Bay Area Foot Care

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name _____ MI ____

Date of Birth _____

SSN _____

Address _____

City _____

State _____Zip_____

Telephone (_____) _____

E-mail:_____

Primary Physician_____

Phone# _____

Referring Physician_____

Phone#_____

☐ **Male** ☐ **Female** ☐ **Non-Binary**

☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced**

☐ **White** ☐ **American Indian / Alaska Native** ☐ **Asian**

☐ **Black or African American** ☐ **Native Hawaiian**

☐ **Hispanic Latino** ☐ **Other** ☐ **Veteran**

Occupation _____

Employer _____

Address_____

_____

CHECK PREFERRED METHOD OF CONTACT

☐ Work Phone (____) _____Ext_____

☐ Cell Phone (____) _____

SPOUSE/PARTNER INFORMATION (If Applicable)

Name _____

Home Phone _____

Work Phone _____Ext_____

INSURANCE INFORMATION

Primary- Ins. Co. Name_____

Policyholder Name_____

☐ Self ☐ Spouse ☐ Dependent ☐ Domestic Partner

Policyholders Date of Birth_____/_____/_____

Employer_____

Secondary- Ins. Co. Name_____

Policyholder Name_____

Policyholders Date of Birth_____/_____/_____

☐ Self ☐ Spouse ☐ Dependent ☐ Domestic Partner

PHARMACY INFORMATION

Pharmacy Name_____

Phone #: _____Fax #:_____

Address_____

City_____ State_____

Zip_____

EMERGENCY CONTACT (If other than Spouse)

Name:_____

Relationship: _____

Telephone (____) _____

GUARANTOR INFORMATION (if different from Patient)

Name_____

Address_____

City_____

State_____Zip_____

Telephone (____) _____

DOB _____/_____/_____

Employer_____

Address_____

Work Phone (___) _____Ext___

PATIENT NAME_____ DATE OF BIRTH_____/_____/_____

Is your treatment today due to:

.....a motor vehicle accident ☐ Yes ☐ No Accident Date_____

.....an accident/ liability case ☐ Yes ☐ No Accident Date_____

Whom may we thank for sending you to our office?

☐ Doctor_____

☐ Patient_____

☐ Social Media_____

☐ Insurance Provider List ☐ Health Fair

☐ Passed by Location ☐ Internet Search

☐ Other_____

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I certify that the above information is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Signature _____ **Date**_____

I hereby authorize the release of any medical information pertaining to my treatment or information necessary for processing insurance claims and payment of medical benefits to myself or the party who accepts assignments. This authorization will remain valid until revoked by me in writing. **I understand that I am legally responsible for all charges whether or not reimbursed by my insurance company.**

Signature _____ **Date** _____

MEDICARE SIGNATURE ON FILE

I request that payment of authorized Medicare benefits, be made on my behalf to **Bay Area Foot Care** for any services furnished to me by the listed provider/supplier. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, and their agents any information needed to determine these benefits or benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider of supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

PATIENT'S NAME (Please Print)	**PROVIDER: Name**
	Bay Area Foot Care
PATIENT'S SIGNATURE	

History & Medical Information

1. **Occupation:** _____ **Is your problem work related?** ☐ Yes ☐ No

2. **Allergies:** (Describe reaction) ☐ **NONE**

☐ Penicillin _____ ☐ Aspirin _____ ☐ Narcotic Agent / Codeine _____
☐ Anesthesia _____ ☐ Shellfish _____ ☐ Sulfa Drugs _____
☐ Nickel / Metal _____ ☐ Radiographic Contrast Dye _____
☐ NSAIDS _____ ☐ Other _____

3. **List all medications/herbs/vitamins:** ☐ **NONE**

Meds	Dose	Start Date	Meds	Dose	Start Date

4. **Family History: (List relationship of family member(s) who have had these problems):**

☐ Diabetes _____ ☐ Heart Disease _____ ☐ Kidney Disease _____
☐ Hypertension _____ ☐ Stroke _____ ☐ Mental Illness _____
☐ Rheumatology _____ ☐ Bleeding Disorders _____ ☐ Cancer _____
☐ Other family History: _____

5. **Height :** _____ **Weight :** _____ **Shoe size:** _____

6. **Social History:**

Tobacco Use (Check one)
☐ Never a smoker ☐ Former Smoker ☐ Current every day smoker ☐ Current some day smoker

Alcohol Use (Check one)
☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Caffeine Use (Check one)
☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Drug use (recreational, IV)
☐ Please specify _____

Exercise habits (Check one)
☐ None ☐ Occasional ☐ Moderate ☐ Heavy

7. **Are you currently pregnant?** ☐ No ☐ Yes _____

8. **Surgical History:** Have you had surgery? ☐ Yes—if yes, describe below ☐ No

Surgery / Date: _____ Surgery / Date: _____

Surgery / Date: _____ Surgery / Date: _____

Surgery / Date: _____ Surgery / Date: _____

9. **Past Medical History:**

☐ Anemia	☐ Gout	☐ Kidney Disease (Dialysis Yes/No)	☐ Liver Disease
☐ Bleeding Disorders	☐ Heart Failure	☐ Lung/Respiratory Disorders	☐ Arthritis of _____
☐ Cancer of _____	☐ Heart Disease	☐ Tuberculosis (Year:_____)	☐ Rheumatoid Arthritis
☐ Epilepsy/Seizures	☐ High Cholesterol	☐ Pacemaker (Year:_____)	☐ Stroke (Year:_____)
☐ Osteoporosis	☐ HIV / AIDS	☐ High Blood Pressure	☐ HYPOthyroidism
☐ Artificial Joints	☐ Raynaud's Disease	☐ Heart Attack/MI (Year:_____)	☐ HYPERthyroidism
☐ Organ Transplant	☐ Asthma	☐ Coronary Artery Disease (CAD)	☐ Prostate Disorders
☐ Nerve Disorders	☐ Back Pain	☐ Blood Clot Lung (PE)	☐ Hepatitis A
☐ Diabetes Type 1 (Year: _____)	☐ Fibromyalgia	☐ Blood Clot Lung (DVT)	☐ Hepatitis B
☐ Chronic Obstructive Pulmonary Disease (COPD)		☐ Diabetes Type 2 (Year: _____)	☐ Hepatitis C
		☐ Other: _____	

10. **<u>Other information you would like the doctor to know:</u>**

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

This form does not constitute legal advice and covers only federal, not state, law.

Open Payments Database

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices, and was provided a link where I can access more information on the Open Payments database.

Patient Name	*Signature*	*Date*

FOR OFFICE USE ONLY

We provided the patient with a copy of our Notice of Privacy Practices, and provided information on how to access the Open Payments database and have made every effort to obtain written acknowledgment but could not because:

- ☐ The patient refused to sign.
- ☐ Other *(Please provide specific details)*

Employee signature	*Date*

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or Director of Operations.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- 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.
- We have made prior 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 co-pay/co-insurance/deductible.
- At Bay Area Foot Care, we ask our new patients with policies featuring annual deductibles to pay $200 on the day of their office visit. This $200 goes toward paying down the out-of-pocket costs associated with the visit and also contributes to paying down the deductible as a whole. Once a policy review reflects that the deductible for the year has been satisfied, we no longer collect the $200.
- All health plans are not the same and do not cover the same services. In the event your health 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 or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan for the physician services. Any balance due is your responsibility. The hospital and other specialists if involved will also bill your insurance for separate charges.
- In some instances, your provider will need to send specimens to an outside laboratory. I understand my insurance plan may not cover the charge of some or all of the laboratory tests ordered and I will be responsible for the charges.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party _____ Date: _____

Bay Area Foot Care

San Francisco / San Rafael / Castro Valley / Oakland / San Leandro / Pleasanton / Walnut Creek
Danville/ Albany/ Alameda/ Concord/ San Carlos / Burlingame/ San Jose/ Santa Rosa/ Foster City
Napa / Vallejo

"No Show" and "Cancellation" Policy & Procedure for Office Visits

At Bay Area Foot Care our goal is to provide quality Podiatry care in a timely manner. We have implemented a no show and cancellation policy which enables us to better utilize available appointments for our patients in need of Podiatric care. The following policy is with regard to patients who fail to keep their scheduled office visit appointment.

We request your consideration of other patients and ask that you contact Bay Area Foot Care promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. Available appointments are in high demand and your early cancellation will give another person the possibility to have access to timely care. Any cancelled or rescheduled appointments with less than a 24-hour notice will be considered a "Late Cancellation".

Bay Area Foot Care reserve the right to charge $50.00 of any patient who fails to cancel their scheduled appointment two consecutive visits in a row. In the event of an actual emergency, consideration will be given, and a one-time exception may be granted.

Surgeries need to be cancelled 1 week in advance; we reserve the right to charge a No Show/Late Cancellation fee of $200. Please help us serve you better by keeping to your scheduled appointments.

How to Cancel / Re-Schedule Your Appointment

To cancel or reschedule appointments call (800) 871-8606. If you have any problems getting through, you can leave a message with your name, appointment date and cancellation reason or request for rescheduling.

Patient Name _____

Patient Signature_____ Date_____

Electronic Communication Informed Consent Form

Please read this information carefully:

With the changing world of healthcare and technology, we are offering our patients an electronic method of communication. You have the right to request that Bay Area Foot Care communicate with you via email and or SMS messaging. You also have the right to know the associated risks with the use of non-encrypted electronic communication.

The transmission of patient information by email and/or texting has a number of risks that patients should consider prior to consenting. These include, but are not limited to, the following risks:

- Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.
- Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
- Employers and on-line services have a right to inspect emails sent through their company systems.
- Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
- Email and texts can be used as evidence in court.
- Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

Conditions for the use of email and text messages:

Our office cannot guarantee but will use all reasonable precautions to maintain security and confidentiality of email and text information sent and received. Our office is not liable for improper disclosure of confidential information that is not caused by intentional misconduct.

Patients/Legal Guardians must acknowledge and consent to the following conditions:

- Email and/or texting are not appropriate for urgent or emergency situations. Our office cannot guarantee that any particular email and/or text will be read and responded to

  within any particular period of time.
- Email and texts should be concise. The patient /legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.

- We will use e-mail to communicate with you only about non-sensitive and non-urgent issues such as:
    - Questions about prescriptions, use of medical equipment or devices
    - Routine follow up questions
    - Appointment scheduling
    - Billing questions

- Your e-mail messages may be forwarded to another office staff member as necessary for appropriate handling.
- Patients /legal guardians should not use email or texts for communication of sensitive medical information.
- Our office is not liable for breaches of confidentiality caused by the patient or any third party.
- It is the Patients / legal guardian's responsibility to follow up and/or schedule an appointment if warranted.

IN A MEDICAL EMERGENCY, DO NOT USE E-MAIL or TEXT MESSAGING.....**CALL 911**

Reminder: do not use e-mail for **urgent problems**. If you have an urgent problem, call our office if during business hours or go to an urgent care facility.

Patient Acknowledgement and Agreement:

_____I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between the office and me, and consent to the conditions and instructions outlined.

_____I understand that I may revoke this consent at any time by so advising Bay Area Foot Care in writing. My revocation of consent will not affect my ability to obtain future health care nor will it cause the off of any benefits to which I am otherwise entitled.

_____I give my consent for e-mail communications to and from Bay Area Foot Care

_____I **do not** give my consent for e-mail communications to and from Bay Area Foot Care

_____I give my consent for text communication from Bay Area Foot Care

_____I **do not** give my consent for text communications from Bay Area Foot Care

Patient printed name: _____

Patient signature: _____ Date: _____

Parent/Legal Guardian printed name: _____

Parent/Legal Guardian signature: _____Date: _____