TEL: 626.869.8769
FAX: 949.579.2069

OPD Foot and Ankle
855 North Lark Ellen Ave. Suite C
West Covina, CA 91791

WELCOME TO OUR OFFICE

Ms. Mrs. Mr. Miss: _____

Last First Middle Initial

Address _____ Cell ( ) _____

City _____ State _____ ZIP _____ Home ( ) _____

E-MAIL _____

SSN# _____ Driver's License: _____

Date of Birth_____Age____Marital Status: Single/Married/Divorced/Separated/Widowed

Employer _____ Occupation _____

Business Address _____ Business Phone _____

Emergency Contact _____ Relationship _____

Address _____ Phone ( ) _____

Whom may we thank for referring you to our office? _____

Family Doctor _____ Last Seen _____

Former Podiatrist _____ Last Seen _____

INSURANCE INFORMATION

Primary Insurance _____ Subscriber's Name _____

Policy # _____ Group # _____

Secondary Insurance_____ Subscriber's Name _____

Policy # _____ Group # _____

AUTHORIZATION AND RELEASE OF INFORMATION

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners.

I authorize that OPD FOOT AND ANKLE act as my agent in helping me obtain payment of my insurance and/or medical benefits.

I authorize and request my insurance company and/or government benefits to pay directly to the doctor or doctor's group insurance benefits otherwise payble to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsibl for payment of all services rendered on my behalf or my dependants.

I hereby give my permission to OPD FOOT AND ANKLE to administer and treat with such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle condition.

I understand that I am financially responsible for all charges whether or not they are covered by insurance, workers' compensation, or third party payer.

I further agree that a photocopy/facsimile of this agreement shall be valid as the original.

PATIENT SIGNATURE_____DATE_____

PATIENT'S NAME _____

PATIENT HISTORY

.What brings you in to our office today _____

. Are you having pain? Where? _____

. Type of Pain Sharp Dull Aching Burning Electrical Shooting Buzzing Numbness

. Pain Scale 1 2 3 4 5 6 7 8 9 10

. Pain Duration seconds minutes hours days constant

. Is the pain __new __old __getting better __same __getting worse

. Anything makes your foot/ankle problem better/worse? _____

. Do your ankles swell during the day? __Yes __No

. Have you lost or gained more than 10 lbs in the past year? __Yes __No

. **Allergies and Sensitivities**: ___No Known Allergies

___Penicillin or other antibiotics __Codeine or other pain medications __Cortisone __Sulfa __Novocain/Anesthetics

___Aspirin ___Iodine/Seafood __ Adhesive Tape __Latex __Food Allergies Other_____

. **Medications Currently Taken**

Blood thinning medications? __Yes __ No _____

Name_____Dose_____ Name_____Dose_____

Name_____Dose_____ Name_____Dose_____

Name_____Dose_____ Name_____Dose_____

Name_____Dose_____ Name_____Dose_____

. **Past Medical History** (circle any that you have or have had, and year diagnosed)

AIDS/HIV	Cholesterol Problem	Heart Disease	Polio
Alzheimer's Disease	Circulation Problems	Heart Murmur	Psychiatric Care
Anemia	Cortisone/Steroid Use	Heart Pacemaker	Rheumatic Fever
Aneurysm	Pre-Diabetes (no meds)	Hepatitis - A -B -C	Rheumatoid Arthritis
Angina/Chest Pain	Diabetes Type 2 (Adult)	Hernia	Shortness of Breath
Arthritis	Diabetes Type 1 (Child)	High Blood Pressure	Sickle Cell Disease
Artificial Heart Valves	DVT's/Embolism	Jaundice	Sinus Problems
Artificial Joints (hip/knee/ankle)	Emphysema / COPD	Kidney Disease	Skin Rash
Asthma	Epilepsy / Seizures	Liver Disease	Stomach Ulcers
Atrial Fibrillation	Fainting	Lower Back Pain	Stroke / TIA
Back Problems	Foot or Leg Cramps	Migraine Headache	Thyroid Disease (hypo/hyper)
Bleeding Disorders/Hemophilia	Foot or Leg Injuries	Multiple Sclerosis	Tuberculosis
Blood Disease	Foot or Leg Surgery	Nervous Condition / Anxiety	Varicose Veins
Bronchitis	Glaucoma	Osteoarthritis	Venereal Disease
Bursitis	Gout	Osteoporosis	
Cancer/Tumor	Heart Attack/MI	Peripheral Neuropathy	
Chemotherapy	Heart Failure/CHF	Pneumonia	

Other condition(s) not listed _____

PATIENT'S NAME _____

. **Past Surgical History** Date Procedure

_____

_____

_____

. **Past Foot Surgeries** Date Procedure

_____

. **Past Hospitalization or Emergency Care** (dates) _____

_____

. **Social History**

Do you drink alcohol? __Yes __No _____Years

Do you smoke? __Yes __ No #____ of packs per day?

Recreational drug use? __Yes __ No

. **Family History**

Please indicate family members who have/had the following conditions:

	Grandparents	Parents	Siblings
Diabetes	_____	_____	_____
Heart Disease or Stroke under age 40	_____	_____	_____
Anesthesia Problems	_____	_____	_____
Foot or Ankle Problems	_____	_____	_____

.**Physical Signs**

Height _____(ft/cm) Weight _____(lbs/kgs) Shoe Size _____

Work Position: Sitting _____ Walking _____ Standing _____

Have you ever worn custom made arch supports/orthotics? Yes____ No____

. For Females

Are you taking birth control pills?	Yes___	No___
Are you pregnant?	Yes___	No___
Are you nursing?	Yes___	No___

Patient's Signature _____ Date_____

OPD FOOT AND ANKLE

FINANCIAL POLICY

Basic Policy
If you do not have insurance, or if the care you receive is not covered service for your medical plan, you must pay in full at the time of your appointment unless the Billing Manager has approved payment terms in advance.

Medical Plan
If you give us the proper documents, we will file your medical claims for you. If you want us to file your claims, you must give us current information about every medical plan you have, including private plans, managed care plans, HMO, PPO, POS plans, state, federal and military programs, and any other type of medical plan you might have. Even if you believe a particular plan will not pay anything for this service, you still must provide us with current information about the plans or we cannot correctly file any medical claims for you.

Co-payments and deductibles must be paid at the time of service. We give discounts to medical plans to avoid additional cost of also processing and sending bills to patients.

You must allow us to make a photocopy of the front and back of each medical plan ID card and your driver's license or state ID card. You must give us your Birth date and the Birth date of the policyholder for each plan. You must give us your Social Security number and the Social Security number of the policyholder for each plan. We only use Social Security numbers to filling your medical claims and collecting payments due. We do not use Social Security numbers for any other purpose.

You must sign a statement allowing us to release your medical records to your medical plan(s), and you must sign an assignment of benefits statement for every medical plan allowing the plan(s) to send payment directly to OPD FOOT AND ANKLE.

If one of your medical plans TRICARE/CHAMPUS or CHAMPVA, you must also allow us to make a photocopy of your current military ID card.

If any of the information you supply is incorrect or if your medical plan has expired, your will be responsible for payment in full.

Non-covered Services
You are responsible for payment in full of items that are deemed non-covered services by your medical plan.

Injury
If your injury is related to an automobile accident, you must supply us with information about your automobile policy and the automobile policy of the person found to be at fault for the accident.

If your injury is work-related, your must supply us with the name, address, and phone number of your employer, the name of the Worker's Compensation Carrier, the case number, and the authorization number.

Missed Appointments
In fairness to the physician and other patients that are waiting for appointments, we require at least 24 hour's notice when cancelling an appointment. You may be charged for missed appointments. Missed appointments cannot be billed to a medical plan. If you miss appointments frequently or if you do not pay for missed appointments, you may be dismissed from our office.
I have read, understood, and agreed to follow the above financial policy.

Signature of patient or legal guardian: _____ Date: _____

Print Full Name of Patient: _____

OPD Foot & Ankle
Kenny Huang, D.P.M.
855 North Lark Ellen Ave., Suite C
West Covina, CA 91791
T: 626.869.8769 F: 949-579-2069

Patient Name: _____

NOTICE OF PRIVACY PRACTICES, ACKNOWLEDGEMENT AND CONSENT

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

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

- We may use and disclose patient medical records only for the following purposes:
  - **Treatment**: providing, coordinating, or managing health care and related services by one or more health care providers.
  - **Payment:** activities related to obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review (e.g., billing insurance provider for patient visit)
  - **Health care operations:** conducting quality assessment and improvement activities, auditing functions, cost-management services and as required by law
- 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 patient's written authorization. Patient may revoke such authorization in writing, except to the extent that we have already taken actions relying on patient authorization.
- We have the right to change our *Privacy Practices* from time to time. Patients may request a current copy by writing to address indicated above.
- Patients have the following right with respect to their protected health information. Patient may exercise these rights by submitting a written request to the address indicated above, attention Privacy Officer:
  - The right to request restriction on certain uses and disclosures of protected health information, including those related family members, other relatives, close personal friends, or any other person identified by patient. We are not required to agree to a requested restriction. However, if we do, we must abide by it unless a patient agrees in writing to remove it.
  - The right to reasonable requests to receive confidential communications of protects health information from this organization by alternative means or locations.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - 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 (Guardian) Signature Date