QC PODIATRY
FOOT AND ANKLE SPECIALISTS

NEW PATIENT FORMS

PLEASE PRINT LEGIBLY AND CLEARLY - ALL INFORMATION MUST BE COMPLETED

Last Name :_____ First Name:_____ MI: ____

Sex : M / F DL#:_____ SSN:_____ DOB:_____

Email: _____ Home Phone:_____

Cell Phone:_____ Street Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Pharmacy Name/address : _____

Phone Number :_____

EMPLOYER INFORMATION

Employer Name:_____ Work Phone:_____

INSURANCE RESPONSIBLE PARTY IF NOT PATIENT

Subscriber Name:_____ Subscriber DOB:_____

Relationship to Patient:_____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship:_____

Phone:_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I hereby authorize Foot and Ankle Specialist , to check for benefits on my behalf for covered services rendered. I request that payment from my insurance company be made directly to the doctor. I certify that the information I have reported regarding my insurance company is correct. **I will notify the office of any changes to my personal information and insurance**. If I am not covered by insurance at any time, I understand that I am financially responsible for services rendered. I understand that I am responsible for any amount not covered by insurance such as services not covered, deductible, coinsurance, and co-pays.

Co-pays, deductible and coinsurance are due at the time of service. This authorization may be revoked by either me or my insurance company at the time of writing.

_____ _____

Signature Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

We understand that medical information about you and your health is personal. As custodians of the information in your medical records, we are committed to protecting the privacy of your information as required by law professional accreditation standards and our internal policies and procedures.

A copy of your Notice of Privacy Practice will be kept in the chart. The notice explains your rights, our legal duties and our privacy practices. It also describes how much medical information about you may be used and disclosed and how you can get access to this information.

For your convenience the following is a summary of the information discussed in the notice

- Our Pledge
- Your personal Information
- Our Privacy Practices
- Your written permission
- Other Restrictions
- Changes
- Questions or complaints

We may use your information for:

- Treatment
- Health information exchanges
- Payment
- Health Care Operations
- Notifications
- Marketing Research
- Special circumstances & the law

Please understand that is summary is not our Notice of Privacy Policies, nor is it a substitute for the notice. We ask that you sign and return this cover letter to us for our records.

Printed Name _____ Signature _____ Date _____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to:
(Please write your insurance company name here)

Foot and Ankle Specialist
16405 Sand Canyon Ave., Suite 270
Irvine, CA 92618

OR, if my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

c/o Foot and Ankle Specialist
16405 Sand Canyon Ave., Suite 270
Irvine, CA 92618

For all professional or medical expenses benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.
This payment will not exceed my indebtedness to the above-mentioned assignee. I have agreed to pay, in a current manner, any balance of said professional service charge over and above this insurance payment.

I also authorize the release of any information pertinent to my account to any insurance company, adjuster, or attorney involved in this case. I further authorize the doctor to complain to the insurance commissioner or Department of Corporations on my behalf for any reason regarding my insurance

A photocopy of this Assignment shall be considered as effective and valid as the original.

Printed Name _____ Signature _____ Date _____

OC PODIATRY
FOOT AND ANKLE SPECIALISTS

NEW PATIENT FORMS

FINANCIAL / OFFICE POLICIES

Our Goal is to provide and maintain a good physician-patient relationship. Letting you know in advance about our financial/office policies. Please read the sections carefully.

According to your insurance plan , you are responsible for all co-payments,deductibles,and coinsurances

- We verify active status, copay, deductibles and co-insurances. It is the patient's responsibility to verify your podiatry benefits and make sure we are an in-network provider/practice
- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office
- 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 or if the claim is denied you are responsible for payment.

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 authorization, you will be responsible for charges for any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services being rendered.

- Surgical Procedures (office, outpatient hospital, and ambulatory surgical center) - we will require payment of your co-pay, co-insurance, or deductible prior to the surgery. We will bill your health plan, and any remaining balance will be your responsibility
- Past due account balances may be subject to collection actions. You will be responsible for any costs incurred, including but not limited to collection fees, attorney fees, and court costs, in addition to the outstanding balance. A $45 service fee will apply to any returned checks.
- Copy of medical records, x-rays, or any documents that need to be completed by our office are subject to a fee
- **Termination Policy** – While we will do our best to deliver the best healthcare with respect, we do not tolerate any type of Physical or Verbal Abuse to our staff . Which are the reasons for immediate termination of our relationship with you

If an appointment is cancelled with less than 24hr notice to our office, or if a scheduled appointment is missed/forgotten, there will be a fee of $50.00 This fee will only be waived in case of an emergency or illness.

Printed Name _____ Signature _____ Date _____

OC PODIATRY
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NEW PATIENT FORMS

Acknowledgement of Privacy Practices and Instructions for Release of Personal health Information

Patient Name : _____ Date of Birth : _____

I hereby authorize medical providers and personnel of OC Podiatry to release and discuss my personal health information to/with :

Name : _____ Relationship: _____

Name : _____ Relationship: _____

Name : _____Relationship: _____

I understand that I have the right to revoke this authorization in writing at any time. I understand that such revocation is not effective to the extent that the clinic has relied on the use or disclosure of the protected health information . I understand that information used disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization .

Check here **[ ]** if you choose not to share your information with anyone or release it to a family member

**Please be aware our practice uses Curogram, a HIPAA compliant site to interact with our patients via text and for appointment reminders.

Patient Signature : _____ Date : _____

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NEW PATIENT FORMS

PLEASE COMPLETE THE FOLLOWING INFORMATION WHICH WILL ASSIST IN DETERMINING AN ACCURATE DIAGNOSIS AND PROPER COURSE OF TREATMENT

PATIENT'S NAME:_____ DATE OF BIRTH:_____AGE:_____

DATE OF LAST PHYSICAL EXAM:_____ BY WHOM:_____

CURRENT PRIMARY CARE PHYSICIAN:_____CITY:_____

OTHER CURRENT MEDICAL SPECIALISTS:_____

List of Medical Conditions for Which You Are Currently Being Treated:	**Previous Surgeries/ Hospitalizations: Year &Reason:**
_____ _____ _____	_____ _____ _____
Current Medications: _____ _____ _____ _____ _____ _____ _____	**Are You Allergic or Sensitive To:** ☐ LATEX ☐ ADHESIVE TAPES ☐ PENICILLIN ☐ OTHER MEDICATIONS: ☐ IODINE ☐ NOVOCAINE _____ ☐ SULFA _____ ☐ ASPIRIN _____ **Are you a Smoker**: **YES / NO / PAST SMOKER** If **YES**, How Many Per Day:_____ **Do You Consume Alcohol**: **YES / NO** If **YES**: How Often/ How Many_____

FAMILY HISTORY:_____

_____

REASON FOR VISIT *Please briefly describe your foot, ankle or leg problems. Include which foot (R, L, or Both) How long the problem existed and any previous treatments.*

_____

_____

_____

_____

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PLEASE COMPLETE THE FOLLOWING INFORMATION WHICH WILL ASSIST IN DETERMINING AN ACCURATE DIAGNOSIS AND PROPER COURSE OF TREATMENT

Please Check Any of the Following Problems You Have Had:

Foot and Leg Conditions:
- ☐ Arch Pain
- ☐ Bone Fracture
- ☐ Bow Legs
- ☐ Bunions
- ☐ Burning
- ☐ Childhood Cast/Brace
- ☐ Coldness
- ☐ Flat Feet
- ☐ Foot Cramps
- ☐ Hammertoes
- ☐ Heel Pain
- ☐ High Arches
- ☐ Leg Cramps

- ☐ Knee Pain
- ☐ Low Back Pain
- ☐ Nerve Injury
- ☐ Numbness
- ☐ Out Toeing
- ☐ In Toeing
- ☐ Pigeon Toes
- ☐ Shin Splints
- ☐ Shoe Wear Problems
- ☐ Sprains
- ☐ Stiffness
- ☐ Swelling
- ☐ Unequal Leg Lengths
- ☐ Varicose Veins

- ☐ Weak Ankles
- ☐ Other _____

Toenail Problems:
- ☐ Brittle
- ☐ Curved
- ☐ Deformed
- ☐ Discolored
- ☐ Fungus
- ☐ Ingrown
- ☐ Thick
- ☐ Other _____

Foot and Skin Problems:
- ☐ Corns (Hard/ Soft)
- ☐ Cracking
- ☐ Dryness
- ☐ Foot Odor
- ☐ Fungus
- ☐ Growths
- ☐ Itching
- ☐ Moist Skin
- ☐ Excessive Perspiration
- ☐ Bruises or Cuts
- ☐ Callus
- ☐ Warts
- ☐ Other _____

Please Check Any of the Following Problems You Have Had:

How Many Hours A Day Are You on Your Feet?	Have You Previously Been Treated By a Podiatrist? **YES / NO** For What Problem?	Do You Wear: ☐ Custom Orthotics ☐ Over The Counter Inserts ☐ Other Support Devices	Shoe Size:

Regular Exercise Activities and Shoes Use

Please List Activity and Briefly Describe Shoe Used: Walking, Running, Hiking, Sports, ETC.

_____

_____

Please Check Any of the Following Conditions You Have Had:

- ☐ Aids/HIV
- ☐ Heart Conditions _____
- ☐ Chest Pain
- ☐ Stroke
- ☐ **HIGH / LOW** Blood Pressure
- ☐ Anemia
- ☐ Diabetes Type _____

- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Hepatitis
- ☐ Rheumatic Fever
- ☐ Asthma
- ☐ Circulatory Problems
- ☐ Thyroid Problems

- ☐ Sudden Weight Change
- ☐ Venereal Disease
- ☐ Acquired Immune Deficiency Syndrome
- ☐ Neurological Problems
- ☐ Epilepsy
- ☐ Depression

- ☐ Substance Abuse
- ☐ Cancer_____
- ☐ Arthritis
- ☐ Gout
- ☐ Varicose Veins
- ☐ Other _____

Consent

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my ankle and feet.

Signature of Patient or Legal Guardian: _____ Date: _____