The Foot Center

8631 W. 3RD ST. SUITE 303-E
LOS ANGELES, CA 90048

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_____

REFFERED 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 RESPOSIBLE 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.)

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We want to welcome you to our office. 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.

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.

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

If surgery is required, it may be scheduled at Linden Surgery Center, a privately owned corporation and managed ambulatory care center in which your provider may be an investor, or Cedar Sinai Medical Center.

A **$50** fee will be charged to you for any appointment missed or cancelled with less than 24 hours notice. A $25 fee will be charged for any returned checks or credit cards. Interest of 12% annually will be charged to all balances unpaid past 90 days.

We would be happy to answer any questions you might have regarding our office policy. Your understanding of our response to this difficult problem is greatly appreciated.

Patient's
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 remainders 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.

THE FOOT CENTER
MEDICAL INFORMATION

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)
ALLERGIES:_____
CURRENT MEDICATIONS:_____
_____

PERSONAL MEDICAL HISTORY:
Please indicate whether you have had any of the following medical problems

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

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:_____