CALIFORNIA FOOT&ANKLE ASSOCIATES, INC.
Excellence In Medicine And Surgery Of The Foot & Ankle
Philip Radovic, DPM, FAAPSM
665 Camino de los Mares, Ste 304
San Clemente, CA 92673

PATIENT INFORMATION

Patient's Last Name _____ First _____ Male or Female

Parent/Guardian Last Name _____ First _____

Cell Phone _____ Home Phone _____ Work Phone _____

Street _____ City _____ State _____ Zip _____

SSN _____ DOB _____ Age _____

Employer _____ May we call you at work? _____

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 _____ Phone# _____

Referred By _____ Relationship _____

Pediatrician/Primary Care _____ Phone# _____

Pharmacy/Location _____ City _____ Phone# _____

Please read and sign below: 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 doctor. I understand that I am financially responsible for all charges whether paid by my insurance provider or not. I authorize the doctor 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.

Signature/Guardian/Responsible party _____ Date _____

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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. **Outstanding 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.

_____ _____

Signature of patient or responsible party Date

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

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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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PEDIATRIC PATIENT HISTORY

Patient Name _____ Date _____

Name of Pediatrician _____

Problem/Complaint _____

Duration _____ Previous Treatment _____

Allergies to Medications: _____

Current Medications: _____

Family History: Which family members have/had

____ Cancer _____

____ Diabetes _____

____ Deafness _____

____ High Blood Pressure _____

____ High Cholesterol _____

____ Heart Disease _____

____ Kidney Disease _____

____ Lupus _____

____ Stroke _____

____ Other _____

Past Medical History: Illness your child has/had

____ Asthma	____ Anemia
____ Cancer	____ Constipation
____Diabetes	____ Bleeding Disorder
____ Heart Murmur	____ Hearing Loss
____ Heart Disease	____Heart Valve Prob.
____ Ear Infections	____ Freq. Sore Throat
____Joint Problems	____ Nausea
____ Seizures	____ Skin Rash
____ Seasonal Allergies	____ Thyroid Disease
____ Vison Problems	____ Other _____

Social History:

Parents are: ____ married ____ separated ____ divorced ____ never married

With whom do you live with _____ Number of Siblings _____Grade in school _____

Hobbies _____

Surgical History/Hospitalizations: _____

_____

Height _____ Weight _____ Shoe Size _____

Signature/Guardian/Responsible party _____Date _____

Please Circle "Yes" or "No" to any current/ongoing symptoms:

GENERAL

Yes No Chills or Fever
Yes No Night Sweats
Yes No Loss of Appetite
Yes No Weight Loss/Weight gain
Yes No Loss of energy

EYES

Yes No Sudden loss of vision
Yes No Tearing
Yes No Redness
Yes No Discharge

EARS

Yes No Loss of hearing
Yes No Pain
Yes No Drainage
Yes No Pulling at ears

NOSE

Yes No Nasal congestion
Yes No Runny nose
Yes No Nose bleeds

MOUTH/THROAT

Yes No Sore throat
Yes No Bleeding gums
Yes No Mouth ulcers

LUNGS

Yes No Chronic Cough
Yes No Coughing up blood
Yes No Shortness of breath
Yes No Wheezing

HEART

Yes No Shortness of breath with activity
Yes No Chest Pain or Pressure
Yes No Heart Palpitations
Yes No Irregular heartbeat
Yes No Swelling of face, legs, ankles or feet

STOMACH/INTESTINES

Yes No Difficulty/Painful swallowing
Yes No Heartburn/indigestion
Yes No Stomach discomfort/pain
Yes No Change in appetite
Yes No Nausea or vomiting
Yes No Vomiting blood
Yes No Blood in stools
Yes No Constipation
Yes No Frequent soiling
Yes No Diarrhea

ENDOCRINE

Yes No Excessive thirst
Yes No Cold/Heat intolerance

URINARY SYSTEM

Yes No Pain on urination
Yes No Cloudy urine
Yes No Daytime wetting
Yes No Incontinence
Yes No Frequent urination

NERVOUS SYSTEM

Yes No Severe headaches
Yes No Dizziness or Lightheadedness
Yes No Loss of balance
Yes No Seizures
Yes No Passing out or fainting
Yes No Numbness or tingling
Yes No Confusion

BONES/MUSCLES/JOINTS

Yes No Back Pain
Yes No Painful Joints
Yes No Swelling of the joints
Yes No Stiff joints
Yes No Muscle Aches
Yes No Muscle weakness

SKIN

Yes No Skin rash
Yes No Skin discoloration
Yes No Easy bruising
Yes No Itching excessively
Yes No Hair Loss
Yes No Finger/Toe Nail changes

BLOOD

Yes No Anemia
Yes No Excessive bleeding
Yes No Enlarged lymph nodes
Yes No Have you had a blood transfusion

ALLERGY/IMMUNOLOGY

Yes No Recurrent infections
Yes No Seasonal allergies

PSYCHIATRIC

Yes No Mood Swings
Yes No Depression
Yes No Anxiety
Yes No Sleep problems
Yes No Hallucinations

OTHER

_____

_____

_____