

The Foot Center
8631 W. 3RD ST. SUITE 303-E
LOS ANGELES, CA 90048
TEL: 310-360-0001
FAX: 310-360-0135

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH ____/____/____

RESPONSIBLE PARTY: _____ SS# _____

HOME ADDRESS: _____ MARITAL STATUS _____

CITY _____ STATE _____ ZIP CODE _____ SEX M F

HOME PHONE:_(____)_____ CELL PHONE_(____)_____

EMAIL ADDRESS: _____

OCCUPATION: _____ EMPLOYER: _____

WORK PHONE:_(____)_____

WORK ADDRESS _____

REFERRED BY: _____ PRIMARY PHYSICIAN: _____

PREVIOUS PODIATRIST: _____

PLEASE NOTE:

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION OR OTHER INFORMATION NEEDED FOR THE PROCESSING OF THE ATTACHED MEDICAL CLAIM AND REQUEST THAT PAYMENT BE MADE DIRECTLY TO THE TREATING DOCTOR. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. IT IS UNDERSTOOD THAT THE PATIENT IS RESPONSIBLE FOR THE MEDICAL SERVICES THEY RECEIVE.

I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND I HAVE READ (OR HAD THE OPPORTUNITY TO READ IF I SO CHOOSE) AND UNDERSTOOD THE NOTICE.

SIGNATURE _____ DATE _____

(Parent signature if patient is a minor.)

**THE FOOT CENTER
MEDICAL INFORMATION**

Height ____ Weight ____

Shoe Size _____

PATIENT NAME: _____

PLEASE PROVIDE BRIEF DESCRIPTION OF THE NATURE OF ILLNESS/INJURY & PRIOR TREATMENTS:

HOW LONG HAVE YOU HAD THIS CONDITION? _____

DATE OF INJURY: _____ (if applicable)

PHARMACY INFORMATION: _____

ALLERGIES: _____

CURRENT MEDICATIONS: _____

PERSONAL MEDICAL HISTORY:

Please indicate whether you have had any of the following medical problems

- | | |
|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Bleeding or clotting disorder | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Weakness/Numbness in extremities |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Other: (please specify) _____ |
| <input type="checkbox"/> High Blood Pressure | _____ |

PAST SURGERIES: If yes, please list all prior operations with dates

PAST SOCIAL HISTORY:

	YES	NO	If Yes, How Often?
Tobacco use:	_____	_____	_____
Alcohol use:	_____	_____	_____
Drug use:	_____	_____	_____
Exercise regularly	_____	_____	_____

If yes to Exercise, list the types of exercise and how much

FAMILY HISTORY: Any illness that runs in the family?

If yes, please list

Signature: _____

Date: _____

THE FOOT CENTER

How do you prefer we contact you (Please circle first choice):

Home Telephone Mobile Work Telephone Email Fax

Cell Telephone Number: _____

____ OK to leave message with detailed information

____ Leave message with call back number only:

Home Telephone Number: _____

____ OK to leave message with detailed information

____ Leave message with call back number only.

Work Telephone Number: _____

____ OK to leave message with detailed information

____ Leave message with call back number only.

Written Communications:

____ OK to E-mail detailed information to the following E-mail address: _____

____ OK to mail reminders and other communications to my home address

____ Ok to fax information to the following number: _____

The Foot Center will not communicate any information to anyone including family members unless he/she names are specified below:

Name: _____ Relationship to the patient: _____

Name: _____ Relationship to the patient: _____

Patient Signature: _____ Date: _____

Print Name: _____ Date of Birth _____

In general, the HIPAA privacy rule gives individual the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication PHI be made by alternative means, such as sending correspondences to the individual's office instead of the individual's home.

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and request for PHI to be minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made to pursuant to an authorization requested by the individual.

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Welcome to The Foot Center. We hope that our association will be of great relief to you. The following is a description of our office policies relative to payment based on your insurance.

All copays, deductibles, and estimated insurance balances are due at the time of services.

It your responsibility to be aware of your insurance benefits, the foot center will make every effort to assist you in understanding the scope of your insurance benefits. It is not the responsibility of The Foot Center to verify your insurance coverage or determine which services are or are not covered.

If your insurance denies payment for any reason, the amount owed is your responsibility and must be paid promptly. As courtesy to our patients, we will bill insurance carriers for services provided by our office, whether or not we are provider for that carrier. Payment of benefit will be subject to all terms, conditions, limitations, and exclusion of your contract at time of service

Any medical supplies purchased in the office must be paid at the date of service. These are not billable and all sales are final.

A **\$50** fee will be charged to you for any appointment missed or cancelled with less than 24 hours notice. A \$35 fee will be charged for any returned checks or credit cards. Interest of 12% annually will be charged to all balance's unpaid past 90 days.

We would be happy to answer any questions you might have regarding our office policy.

I have read and understand the above information and accept full responsibility if any insurance does not pay for services rendered.

Patient's
Signature _____ Date _____