CALIFORNIA FOOT&ANKLE ASSOCIATES, INC.®
*Excellence In Medicine And Surgery Of The Foot & Ankle*

## PATIENT INFORMATION

Patient's Last Name _____First _____ Male or Female

Cell Phone _____Home Phone _____Work Phone _____

Street _____City _____State ___ Zip _____

SSN _____DOB _____ Age _____

Employer _____ May we call you at work? _____ Email Address:_____

## INSURANCE INFORMATION

Primary Insurance _____Phone# _____

Member ID# _____ Group# _____ Insured's Name _____

Date of Birth _____ Secondary Insurance _____

Phone# _____

Member ID# _____Group# _____

Insured's Name _____Date of Birth _____

## CONTACT INFORMATION

Emergency Contact _____Relationship _____ Phone# _____

Referred By _____Relationship _____

Referring Physician/Primary Care Physician _____/_____

Pharmacy/Location_____City _____Phone# _____

**I CONSENT TO TREATMENT AS NECESSARY OR DESIRABLE TO THE CARE OF THE PATIENT NAMED ABOVE INCLUDING BUT NOT RESTRICTED TO DRUGS, MEDICINE, PERFORMANCE OF OPERATION, AND CONDUCT OF LABORATORY, X-RAYS, OR OTHER STUDIES THAT MAY BE USED BY DR. RADOVIC, HIS ASSISTANTS, OR ANY OTHER QUALIFIED DESIGNATE. I AGREE TO ARBITRATOR MEDIATION IN THE CASE OF DEBATE IN REGARD TO TREATMENT. I** directly assign all medical and surgical benefits to the CFAA/Dr. Radovic. I understand that I am financially responsible for all charges whether paid by my insurance provider or not. I authorize the doctor/CFAA to release all information necessary to secure the payment of benefits. I understand that fees for service are payable at the time of service unless other arrangements are made in advance. It is my responsibility to pay any deductible or co-insurance. Our office allows 60 days for your insurance to pay. After 60 days you will be billed for any outstanding balance on your account. All outstanding balances are due upon receipt of the statement.

**Subscriber/Insured Signature** _____ **Date** _____

*665 Camino de* los Mares, Suite 304 San Clemente, CA 92673 Ph. 949-493-8020 Fax 949-488-0868

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# Financial Policy

Thank you for choosing California Foot and Ankle Associates as your health care provider. Your clear understanding of our patient financial policy is important to our professional relationship. Please understand that payment for services is part of this relationship.

1.**Insurance**: We participate in many insurance plans, including Medicare. We will bill your primary insurance as a courtesy to you. In order to properly bill your insurance, we require that you disclose all insurance information, as well as any change in insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Knowing your insurance benefits is your responsibility. It is the responsibility of each patient to know their contract limitations. Please contact your insurance company with any questions you may have regarding coverage.

**2.Co-payments and Deductibles**: All co-payments and past due balances are due at the time of your appointment. We accept cash, check or credit card. Failure on our part to collect these monies from patients can be considered fraud. Please help us by paying your co-payment at each visit.

**3.Non-Covered Services**: Please be aware that some or perhaps all the services you may receive may not be covered or not considered reasonable or necessary by your insurance. i.e., "not medically necessary", "lack of medical necessity". You must pay for the services in full at the time of the visit.

4.**Claims Submission**: As a courtesy to our patients, we will submit insurance claims and assist in any reasonable way we can to get claims promptly paid. Your insurance may need you to supply certain information to them. 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 the claim. Your insurance benefit is a contract between you and the insurance company.

**5.Self-Pay Accounts:** These are patients without insurance coverage or patients covered by insurance plans in which the office does not participate. It is always the patient's responsibility to know if our office is participating in their plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible.

**6.Durable Medical Equipment:** Our office provides durable medical equipment as prescribed by Dr. Radovic. Your insurance will be billed; however, you will be responsible to pay any unpaid balances or co-insurance. Some products are not covered by insurance, in which case, you will be notified of the cost of the item. For a better understanding of your DME coverage please contact your insurance carrier. DME is intended for a single patient only, and for this reason, DME cannot be returned.

**7.0utstanding Balance Policy:** It is our office policy that all past due accounts are sent two statements and one letter. If no resolution can be made, the account may be sent to a collection agency. In the event, that an account is turned over to collections, the person financially responsible may be billed for all collection costs and past due balances.

**8. Fees:** Medical Records $50, Digital X-rays $25, Disability or Insurance Forms $50 and Returned Checks $50 by cash or money order.

I have read, understand, and accept all responsibilities associated with this financial policy.

Subscriber/Insured Name: _____

Subscriber/Insured Signature_____ Date _____

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# NOTICE OF PRIVACY PRACTICES

*This notice describes how patient protected health information may be used and disclosed and the patient's right to access this information.*

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires that all medical records and other individually identifiable health information used or disclosed by this organization be kept properly confidential. A patient has the right to understand and control how their health information is used or disclosed. Any misuse of personal health information is subject to penalties.

We may use and disclose patient medical records for the following purposes: 1) Treatment: providing, coordinating, or managing health care and related services by the health care provider. 2) Payment: activitie,related to obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. 3) Health Care Operations: conducting quality assessment and improvement activities, auditing functions.

We may create and distribute non-identified health information by removing all references to individually identifiable information.

We may contact patients to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services.

Any other uses and disclosures may be made only with the patient's written authorization. The patient may revoke such authorization in writing, except to the extent that we have already taken actions relying on the patient's authorization.

We have the right to change our Privacy Practices from time to time. Patients may request a current copy by writing to the address below.

Patients have the following rights with respect to their protected health information. Patients may exercise these rights by submitting a written request to the address below, attention Privacy Officer.

1) The right to request restrictions on certain uses and disclosures of protected health information, including those related to family members, other relatives, close personal friends, or any other person identified by the patient. We are not required to agree to a requested restriction. However, if we do we must abide by it unless the patient agrees to remove it in writing.
2) The right to reasonable requests to receive confidential communications of protected health information from this organization by alternative means or locations.
3) The right to inspect and copy protected health information.
4) The right to amend protected health information.
5) The right to receive an accounting of disclosures of protected health information.
6) The right to request a paper copy of this notice.

*I hereby acknowledge that I have been given the right to review this organization's Privacy Practices and give my consent to use my protected health information under the conditions provided.*

Patient Name: _____ _ Date: _____

Patient/Guardian Signature: _____

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Patient Name: _____ Date: _____

**MEDICAL HISTORY**

1. Explain your foot/ankle problem ____Right ____ Left _____

   _____

2. When did your pain/discomfort begin: _____

   Describe the pain: __ Dull __ Sharp __ Radiating __ Burning __Aching __ Cramping __Continuous __ Intermittent

   Rate your pain on a scale of 1-10: 1 2 3 4 5 6 7 8 9 10

3. Have you had any physical trauma? _____ yes _____no Is it work related? _____ yes _____ no

4. Prior Treatment: Please check all that apply.
   ____Previous X-rays ____ Steroid Injection: How Many ____ Date of Last Injection _____
   ____Previous CT/MRI ____Anti Inflammatory or Pain Medication: Are you currently taking them? _____
   ____Previous Labs ____ Custom Orthotics: Are you currently using them? _____

5. **Allergies**:
   ____ None ____ Anesthesia ____ Aspirin ____ Codeine ____Penicillin ____ Metal
   ____ Radiographic Dye ____ Shellfish ____ Sulfa Drugs ____ Other_____

6. **Medications** including vitamins and herbs: _____

   _____

7. **Family History:**
   __ Bleeding Disorders __ Heart Disease __Mental Illness __ Rheumatic Disorder
   __ Diabetes __ Hypertension __ Neurological Disorders __ Stroke
   __ Cancer __ Kidney Disease __ Pulmonary Disease __ Other_____

8. **Past Medical History**:

| | | | |
|---|---|---|---|
| __ Anemia | __ Gout | __ Kidney Disease | __ Osteoarthritis |
| __ Bleeding Disorders | __ Heart Failure | __ Mitral Valve Prolapse | __ Respiratory Disorders |
| __ Cancer _____ | __ Hepatitis | __ Nerve Disorders | __ Rheumatic fever |
| __ Diabetes | __ High Cholesterol | __ Neurological Disorders | __ Sleep Apnea |
| __ Epilepsy | __ HIV/AIDS | __ Pacemaker | __ Stroke |
| __ Other _____ | __ High Blood Pressure | __ Prostate Disorders | __ Thyroid Disorders |

9. Are you currently pregnant? _____ No _____ Yes

10. **Social History**: Please check what applies to you.
    Tobacco Use ____ current user ____ former user ____ Alcohol Use ____ Caffeine
    ____ Recreational Drug Use ____Exercise: _____

11. **Surgical History** - Please describe:
    _____

    _____

12. **Height**: _____ **Weight**: _____ **Shoe Size**: _____

13. **Occupation:** _____

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# ***REVIEW OF SYSTEMS***

Patient Name: _____ Date: _____

**Circle "*DENY ALL*" or any that you are currently experiencing or have recently experienced.**

**Constitutional**
Chills. A decline in health. Fatigue. Fever. Weakness. Weight gain. Weight Loss. ***DENY ALL***

**Head**
Dizziness. Fainting. Head injury. Headaches. Pain. Sweats. ***DENY ALL***

**Eyes**
Blurry Vision. Cataracts. Discharge. Double Vision. Excessive Tearing. Eye Pain. Eyeglass Contacts. Vision Loss. Glaucoma. Infections. Pain with Light. Recent Injury. Redness. Unusual Sensations. ***DENY ALL***

**ENT**

**Nose**
Discharge. Frequent Colds. Hay Fever. Infections. Nasal Obstruction. Nosebleeds. Sinus Infections.

**Mouth**
Bleeding Gums. Change in Dentition. Hoarseness. Postnasal Drip. Tongue Burning. Voice changes.

**Ears**
Discharge. Dizziness. Hearing Aid. Hearing Impairment. Infections. Pain. Ringing in Ears.

**Throat Neck**
Frequent Sore Throats. Lumps. Tenderness. Tonsils Enlarged.

***DENY ALL***

**Respiratory**
Asthma. Cough. Wheezing. Bronchitis. Coughing Blood. Pain. Pleurisy. Positive TB Test. Recent Chest X-Ray. Short of Breath. Sputum. Tuberculosis. ***DENY ALL***

**Cardiovascular**
Chest Pain. Palpitations. Varicose Veins. Extremity(s) Cool. Extremity(s) Discolored. Hair Loss on Legs. Heart Murmur. Heart Tests (Not EKG). High Blood Pressure. History of Heart Attack. Leg Pain - Walking. Recent Electrocardiogram. Rheumatic fever. Short of Breath - Exertion. Short of Breath - Lying Flat. Short of Breath - Sleeping. Swelling of Legs. Thrombophlebitis. Ulcers on Legs. ***DENY ALL***

**Gastrointestinal**
Abdominal Pain. Constipation. Diarrhea. Heartburn. Jaundice. Liver disease. Rectal Bleeding. Abdominal X-Ray Tests. Antacid Use. Black Tarry Stools. Change in Frequency of BM. Change in stool caliber. Change in Stool Color. Change in Stool Consistency. Decreased Appetite. Excessive hunger. Excessive thirst. Gallbladder Disease. Hemorrhoids. Hepatitis. Infections. Laxative use. Nausea. Rectal Pain. Swallowing Problem. Vomiting. Vomiting Blood. ***DENY ALL***

**Musculoskeletal**
Arthritis. Joint Pain. Gout. Back problems. Deformities. Joint Stiffness. Muscle Cramps. Muscle Stiffness. Paralysis. Restricted Motion. Weakness. ***DENY ALL***

**Psychiatric**
Depression. Behavioral Change. Disorientation. Disturbing Thoughts. Excessive Stress. Hallucinations. Memory Loss. Mood Changes. Nervousness. Psychiatric Disorders. ***DENY ALL***

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## ***REVIEW OF SYSTEMS CONT'***

**Circle "*DENY ALL*" or any that you are currently experiencing or have recently experienced.**

**Breasts**
Discharge. Lumps. Pain. Self-Examination. Tenderness. ***DENY ALL***

**Skin**
Eczema. Itching. Dryness. Easy bruisability. Hair dye. Hair Texture Change. Hives. Lumps. Mole Increased Size. Nail Appearance Change. Nail Texture Change. Rashes. Skin Color Change. ***DENY ALL***

**Neurological**
Loss of Consciousness. Blackouts. Burning. Dizziness. Fainting. Head Injury. Headaches. Memory loss. Numbness. Paralysis. Speech Disorders. Strokes. Tingling. Tremors. Unsteady Gait. ***DENY ALL***

**Endocrine**
Weakness. Weight Gain. Weight Loss. Cold Intolerance. Excessive urination. Fatigue. Goiter. Heat Intolerance. Increased thirst. Neck Pain. Sweats. Thyroid trouble. ***DENY ALL***

**Hematologic/Lymph**
Anemia. Bleeding Easily. Blood Clots. Easy Bruisability. Lumps. Radiation Exposure. Swollen glands. Transfusion Reaction. ***DENY ALL***

**Allergic/Immunologic**
Coughing. Coughing With Exercise. Hives. Itchy Eyes. Itchy Nose. Recurrent Infections. Runny Nose. Sneezing. Stuffy Nose. Watery Eyes. Wheezing. Wheezing with exercise. ***DENY ALL***

**Genitourinary**

**Urinary**
Awakening to urinate. Bed-Wetting. Blood in Urine. Burning. Difficulty starting stream. Excessive urination. Flank pain. Frequency. Incontinence. Infections. Pain on urination. Retention. Stones. Urgency. Urine discoloration. Urine Odor. ***DENY ALL***

**Male Genitalia**
Discharge. Fertility Problems. Hernias. Impotence. Lesions. Pain. Prostate Problems. Scrotal Masses. Sexual Problems. Venereal disease. ***DENY ALL***

***Patient Name:*** _____

***Signature:*** _____

***Date:*** _____