foot & ankle
SPECIALTY GROUP

Date: _____

Patient Name: _____ Age: _____ DOB: ____/____/____

Address: _____ Home Tel: (____) _____

City_____ State____Zip_____ Wk Tel: (____) _____

Email:_____ Cell Tel: (____) _____

SS# _____

*Emergency Contact: _____ Phone: _____

How did you hear about THE FOOT AND ANKLE SPECIALTY GROUP?

_____

Have you been to our website (WWW.YOURFOOTDOC.COM)?____was our website helpful? ☐ No ☐ Yes

If No, pls. list reason: _____

Employer_____Address _____

Occupation:_____Marital Status: _____

Primary Insurance Co._____Policy # _____

Group #_____Name of person insured_____SS# _____

Eligibility Phone #_____Copay _____

Secondary Insurance Co._____Policy # _____

Group #_____Name of person insured_____SS# _____

Eligibility Phone #_____Copay _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with_____and assign directly to Foot and Ankle specialty group, Professional Corporation, all Medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. If the nature of the disability be such that it is not covered by insurance, I will be responsible to the doctor for payment of the entire bill. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian Date

Patient Signature Date

HEALTH INFORMATON

Have you been diagnosed with any chronic problems?
If so, please list them. _____ _____

_____ _____

Personal Past Medical History:

Do you have any chronic medical problems? (Circle all that apply)

High Blood Pressure	Diabetes	Cancer
Heart Disease	Kidney Disease	HIV or AIDS
Heart Failure	Psychiatric Diagnosis	Stroke
Seizures	Bleeding Problems	Hepatitis
Heart Attack	Liver Disease	Emphysema
Chest Pain	Gastric Reflux	Stomach Problems
	Asthma	Other _____

Is there a personal or family history of anesthetic complications? ☐ No ☐ Yes
If yes, please explain _____

Family History:

Do you have a family history of any medical problems? (Circle all that apply) Please indicate family member.

High Blood Pressure	Diabetes	Cancer	Asthma
Heart Disease	Kidney Disease	HIV or AIDS	Other _____
Heart Failure	Psychiatric Diagnosis	Stroke	
Seizures	Bleeding Problems	Hepatitis	
Heart Attack	Liver Disease	Emphysema	
Chest Pain	Gastric Reflux	Stomach Problems	

Please list all prior Hospitalizations/ or Operations:

1. _____ _____ _____
2. _____ _____ _____
3. _____ _____ _____
4. _____ _____ _____
5. _____ _____ _____

Please list **ALL** medications:
(Prescriptions, Over the Counter Medicines, Aspirin, Vitamins and Herbal Supplements such as Fish Oil)

1. _____ 6. _____

2. _____ 7. _____

3. _____ 8. _____

4. _____ 9. _____

5. _____ 10. _____

Please list **ALL** allergies and describe reactions: (i.e. Shellfish, Latex, Penicillin, etc.).

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Social History:

Have you ever used tobacco products? ☐ No ☐ Yes If yes, how long?_____how much?_____

Which tobacco product(s) have you used?_____

If you are a former smoker, state the year you stopped: _____

Alcohol Consumption: _____Never (Do not consume alcohol)_____Rare (1-2 drinks a week)

_____ Moderate (7-10 drinks a week) _____Heavy (daily or more than 10 drinks a wk)

Did you ever drink heavily in the past? ☐ No ☐ Yes

History of drug use? ☐ No ☐ Yes

Do you currently have thoughts of harming yourself? ☐ No ☐ Yes

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Review of Systems:

Please answer the following Yes or No questions to the best of your ability. Do you have any of the following conditions, illnesses or symptoms?

CARDIOVASCULAR

High Blood Pressure	Y ___	N ____	Heart Failure	Y___	N _____
Heart Attack	Y ___	N ____	Irregular Heartbeat	Y___	N _____
Angina/chest pain	Y ___	N ____	Heart Murmur	Y___	N _____
Heart bypass surgery	Y ___	N ____	Do you exercise?	Y___	N _____
Pacemaker	Y ___	N ____	Comments: _____		

NEUROLOGICAL

Stroke	Y ___	N ____	Abnormal Chest X-ray	Y___	N _____
Seizures	Y ___	N ____	Asthma	Y___	N _____
Fainting	Y ___	N ____	Bronchitis	Y___	N _____
Dizziness	Y ___	N ____	Emphysema	Y___	N _____
Headache	Y ___	N ____	Recent Chest Infection	Y___	N _____
Double Vision	Y ___	N ____	Shortness of Breath	Y___	N_____
			Shortness of Breath at night	Y___	N_____

PSYCHIATIC

			Shortness of Breath on exertion	Y___	N_____
Depression	Y ___	N ____	Cough	Y___	N _____
Anxiety	Y ___	N ____	Cough with Sputum	Y___	N _____
Psychiatric Care	Y___	N____	Sleep Apnea	Y___	N _____
Obsessive Compulsive			-Use a C-PAP Machine?	Y___	N _____
Disorder	Y___	N____			

MUSCULOSKELETAL

ENDOCRINE			Sciatica	Y___	N _____
Diabetes	Y ___	N ____	Herniated disc	Y___	N _____
Thyroid Disease	Y ___	N ____	Arthritis	Y___	N _____
Taken Steroids	Y ___	N ____	Rheumatoid	Y___	N _____
			Neck, Back, Arm, Leg Prob	Y___	N _____

HEMATOLOGIC/ONCOLOGIC/

Bleeding Tendency	Y___	N _____	INFECTIOUS		
			GASTROINTESTINAL		
Easy Bruising	Y___	N _____	Jaundice	Y ___	N ____
Anemia	Y___	N _____	Hepatitis	Y ___	N ____
Sickle Cell Disease	Y___	N _____	Ulcers	Y ___	N ____
Blood clots in legs	Y___	N _____	Hiatal Hernia	Y ___	N ____
Blood clots in lungs	Y___	N _____	Heartburn	Y ___	N ____
Radiation Therapy	Y___	N _____			

URINARY

			SKIN		
Kidney Disease	Y___	N _____	Basal cell skin cancer	Y____	N_____
Urinary Disease	Y___	N _____	Melanoma	Y___	N ____
Dialysis	Y___	N _____	Staph Infection	Y ___	N ____
			EYES		
Cataracts				Y_____	N____
Glaucoma				Y _____	N ____

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, and health care operations (TPO) and for other purposes permitted or required by law. It also describes your rights to access and control your protected health information. "Protected heath information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health services.

Uses and Disclosures of Protected Health Information Your protected health information (PHI) may be used and disclosed by your Physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, support the operation of the physician's practice, and any other use required by law.

Warning Regarding HIPAA and Email/Text Communications

Dr. Salma Aziz and her practice take every step possible to maintain your privacy and to stay compliant with all HIPAA laws. However, currently in technology it is not possible to ensure complete privacy between you and our practice for email and text communications. In other words, if you are to text or email any of your medical information or photos to our practice it cannot be guaranteed that all the information is compliant with HIPAA privacy laws and it is possible that some of it could be inadvertently exposed. For this reason, we want to make clear that HIPAA compliance is not possible for all text and emails between you and either Dr. Aziz or any of her staff and you should be warned of the possibility of sensitive information being unprotected. Your signature below memorializes your understanding of this important issue.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information as necessary to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by your name in the waiting room when your physician is ready to see you. We may disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners: Funeral Directors, and Organ Donation: Research, Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: required Uses and Disclosures: Under the Law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to Investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your Consent, Authorization or Opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that you physician or the physician's practice has t taken an action in reliance on the use or disclosure indicated in the authorization.

Your rights: Following is a statement of your rights with respect to your protected health information.

You have the right to request a restriction of your protected health information: Under Federal law, however, you may not inspect or copy the following records: psychotherapy notes: information compiled in reasonable anticipation of, or use in, a civil, criminal or a administration action or proceedings, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of you protected health information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclose your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare Professional.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location: You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to have your physician amend you protected health information: If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information:

We reserve the right to change terms of this notice and will inform you by mail of any changes, you then have the right to object or withdraw as provided in this notice.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by telephone at our main telephone number (949)766-8505

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

_____

Patient Name

_____ _____

Patient Signature (Guardian) Date

_____ _____

Foot and Ankle Specialty Group
22032 El Paseo suite #140
Rancho Santa Margarita, Ca 92688
949-766-8505
949-766-5782

PATIENT FINANCIAL REPONSIBILITY POLICY

YOUR UNDERSTANDING OF OUR FINANCIAL POLICIES IS AN ESSENTIAL ELEMENT OF YOUR CARE AND TREATMENT. IF YOU HAVE ANY QUESTIONS, PLEASE ASK FOR THE OFFICE SUPERVISOR, OR CONTACT OUR BILLING DEPT: 973-256-1998 EXT *126

- UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE BY YOU, OR YOUR HEALTH INSURANCE CARRIER, PAYMENT FOR OFFICE SERVICES ARE DUE AT THE TIME OF SERVICE. WE WILL ACCEPT VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, CASH OR CHECK.
- 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, THE PATIENT IS RESPONSIBLE.
- WE HAVE MADE ARRANGEMENTS WITH CERTAIN INSURERS AND OTHER HEALTH PLANS TO ACCEPT AN ASSIGNMENT OF BENEFITS. WE WILL BILL THOSE PLANS WITH WHICH WE HAVE AN AGREEMENT AND WILL ONLY REQUIRE YOU TO PAY THE COPAY/ COINSURANCE/ DEDUCTIBLE AT THE TIME OF SERVICE.
- IF YOU HAVE INSURANCE COVERAGE WITH A PLAN THAT WE DO NOT HAVE A CONTACT WITH, WE CAN OFFER YOU A 'CASH' PRICE, AND GIVE YOU A RECEIPT SO YOU CAN FILE WITH YOUR INSURACE PLAN.
- ALL HEALTH PLANS ARE NOT THE SAME AND DO NOT COVER THE SAME SERVICES. IN THE EVENT YOUR PLAN DETERMINES A SERVICE TO BE "NOT COVERED", OR YOU DO NOT HAVE AN AUTHORIZATION, YOU WILL BE RESPONSIBLE FOR THE COMPLETE CHARGE. WE WILL ATTEMPT TO VERIFY BENEFITS FOR SOME SPECIALIZED SERVICES; HOWEVER, YOU REMAIN RESPONSIBLE FOR ANY SERVICES RENDERED. PATIENTS ARE ENCOURAGED TO CONTACT THEIR PLANS FOR CLARIFICATION.
- YOU MUST INFORM THE OFFICE OF ALL INSURANCE CHANGES AND AUTHORIZATION/ REFERRAL REQUIREMENTS. IN THE EVEN THE OFFICE IS NOT INFORMED, YOU WILL BE RESPONSIBLE FOR ANY CHARGES DENIED.
- FOR MOST SERVICES PROVIDED IN THE HOSPITAL/ SURGERY CENTER, WE WILL BILL YOUR HEALTH PLAN. ANY BALANCE DUE IS YOUR RESPONSIBILITY.
- THERE ARE CERTAIN ELECTIVE SURGICAL PROCEDURES FOR WHICH WE REQUIRE A PRE-PAYMENT. YOU WILL BE INFORMED IN ADVANCE IF YOUR PROCEDURE IS ONE OF THOSE. IN THAT EVENT, THE PAYMENT WILL BE DUE ONE WEEK PRIOR TO SURGERY.
- PAST DUE ACCOUNTS ARE SUBJECT TO COLLECTIONS PROCEEDINGS. ALL COSTS INCURRED INCLUDING, BUT NOT LIMITED TO, COLLECTIONS FEES. ATTORNEY FEES, AND COURT FEES SHALL BE YOUR RESPONSIBILITY IN ADDITION TO THE BALANCE DUE TO THE OFFICE.
- THERE IS A SERVICE FEE FOR ALL RETURNED CHECKS OF $35.00, $45.00 FEE FOR MISSED APPOINTMENTS NOT CANCELLED WITH 24 HOURS ADVANCE NOTICE, $45.00 FOR EDD/ DISABILITY PAPERWORK AND $20 FOR EACH EXTENSION. $35.00 FOR MEDICAL RECORDS.

NO SHOW/CANCELLATION POLICY

All appointment no-shows and same day cancellations that are scheduled will require a $45.00 service fee that will be charged. All cancellations must be 48 hours (two business days) prior to the scheduled appointment time to avoid this fee. By signing this document, you have acknowledged that you understand the service fee for No Show/Same Day Cancellations and have authorized the specific credit card to charge in the event of this situation. This consultation fee will also be charged at the end of the business day prior to your consult date. Thank you for your understanding and cooperation.

Thank you for your understanding and cooperation.

_____ _____

Patient Signature (Guardian) Date