Step Forward Foot & Ankle
18151 Bear Valley Rd. Hesperia, CA 92345
Phone: 760-948-7400 Fax: 760-948-7866

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: _____

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: _____

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

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 ocassasional 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:

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

Have you ever experienced any ill effects or reactions from?

- ☐ Penicillin
- ☐ Cortisone
- ☐ Adhesive Tape
- ☐ Any Antibiotic
- ☐ Codeine
- ☐ Aspirin
- ☐ Novocain
- ☐ Sulfa Drugs
- ☐ Iodine
- ☐ Other Medications _____ _____

Have you ever had surgery for any of the following?

- ☐ Appendix
- ☐ Bladder
- ☐ Breast Biopsy
- ☐ Cyst
- ☐ Ear
- ☐ Eye
- ☐ Fracture Repair
- ☐ Hysterectomy
- ☐ Intestines
- ☐ Kidney
- ☐ Leg Bypass
- ☐ Liver
- ☐ Pacemaker
- ☐ Sinus
- ☐ Stomach
- ☐ Tonsils
- ☐ Tubal Ligation
- ☐ Vasectomy

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 rnedicai care. We are committed to serving you wiih skill and qual ity care. The medical services provided byour office are services you have electt:d to rm::ive which may imply a tbancial responsibility on your part.

INSURANCE: We participte 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 inomance 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.** ln 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.

l 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 STATMENT: 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 undersrand that it is my responsibility to inforn the doctor's office if there is a change in my health insurance.

Patient Name: _____Patient Signature: _____

Financialy Responsible Party (If not the Patient)

Name: _____Signature of Legal Guardian: _____

Relationship to Patient: _____ Date: _____

Step Forward Foot & Ankle
18151 Bear Valley Rd. Hesperia, CA 92345
Phone: 760-948-7400 Fax: 760-948-7866

HIPAA Preferences and Acknowledgent 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 communicae with you.

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

Name of Person	**Relationship**

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	**Relationship**
Phone 1	☐ You may leave a voicemail ☐ You may send a text ☐ You may call me
Phone 2	☐ You may leave a voicemail ☐ You may send a text ☐ You may call me
Phone 3	☐ You may leave a voicemail ☐ You may send a text ☐ You may call me
Email Address: *(note, email is not secure)*	☐ You may send information about upcoming appointments. ☐ You may send information about lab results.
Other	
Other	

Name: _____ Signature: _____

Date: _____