis
☐ Rash
☐ Rectal Bleeding
☐ Rheumatoid Arthritis
☐ Sciatica
☐ Seizures
☐ Serious Infection Where _____
☐ Shortness of breath
☐ Skin Cancer
☐ Stomach Ulcer
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis
☐ Ulceration
☐ Unexplained weight loss
☐ Vascular Grafts
☐ Weight loss
☐ Wheezing

PLEASE SIGN: The information is accurate to the best of my knowledge. _____

DISCLOSURE AND CONSENT FORM

Metroplex Foot & Ankle Center

Patient Last Name _____First Name _____ DOB: _____

Authorization for Medical Treatment:

I authorize the physicians in charge of the care of this patient to administer any treatment as may be necessary or advisable in the diagnosis and treatment of this patient. This authorization includes but is not limited to routine diagnostic procedures, laboratory tests, rehabilitation therapy and x-rays. I acknowledge that no guarantees have been made to be as to results of my treatments, tests or procedures. I also authorize copies of the medical records to be released to other physicians and health care facilities as deemed necessary by any physician whose care the patient is under.

Assignment of Benefits

I assign all benefits to and authorize direct payment of benefits to Metroplex Foot and Ankle Center, PLLC, all insurance benefits and or Medicare/Medicaid benefits to which I may be entitled. This assignment specifically included, but is not limited to, major medical and disability insurance proceeds and benefits. It also specifically includes proceeds and benefits accruing under any settlement, structured or otherwise or awarded in judgment for personal injuries caused by a third party. A photocopy of this assignment shall be as valid as the original.

Statement of Responsibility

I understand that I am financially responsible to Metroplex Foot and Ankle Center, PLLC as the patient, guardian, conservator, or insured for all charges not covered by the above assignment, which charges may include any medical insurance deductibles and co-insurance. I understand that to sign as a guarantor means that if the patient does not pay for all charges, I, as guarantor will be responsible for such payment.

Non-covered Medicare/Medicaid Services:

Medicare/Medicaid have certain outpatient procedures that are excluded from coverage, including but not limited to those of routing diagnostic workups or routine physical examinations. If the patient's medical chart indicates that the patient's treatment is one for which no Medicare/Medicaid benefits are allowable, I understand that all charges incurred during treatment will be the patient's own financial responsibility. There are other limitations and charges for which the patient may be responsible; the patient will be provided additional information with regard to these charges and limitations on a separate written form.

Authorization to Release information to Insurance Company/Third Party Payer:

I authorize Metroplex Foot and Ankle Center, PLLC and any physician, therapist, practitioner, pharmacist or other person, any hospital including Veterans Administration or government hospital, any medical service organization, any insurance company, or any other institution or organization to release any medical information about the patient necessary to determine any benefits which may be payable for this treatment.

Personal Valuables:

Metroplex Foot and Ankle Center, PLLC, shall not be liable for the loss of or damage to any personal property.

Consent for E-Prescribing & Medication History:

I authorize Metroplex Foot and Ankle Center and its providers o view my external prescription history via Surescripts prescription service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here. It may include prescriptions back in time for several years. I understand this will allow my providers to better coordinate my care and medication history to maximize the effectiveness and safety of my treatment plan.

The undersigned certified that he or she has read the foregoing or is the guarantor/guardian and is duly authorized by or on behalf of the patient to execute the above and accept its terms.

Patient or Guarantor Signature _____ *Date:* _____

Guarantor name (if different from above): _____

FINANCIAL RESPONSIBILITY FORM

It is your responsibility to provide us with your most current insurance in formation.
If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered. We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance comp any. We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company.

You are financially responsible for services not covered by your insurance company.
Before receiving services, you must verify that we are participating providers for your insurance company. In the event we are not participating providers, we will file the initial claim as a courtesy. Payment, however, is due in full at the time of service. We charge the usual and customary fees for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Copayments, coinsurance, and/or deductibles are due at the time of service. We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim regardless of our estimation.

It is your responsibility to provide us with your most current billing information.
You must provide your most current billing address, all available telephone numbers, and any other important contact information. If your address or contact information changes, it is your responsibility to contact us with the updated information. We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30 days after receipt of the initial statement. You can call (817) 595-1310.

Payment in full is due upon receipt of the statement.
Patient balances not paid in full within 30 days of the statement issue date are deemed past due. Past due accounts may be subject to a $5 .00 monthly late fee and/or a 1.5% monthly interest fee and may be referred to a professional collection agency and/or attorney for further collection activity. You will be responsible to pay all collection costs incurred, including attorney's fees and court costs if applicable.

If you are not able to pay the balance due in full, you must arrange a payment schedule. Any late fees already incurred on past due balances will be included in any mutually agreed upon arrangements. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney. You will be responsible for all collection costs incurred, including attorney's fees and court costs if applicable.

In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add $25.00 to your original balance. In addition, we may seek all additional legal remedies provided to us under Texas law. We may charge you a "No Show" fee of $75.00 if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date.

Failure to keep your account balance current may require us to cancel or reschedule your appointment.

Patient or Guarantor Signature:_____ Date:_____

Guarantor name (if different from above): _____

Steven G. Lund, DPM
Leslie R. Rousseau, DPM

Metroplex
Foot & Ankle Center

UPDATED No Show Fee
Effective 10/15/2025

We understand that you may sometimes need to reschedule appointments. When we make your appointment, please understand we are reserving time for you to see a provider. This courtesy makes it possible to give the best service here at Metroplex Foot and Ankle Center. If you need to reschedule an appointment, please call at least 24 hours in advance or call the clinic as soon as possible.
If you have no showed your appointment you will be charged a **$75 No Show Fee**. After three consecutive no shows to your appointment, our practice may decide to terminate its relationship with you.
We thank you for your trust in us here at Metroplex Foot and Ankle Center.
Patient Signature: _____Date:_____

Patient Form Fees

(The following fees are to be paid **prior** to completion)

FMLA & Short-term disability	$45
Medical Records	$35

NOTE:
-Forms may take up to 7 business days to be completed which may be affected if your physician is out of the office.
-IF you need to expedite (24-hour turnaround) any forms there will be an extra fee of $15 for each form. (Forms dropped off on a Friday will not be returned until the next business day)

Patient Signature: _____Date:_____

8704 Medical City Way, Fort Worth, TX 76177
Phone (817) 595-1310 Fax (817) 595-1321
www.metrofootankle.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Metroplex Foot & Ankle Center

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that Metroplex Foot and Ankle Center, PLLC, reserves the right to change their Notice of Privacy Practices and prior to implementation will post a copy in the physician office. I may request a copy of the updated Notice of Privacy Practices by calling the physician's office or requesting a copy in person at my appointment.

Patient or Guardian Signature _____ Date: _____

Guardian name (if different from above): : _____

The following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for Metroplex Foot and Ankle Center, PLLC. to share my protected health information with:

Name _____Relationship: _____

Name _____ Relationship: _____

Name _____Relationship:_____

Emergency contact _____ Emergency phone number _____