StrideCare

Paris Foot and Ankle
Dr. Michael S. Lenertz
Dr. Tracy A. Hjlemstad

Patient _____
Date of birth_____
Sex: ____Male ____ Female
___Single ___Married ___Divorced ___Widow
Social Security #_____
Primary doctor:_____
Referring doctor: _____
Address:_____
Mobile Phone _____
Home Phone:_____
Email Address: _____
Emergency Contact Name:_____
Phone Number:_____
Have you seen a podiatrist in the past:_____
If so, who:_____ Last visit_____
Pharmacy:_____

Who is responsible for this account:

_____
Relationship to patient:_____

I authorize the treating physicians Micheal Lenertz and Tracy Hjelmstad of Stride Healthcare to release medical information about me to the social security administration and health care financing administration or its intermediaries, or carriers, any information for this or a related medical claim I permit a copy of the authorization to be used in place of the original and request payment of medical insurance benefits to Michael Lenertz DPM, PA and Tracy Hjelmstad DPM, PA. Regulations pertaining to Medicare assignments of benefits apply.

Patient/ Gaurdian signature Date

I also authorize the same release of information to any medicare supplement insurance entities and further request payment of medical insurance benefits to the party who accepts the assignment.

Patient signature/guardian Date

Consent for treatment: I hereby give my consent for medical treatment by the physicians Michael Lenertz DPM, PA and Tracy Hjelmstad DPM.

Payment Policy: I understand that I am financially responsible for all charges, co-payments and deductibles remaining after insurance payment, and all charges no covered by my insurance company(ies), Medicare or third party payor.

Assignment of benefits: I assign to the treating physicians Michael Lenertz DMP, PA and Tracy Hjelmstad DPM, Stride Healthcare, and its affiliates, all payments for the services rendered to my dependents or myself or filed to the insurance on my behalf.

Patient/Gaurdian signature Date

I authorize the disclosure of any of my information to the following persons
Name:_____ Relationship_____
Name:_____ Relationship_____

Consent to Obtain Patient Medication History:
Patient Medication history is a list of prescription medications that our practice providers or other providers have prescribed for you. A variety of sources including pharmacies and health insurers contribute to this collection.

The collection is stored in the practice electronic medical record system and becomes apart of your personal medical records. Medication history is very important in helping health care providers treat your symptoms/illness properly.

It is very important that you and your provider discuss all your medications to insure your medication history is 100% accurate. Some pharmacies do not make drug history information available and your history might not include drug purchases without using your health insurance. Over the counter drugs, supplements, and herbal remedies that you take on your own will not be included.

I give permission to allow the health care provider to obtain my medication history from my pharmacy, health plan and other health care providers.

Patient/Gaurdian signature Date

Routine Foot care: Medicare allows you to come to the podiatrist every 62 days for the care of painful, ingrown, infected, inflamed toenails with signs of fungal infection. YOU WILL BE NOTIFIED prior to being seen if you presenting earlier than 62 days. An ABN will need to be signed with service performed and the approximate cost.

For diabetic patients YOU WILL NEED to have been seen by your primary doctor or endocrinologist within 6 months of your visit. If you have not seen your doctor in last 6 months of appointment services will not be covered.
I understand in the event that I do not qualify for coverage and still wish to be treated payment will be due at time of service.

Patient/Gaurdian Signature Date

Authorization for use and disclosure of Protected Health Information.
I hereby authorize Michael Lenertz DPM, PA and Tracy Hjelmstad DPM, PA and Stride Healthcare and its affiliates, its employees, and agents to use and disclose protected health information (information relating to the diagnosis, treatment, claims payment, and health care services provided to me and which identifies my name, address, social security number, member ID number) for the purpose of helping me to resolve claim and benefit coverage issues.

I understand that any personal health information or other information related to the person or organization identified above maybe subject to re-disclosure by such person/ organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice. However, this authorization may not be revoked if, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I understand that the information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign this authorization will not affect my eligibility for benefits or enrollment or payments for coverage of services.

I have been advised of this practice's Privacy Practices, Release of Billing information policy, Assignment of Benefits policy and grant the practice medication history.

Patient/Gaurdian Signature Date

Financial Policy and Disclosure
Patients are responsible for the payment of all services provided by Stride healthcare and its subsidiaries.

SELF PAY: All services rendered are charged to patient and not a insurance company, once you elect to self-pay the patient is responsible for all the charges. Stride care maintains a self-pay fee schedule for patients that do not have insurance coverage or opt out to not use their benefits.
Down payment is 75% of estimated charges and payment arrangements cannot extend longer than 3 months.

INSURANCE: We will file your insurance as a courtesy to you if we have complete and accurate insurance information. If services are not covered by your insurance company, you will be responsible for the charges for the time of service. Deductibles, copayments, and coinsurance will be collected at the time services are rendered.
In special cases we may need your help in contacting your insurance company for the payment of your services.

Responsible Party 's Signature Date

Consent for Photography
I give my consent to have my photo taken for my electronic records. On occasion you may be asked for a picture of your foot condition to take progress/healing.

Patient Signature/Gaurdian Date

StrideCare

Authorization for release of patient information

Name:_____
First MI Last

DOB:_____/_____/_____ Social Security Number_____

I, the undersigned, authorize the release or request access to the information specified below

_____
Physicians Name

_____
Physicians Address

Physicians Phone Number_____ Fax Number_____

From the above-named patient's medical records:

PATIENT INFORMATION IS NEEDED FOR:	INFORMATION TO BE RELEASED:
___ Continuing Medical Care	___ H&P
___ Insurance	___ Operative Reports
___ School	___ Xray Reports/ Imaging
___ Military	___ Progress Notes
___ Personal Use	___ Lab/Pathology
___ Social Security/Disability	___ Emergency Room Records
___ Legal Purposes	___ Care Plan
___ Other:_____	___ Consultation Report
	___ Face Sheet
	___ EKG
	___ Discharge Summary
	___ Other:_____

The above information may be released to:

Paris Foot and Ankle Clinic
Michael Lenertz DPM and Tracy Hjelmstad DPM
1055 Clarksville Street Suite 160
Paris, TX 75460
(P) 903-706-5254 and (F) 903-706-5540

I understand that my records are confidential and cannot be disclosed without written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that that the specified information to be released may include but is not limited to: history, diagnosis's, and/or treatment of drug and alcohol abuse, mental illness or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned to my signing of this authorization, except in certain circumstances such as for the participation of research programs or authorization of the release of testing results for pre employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that the action has been taken in reliance upon the authorization. I understand that I may be charged retrieval/ processing fee and for copies of my medical records according to the Texas Hospital Licensing Law.

This authorization will not expire unless I revoke the authorization in writing

_____ _____

Patient/Gaurdian Signature Printed Name of Patient Date

Patient Name:_____ DOB:_____

Medications you are allergic to:_____
Are you diabetic:_____ **if so what was your last a1c**____ **Dr treating your diabetes**_____
Marital Staus: married single divorced widowed separated domestic partner
Have you ever smoked:_____ How many years_____ packs per day_____ when did you quit smoking_____
Do you use smokeless tobacco_____ **Do you use a vape** _____
Do you drink alcohol: None Occasionally Moderately Heavy
Caffeine : None Occasionally Moderately Heavy
Do you use recreational / street drugs: _____
Do you exercise: None Occasionally Moderately Heavy
Occupation:_____

What is your reason for the visit:_____
How long ago did this start:_____ **Describe pain: BURNING/ DULL/ SHARP/ ITCHING/ STABBING/ NO PAIN**
How would you rate your pain on a scale of 1-10 _____ Shoe Size:_____ Height:_____ Weight:_____
Have you had recent xrays on your foot _____ **if so, when and where**_____

What makes your pain or problem worse (circle)
WALKING STANDING RESTING DRESS SHOES HIGH HEELS FLAT SHOES CLOSED TOE SHOES

Does anything make the pain feel better_____
Treatments tried for this problem _____
How has the problem affected your lifestyle or ability to work _____
Was this problem caused from a injury, if so, what_____
Is the pain in the _____ **left foot** _____ **right foot** _____ **Both feet**
Do you have a hard time climbing stairs_____
Do you use or limited to: Walker Cane Wheelchair
Do you have a history of falls in the last year:_____
Do you worry about falling:_____
Have you lost feeling in your feet: ____Yes ____ No **Do you wear compression socks:** ____ Yes ____ No
Do you wear custom orthotics: ___ Yes ____ No

List any and all surgeries that you have had in the past

_____
_____
_____

CIRCLE ANY PROBLEMS YOU HAVE OR TAKE MEDICATION FOR

AIDS/HIV	FROST BITE	NEUROPATHY
ALZHEIMERS	GOUT	ORGAN TRANSPLANT
DEMENTIA	HARD OF HEARING	OSTEOPOROSIS
ANEMIA	HEADACHE	PACEMAKER
ARTHRITIS	MIGRAINES	PAIN MANAGEMENT
ASTHMA	HEART DISEASE	PARKINSONS
BACK PAIN	HEPATITIS	PERIPHERAL VASCULAR DISEASE
BELLS PALSY	HIGH BLOOD PRESSURE	POLIO
BLEEDING DISORDER	HERNIA	RAYNAUDS DISEASE
CANCER_____	KIDNEY DISEASE	SEIZURES
CEREBRAL PALSY	LEG ULCERS	STROKE
CORANARY ARTERY DISEASE		TOENAIL FUNGUS
DIABETES	FOOT ULCERS	TOE AMPUTATION
DIALYSIS	LIVER DISEASE	THYROID DISEASE
EDEMA	LUNG DISEASE	TUBERCULOSIS
FIBROMYALGIA	MULTIPLE SCLEROSIS	TUMOR
FOOT DEFORMITY	HEART ATTACK	WARTS

List you medications and dosage

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

List any health problems for your family history

Mother: _____
Father: _____
Brother: _____
Sister: _____
Children: _____
Maternal Grandmother: _____
Maternal Grandfather: _____
Paternal Grandmother: _____
Paternal Grandfather: _____

Please mark where the pain is located: