



MCNT Fort Worth
Gary V. Bartholomew, D.P.M.
909 Ninth Ave., Suite 300
Fort Worth, TX 76104
p (817)366-7191 f (817)336-0142
email: gbfoot@aol.com

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date: \_\_\_\_\_

Your Occupation: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Shoe Size: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

I Prefer to be addressed as: Mr., Mrs., Ms., Dr., by first name: \_\_\_\_\_ other: \_\_\_\_\_

In case of emergency, whom may we contact? \_\_\_\_\_ phone: \_\_\_\_\_

Friend/Relative not living with you? \_\_\_\_\_ phone: \_\_\_\_\_

Your Pharmacy: \_\_\_\_\_ phone: \_\_\_\_\_

What Kind of Problem are you having?

- 1. Heel Pain
2. Arch Pain
3. Ankle Pain
4. Infection
5. Ingrown Nail
6. Fungus on Skin
7. Fungus on Nail
8. Injury to Foot
9. Corn/Callouses
10. Bunion
11. Hammertoes
12. Diabetes
13. Ulcers
14. Previous Foot Surgery

Where are you having this foot problem?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long have you had this problem?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What have you done for this problem?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

15. Other Foot Problem (please describe): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What kind of shoe do you wear most of the time? \_\_\_\_\_

Do you now or previously wear shoe inserts? \_\_\_\_\_

Do you now or previously wear orthotics? \_\_\_\_\_

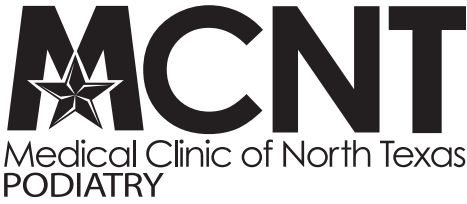
What foot problems have you been treated for in the past? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Who treated your foot in the past?

Podiatrist name: \_\_\_\_\_

Orthopedic name: \_\_\_\_\_



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Allergies: Circle each item that you have had a skin or other reaction to in the past:

- Aspirin
Morphine
Codeine
Demerol
Sulfa Drugs
Tylenol
Novacaine
Other anesthetics
Other: \_\_\_\_\_

Do you smoke: yes / no
If yes, how many packs? \_\_\_\_\_

Alcoholic beverages? (circle one)
None Rarely Moderately Daily Quit

Do you have or have you ever been treated for:
(circle all that apply)

- Stroke Hepatitis
Diabetes Epilepsy
Gout Vascular Disease
Asthma Liver Disease
Poor Circulation Nerve Disorder
Rheumatic Fever Stomach Ulcer
Kidney Disorder Headaches
High Blood Pressure Hearing Disorder
Anemia Thyroid Problem
Tuberculosis HIV
Psychiatric Disorder Bleeding Problem
Cancer Arthritis
Lung Disease Eye Disorder
Heart Condition Keloid/Scar
Leg Cramps Other: \_\_\_\_\_
Heart Attack \_\_\_\_\_

List Medication taken now and how much:

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

Are you currently pregnant? yes / no

Are you slow to heal after cuts? yes / no

Is there anything else we should know about your health? \_\_\_\_\_

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

Have any of your family members had similar and/or other disease? \_\_\_\_\_

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

## NEW PATIENT INFORMATION FORM

\_\_\_\_\_  
PHYSICIAN'S NAME

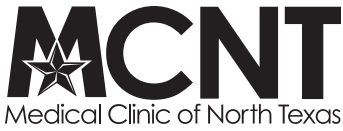
PATIENT'S FULL NAME		MAIDEN NAME	
ADDRESS		APT. #	PHONE NUMBER ( ) - EMAIL
CITY	STATE	ZIP CODE	WORK NUMBER ( ) - CELL NUMBER ( ) -
SEX <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> OTHER	<input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED
		DATE OF BIRTH	PATIENT'S SOCIAL SECURITY #
MM/DD/YY			
PATIENT'S EMPLOYER			
EMPLOYER'S ADDRESS			
SPOUSE/GUARDIAN'S NAME		WORK NUMBER ( ) - CELL NUMBER ( ) -	DATE OF BIRTH
			MM/DD/YY
SOCIAL SECURITY #			
EMPLOYER		ADDRESS	
IN CASE OF EMERGENCY CONTACT		RELATIONSHIP	PHONE NUMBER ( ) -
<b>ETHNICITY &amp; RACE (please complete both sections)</b>			
<b>ETHNICITY</b> PLEASE CHECK THE BOX BELOW THAT APPLIES TO YOU.  <input type="checkbox"/> HISPANIC OR LATINO  <input type="checkbox"/> NOT HISPANIC OR LATINO		<b>RACE</b> PLEASE SELECT THE RACIAL CATEGORY WITH WHICH YOU MOST CLOSELY IDENTIFY WITH:  <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> ASIAN OR PACIFIC ISLANDER <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> NATIVE HAWAIIAN <input type="checkbox"/> WHITE OR CAUCASIAN <input type="checkbox"/> OTHER PLEASE SPECIFY: _____	
<b>LANGUAGE PREFERENCE</b>			
WHAT IS THE PATIENT'S LANGUAGE OF PREFERENCE?			
<input type="checkbox"/> ENGLISH <input type="checkbox"/> SPANISH <input type="checkbox"/> OTHER <input type="checkbox"/> I WOULD PREFER NOT TO PROVIDE THIS INFORMATION.			

### INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize the Medical Clinic of North Texas, P.A. to release to my insurance carrier and/or their agents any information necessary to determine benefits payable for related services. I authorize the payment of medical benefits to the Medical Clinic of North Texas, P.A. I understand that I am ultimately responsible for all services whether covered by insurance or not. I also authorize my physician, based on his/her discretion, to access my chart for utilization management review.

DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_



# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

DATE TODAY: \_\_\_\_\_

NAME: \_\_\_\_\_ D.O.B. \_\_\_\_\_  
LAST FIRST M.I.

I have been provided with a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information. I understand the Medical Clinic of North Texas, P.A. reserves the right to change their Notice of Privacy Practices and prior to implementation will provide an updated copy on the clinic website, www.MCNT.com, and in the physician's office. I may request a copy of the updated Notice of Privacy Practices by calling my physician's office or requesting a copy in person at my appointment.

\_\_\_\_\_  
Patient/Legal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

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 Medical Clinic of North Texas, P.A. to share my protected health information with:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

**PARENT or GUARDIAN: Please fill out ONLY if the office visit is for a minor.**  
**MEDICAL CLINIC OF NORTH TEXAS, P.A.**  
**CONSENT TO MEDICAL TREATMENT OF A MINOR**

Date: \_\_\_\_\_

Parent's Name(s): \_\_\_\_\_ DOB: \_\_\_\_\_

Name of Person Giving Consent: \_\_\_\_\_

Relationship (Parent, Guardian, Managing Conservator of the child): \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ (Home): \_\_\_\_\_ (Cell): \_\_\_\_\_

To Whom It May Concern:

I hereby give my permission for **Medical Clinic of North Texas, P.A.**, and its physicians, nurse practitioners, physician assistants, and other associates to examine and treat my child whose name and age is listed below:

\_\_\_\_\_ who is \_\_\_\_\_ years of age.

Patient's Name

In addition, in the event that I cannot be contacted, I hereby give my consent to the following individuals or institutions to consent to medical treatment for the foregoing child.

\_\_\_\_\_  
Names of Individuals who have care and control over the foregoing child (e.g. babysitter, grandparent)

\_\_\_\_\_  
Names of Institutions (School, daycare, etc.)

**Consent to Counseling and Provision of Contraception.** Texas permits minors to be treated for sexually transmitted diseases and pregnancy without parental consent and as such, I understand that appointments may include discussion, testing and treatment of sexually transmitted diseases and/or pregnancy issues. Texas does not, however, permit a health care provider to counsel and provide contraception to minors without parental consent except under limited circumstances. Check **Yes** or **No** as to whether you consent to the counseling and prescription of contraception for the minor whose name appears above.

**Yes**, I consent to the counseling and provision of contraception to my child.

**No**, I do not consent to the counseling and provision of contraception to my child.

**X** \_\_\_\_\_  
**Signature of Parent, Guardian, or Managing Conservator**

Witnesses to Signature Above:

\_\_\_\_\_  
Name Address

\_\_\_\_\_  
Name Address

DATE TODAY: \_\_\_\_\_

NAME: \_\_\_\_\_ D.O.B. \_\_\_\_\_  
LAST FIRST M.I.

Thank you for choosing the Medical Clinic of North Texas, P.A. (MCNT) as your health care provider. We are committed to providing excellent health care services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of our financial policy.

### All patients must read and sign this form prior to receiving services.

- **It is your responsibility to provide us with your most current insurance information.**
- 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 company.
- If you have **Medicaid** coverage of any kind, you must notify us prior to your visit. This is part of your agreement with Medicaid, and **failure to notify us** of Medicaid coverage will result in full financial responsibility for services rendered.
- 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. It is also necessary that our primary care physician is listed as your primary care provider with your insurance company, if required by your contract with your insurance company. In the event we are not participating providers or our physician is not listed as your primary care provider with your insurance company, we will file the initial claim as a courtesy. Payment, however, is due in full at the time of service.
- We charge what is usual and customary 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) 514-5200** or **1-800-555-1429**.
- **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 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 contact our billing office to discuss 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.
- If your account is assigned to a professional collection agency, you will be notified by certified mail that you will no longer be able to receive services from any of the physicians at the Medical Clinic of North Texas, P.A. Failure to accept this certified letter (and/or to pick it up at the post office) serves as notice of termination of services.
- In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add \$25 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 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.**

Full payment is due at the time of service. We accept cash, checks and credit cards. I have read and understand this Financial Policy.

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date