Foot & Ankle INSTITUTE
www.txfai.com

Dr. Asia E. Lo
Foot and Ankle Specialist

Dr. Samuel S. Mendicino
Foot and Ankle Specialist

NEW PATIENT FORM

PLEASE COMPLETE ALL INFORMATION AND PRINT CLEARLY

Today's Date: _____ Social Security #: _____ Sex: ☐ Male ☐ Female

Marital Status: ☐ S ☐ M ☐ W ☐ D Birthdate: _____ Age: _____

Patient's Full Name: _____

Home Address: _____ City: _____ State: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

List your employer, or if filling this for a minor, please list parent's employment.

Employer: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____

In case of emergency, who may we contact?

Name: _____ Phone: _____

Who is your family doctor?

Name: _____ Phone: _____

Street Address: _____ City: _____ State: _____

How were you referred to us?

☐ Another Patient ☐ Friend/Relative ☐ Doctor ☐ Insurance Directory ☐ Internet

☐ Yellow Pages ☐ Newspaper ☐ Other _____

If referred by patient or doctor, what is their name? _____

Is this claim related to an accident? ☐ Yes ☐ No If yes, related to: ☐ Employment ☐ Personal ☐ Auto

Date of injury: _____

What are your symptoms for today's visit? _____

_____

Name of Pharmacy: _____ Phone: _____

PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST

West Houston Doctor's Center
12121 Richmond Ave.
Suite 415
Houston, TX 77082
Ph: (281) 531-4100
Fax: (281) 531-9600

WHMC Wound Healing Center
12606 West Houston Center Blvd.
Suite 160
Houston, Texas 77082
Ph: (281) 531-4100
Fax: (281) 531-9600

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To the best of my knowledge, the patient information I have provided is correct. I hereby give my permission to the Foot & Ankle Institute and its employees, to administer treatment and to perform such procedures as may be deemed necessary in the diagnoses and/or treatment of my foot/ankle condition.

Signature of patient (or parent if minor) _____ Date _____

SIGNATURE ON FILE:

I hereby authorize Centers For Advanced Foot Care d.b.a. the Foot & Ankle Institute to submit a claim to my insurance carrier or it intermediaries for all covered services rendered by the physician, and direct my insurance carrier or its intermediaries to issue payment check(s) directly to Centers For Advanced Foot Care. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information need to determine these benefits or the benefits payable for related services.

I understand that I am financially responsible to the Foot & Ankle Institute for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

Signature of patient (or parent if minor) _____ Date _____

MEDICAL RECORDS ACCESS:

I authorize Foot & Ankle Institute and its employees to have complete access to medical records from West Houston Medical Center or from any other hospital facility.

Signature of patient (or parent if minor) _____ Date _____

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Dr. Asia E. Lo
Board Certified in Reconstructive
Foot and Ankle Surgery
American Board of Foot and Ankle Surgery

Dr. Samuel S. Mendicino
Board Certified in Foot and Ankle Surgery
American Board of Foot and Ankle Surgery
Lower Extremity Peripheral Nerve Surgery

MEDICAL APPOINTMENT CANCELLATION / NO SHOW POLICY

Thank you for trusting your medical care to the Foot & Ankle Institute. When you schedule an appointment with the Foot & Ankle Institute, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Effective April 1, 2022 any new or established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours notice** will be considered a No Show and charged **a $ 25.00 fee.**
- The fee is charged to the patient, not the insurance company, and **is due at the time of the patient's next office visit.**
- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our office staff, who may be able to waive the No Show fee. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message. Messages left are acceptable.

Foot & Ankle Institute - (281) 531-4100

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

PATIENT SIGNATURE (OR PARENT/LEGAL GUARDIAN): _____

PRINTED PATIENT'S NAME: _____ DATE: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understood the Notice.

A COPY IS PROVIDED ON THE TABLE IN THE WAITING ROOM

Patient Name (please print) _____ **Date** _____

Parent or Authorized Representative (if applicable) _____

Signature _____

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