

Step Forward Foot & Ankle

18151 Bear Valley Rd. Hesperia, CA 92345

Phone: 760-948-7400 Fax: 760-948-7866

Email: info@StepForwardFootAndAnkle.net

PATIENT INFORMATION FORM

First Name: _____ Last Name: _____

Mailing Address: _____

Home Phone: _____ Cell Phone: _____ SSN# _____ - _____ - _____

Date of Birth: _____ Age: _____ Sex: M F Marital Status: _____

E-mail Address: _____

Primary Language: _____ Race: _____ Ethnicity: Are you Hispanic or Latino? Y N

Emergency Contact Name: _____ Phone: _____

Emergency Contact Relationship to Patient: _____

Primary Insurance

Insurance Company Name: _____

Name of Card Holder: _____ Employer: _____

ID Number: _____ Group Number: _____

Insured Date of Birth (If different from Patient): _____

Secondary Insurance

Insurance Company Name: _____

Name of Card Holder: _____ Employer: _____

ID Number: _____ Group Number: _____

I hereby give permission to Step Forward Foot & Ankle to examine and/or perform diagnostic tests, and treat my condition medically, surgically, or orthopedically. The undersigned consents to and authorizes the administration and performance of medical care that may be in the judgment of the physician considered advisable and necessary, why may include the performance of certain blood tests for communicable diseases such as Hepatitis and HIV. Step Forward Foot & Ankle is authorized to furnish information, necessary to process claims, to an insurer, compensation carrier or welfare agency that may be providing financial acceptance of hospital care. I understand that although I have medical insurance, I am solely responsible for payment of medical bills. I agree to pay all fees billed to me immediately upon completion of all services unless other arrangements have been made in advance. I also understand that payment is not dependent upon my insurance.

Signature: _____ Date: _____

NEW PATIENT MEDICAL INFORMATION FORM

What currently bothers you about your feet and/or ankles? _____

When did it begin or when did the injury occur? _____ / _____ / _____

Where did the injury occur? Home Work Auto Other _____

Describe the accident/event: _____

Describe any treatment or home remedies: _____

How much are you on your feet? 20% 40% 60% 100%

How would you describe the pain? (*circle as many as apply*)

sharp dull aches throbs burns radiates
intermittent occasional constant intense moderate mild

When does it hurt the most? Morning / Evening

What seems to **increase** your discomfort? _____

What seems to **decrease** your discomfort? _____

Which of the following activities have you participated in with-in the last six months? (*circle as many as apply*)

Baseball Basketball Tennis Racquetball Football Soccer Swimming
Horseback Riding Skiing Gardening Painting Home Renovation Moving Dancing

Other: _____

What type of work do you do? _____ for _____ years _____ months

How much are you on your feet at work? _____

If retired, what was your former occupation? _____

Do you feel that you are improving? Yes / No

Who is your family doctor? _____ Phone: _____

Date of last physical exam _____ / _____ / _____

Who referred you to this office? _____

What pharmacy do you use? _____

Comments: _____

MEDICAL HISTORY

Do you have, or have you ever been treated for:

- | | | |
|---|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Heart Murmurs | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Inflammatory Arthritis | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Kidney Disorders | <input type="checkbox"/> Thyroid Disorders |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Liver Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Ulcers (Gastric or Duodenal) |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Difficulty with Balance | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Cancer, what kind?
_____ |
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Poor Circulation | |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Psychiatric Disorders | |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other _____ |

Height: _____ Weight: _____ Women- Are you Pregnant? Yes / No Children's Ages _____

Do you smoke? Yes / No Packs per day _____ Years _____?

If you quit when did you do so? _____

Alcoholic beverages? None Rarely Moderately Daily Quit

Recreational Drugs? None Rarely Moderately Daily Quit

Do you have diabetes? Yes / No If yes, how long have you had it? _____ years _____ months

What was your last blood sugar? _____ When was it last checked? _____

Have you ever been hospitalized due to diabetes? Yes / No When? _____

Explain: _____

PLEASE LIST ALL CURRENT MEDICATIONS IN THE BOX BELOW:

Have you ever experienced any ill effects or reactions from?

- | | | |
|---|--------------------------------------|--|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Cortisone | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Other Medications

_____ |
| <input type="checkbox"/> Adhesive Tape | <input type="checkbox"/> Novocain | |
| <input type="checkbox"/> Any Antibiotic | <input type="checkbox"/> Sulfa Drugs | |

Have you ever had surgery for any of the following?

- | | | | | |
|--|--|-------------------------------------|------------------------------------|---|
| <input type="checkbox"/> Appendix | <input type="checkbox"/> Ear | <input type="checkbox"/> Intestines | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tubal Ligation |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Eye | <input type="checkbox"/> Kidney | <input type="checkbox"/> Sinus | <input type="checkbox"/> Vasectomy |
| <input type="checkbox"/> Breast Biopsy | <input type="checkbox"/> Fracture Repair | <input type="checkbox"/> Leg Bypass | <input type="checkbox"/> Stomach | |
| <input type="checkbox"/> Cyst | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Liver | <input type="checkbox"/> Tonsils | |

Have you ever had any complications after surgery? Yes / No

Please Explain: _____

Have you ever taken any steroids? Yes / No When? _____ Why? _____

Name: _____ Signature: _____

Date: _____

Financial Policy For Step Forward Foot & Ankle

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE: We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However, that does not mean that all services are covered. **Patients are responsible for paying their annual deductible if it has not yet been met.** You are also responsible for any copayments, which are usually 20% for the allowed amount for an item or service.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

COINSURANCES/COPAYMENTS AND DEDUCTIBLES: All coinsurances, copayments and deductibles must be paid at the time of services. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments or deductibles from patients can be considered fraud. Please help us in upholding the law by paying your copayment at each visit.

SELF PAY: Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES: Please be aware that some of the services that you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment of these services.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates us, that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. **Therefore, you are financially responsible for the services received, unless your referral is presented at the time of this visit.** If you do not have a referral from your primary care physician at the time of a visit, you will be financially responsible for all services received due in full upon completion of the visit. You will also be given the option to reschedule your appointment.

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

PATIENT BILLING: You will be sent up to three (3) notices/statements of your financial responsibility (copay/coinsurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account may be forwarded to collections. Please let the office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check or Visa/MasterCard/AMEX. **An additional \$25.00 will be added to your statement if the check is returned for insufficient funds.** In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance.

I have read the above policy regarding my financial responsibility to Step Forward Foot & Ankle for medical services provided. I agree to pay Step Forward Foot & Ankle any balance unpaid by my insurance carrier for myself or the below named person.

PRIVATE STATEMENT: Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

Assignment of Benefits

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Step Forward Foot & Ankle all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, copayments, coinsurances and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested by physicians to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance.

Patient Name: _____ Patient Signature: _____

Financially Responsible Party (If not the Patient)

Name: _____ Signature of Legal Guardian: _____

Relationship to Patient: _____ Date: _____

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HIPAA Preferences and Acknowledgment Form

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

*** Note, you may refuse to sign this acknowledgement ***

Our Notice of Privacy Practice is:

- Posted in our waiting room
- On our website at www.StepForwardFootAndAnkle.com
- Available as a printout at the front desk

I, _____ have received a copy of _____
(Step Forward Foot and Ankle) Notice of Privacy Practices.

Name: _____ Signature: _____

Date: _____

AUTHORIZATION TO RELEASE AND SHARE INFORMATION

Purpose: This form is used to obtain authorization to release information regarding your treatment to persons other than yourself and to determine allowable methods we may communicate with you.

I, _____ authorize the following person(s) to have access to information protected by the HIPAA Privacy and Security Rule about myself:

Name of Person	Relationship

There is no one I wish to share my information with.

Name: _____ Signature: _____

Date: _____

AUTHORIZATION TO COMMUNICATE

Purpose: This form is used to obtain authorization and to determine allowable methods we may communicate with you.

I, _____ authorize the practice to communicate with me about my health information, test results and upcoming appointments in the following manners:

Method of Communication	Ways of Communication
Phone 1	<input type="checkbox"/> You may leave a voicemail <input type="checkbox"/> You may send a text <input type="checkbox"/> You may call me
Phone 2	<input type="checkbox"/> You may leave a voicemail <input type="checkbox"/> You may send a text <input type="checkbox"/> You may call me
Phone 3	<input type="checkbox"/> You may leave a voicemail <input type="checkbox"/> You may send a text <input type="checkbox"/> You may call me
Email Address: <i>(note, email is not secure)</i>	<input type="checkbox"/> You may send information about upcoming appointments. <input type="checkbox"/> You may send information about lab results.
Other	
Other	

Name: _____ Signature: _____

Date: _____