Patient Information (please print)			
Name: SSN: Last: First: Initial:		Sex:	DOB:
Address:		Phone number:	
Street:	City:	State:	Zip:
Mailing Address (if other than permanent residence):			
Street:	City:	State:	Zip:
If Minor- Who assumes financial responsibility?			
Name:	Address:	Phone number:	
Name of person to contact in case of emergency:		Phone number:	

Employment Information

Name of Employer: Occupation:

Assignment of Benefits

I hereby assign all medical and/or surgical benefits, to which I am entitled, including Medicare, private insurance and any other plan, to Alamitos-Seal Beach Podiatry Group. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for any co-payments, deductibles or non-covered services.

_____ _____

Signature Date

As patient or legal guardian of a minor patient, I agree to pay for all services rendered in accordance with the terms and conditions set forth in the financial policy of the office, of which I have received a copy. In the event legal action should become necessary to enforce payment of any charges, I agree to be responsible for and pay all reasonable attorney's fees and court costs required.

I hereby give my permission to the doctors of Alamitos-Seal Beach Podiatry Group to administer treatment, and to perform such procedures as may be deemed medically necessary in the diagnosis and/or treatment of my foot/ankle condition once those procedures have been fully explained to me in advance.

_____ _____

Signature Date

Medical & Podiatric History

Please complete the following information which will assist in determining an accurate diagnosis and proper course of treatment

Name:	**Age:**	**DOB:**	**M/F**

Height: **Weight:**

Primary Care Physician:
Name: _____
City, State: _____

Pharmacy:
Name: _____
Address: _____
Phone number: _____

Medical Conditions:

_____
_____
_____
_____
_____

Current Medications:

Name:	Dosage:

Allergies/Sensitivities:

- ☐ Sulfa
- ☐ Codeine
- ☐ Penicillin
- ☐ Morphine
- ☐ Lidocaine
- ☐ NSAIDs
- ☐ Adhesive Tape
- ☐ Latex
- ☐ Other: _____
- ☐ No Allergies or Sensitivities

Family History

Age	Sex	Health Conditions

Previous Surgeries/Hospitalizations:

Reason	Year

Reason for Visit

Please briefly describe your foot, ankle or leg conditions. Include which foot (right, left or both), how long the problem has existed and any previous treatment.

1. _____
   _____
2. _____
   _____
3. _____

Are you a smoker? ☐ Yes ☐ No If yes, how many years? _____ Packs/day _____

Do you consume alcohol? ☐ Yes ☐ No If yes, how many drinks/week? _____

How many hours are you on your feet/day? _____

Shoe size: _____

Do you wear any of the follow supports?

☐ Prescription orthotics

☐ Over the counter orthotics

☐ Other: _____

Have you been previously treated by a podiatrist? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

_____

Remarks

_____

_____

_____

_____

ALAMITOS-SEAL BEACH PODIATRY GROUP

JEREMY COOK, D.P.M | FAYE IZADI, D.P.M | RYAN ALLEN, D.P.M

Patient Referral Form

Patient name: _____ DOB: _____ Date: _____

Were you previously treated here? YES / NO (if yes, please specify which office location and year)

□ Los Alamitos (year): _____ □ Seal Beach (year): _____

Who may we thank for referring you to our office?

□ Family: _____ □ Friend: _____

□ Doctor: _____ □ Insurance Referral: _____

□ Internet (please specify):

□ Google □ Yelp □ Other: _____

What terms or names did you search? _____

Did you look at other podiatry practices before deciding on our office? YES / NO

(if yes, can you tell us what influenced your decision to choose our practice?)

_____

Release of Medical Information

I authorize Alamitos-Seal Beach Podiatry Group to discuss my condition and/or medical treatment with the following persons:

Name:	Phone number:
_____	_____
_____	_____
_____	_____

I understand that Alamitos-Seal Beach Podiatry Group will not discuss my personal health information with anyone not listed above.

_____ _____

Signature Date

ALAMITOS-SEAL BEACH PODIATRY GROUP

JEREMY COOK, D.P.M | FAYE IZADI, D.P.M | RYAN ALLEN, D.P.M

Financial Policy

Thank you for choosing us as your podiatric health care provider. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

Financial agreements may be made in one of three ways:

1. **Cash**

   Full payment is due at the time of service. We accept cash, check or credit card. This allows your account balance to remain current, with full disclosure of charges when services are rendered. We offer extended payment plans for patients, prior approval, from our office manager.

2. **HMO Insurance Plan**

   If you are a member of an insurance plan that requires authorization to see a specialist, we ask that you contact your primary care physician for an authorization to our office. This process is required for your initial office consult, and may take up to 2-3 weeks to obtain. **Patients who arrive to our office without proper authorizations may be liable for the cost of the consult and/or treatment rendered.** Follow up visits should be scheduled with adequate time to arrange for authorization to be obtained. Co-payments and deductibles are also due at the time services are rendered.

3. **All Other Insurance Plans (Medicare, PPO, etc.)**

   We require all patients to present their current medical insurance card at the time of visit. We will bill your provided insurance company for services rendered in this office in a timely manner. We will allow up to 60 days for your insurance company to pay any claims submitted. Any unpaid balances/claims are the financial responsibility of the patient. **For office visits and treatments we require payment of your co-payment and/or unpaid deductible at the time services are rendered.** Delinquent accounts are subject to collection procedures and will be assessed a special handling fee, typically 30% of the unpaid balance, when collection procedures are initiated.

Missed Appointments

When a patient misses a scheduled appointment it deprives our office the opportunity to provide services to other patients needing care. Often times there is a waiting list of patients desiring treatment in our office. We try to accommodate these patients with openings created from canceled appointments. **Therefore, if you need to cancel or reschedule your appointment we require that you provide 24 hour notice.** This will allow us to offer your appointment to others needing care. **In the event that a patient misses an appointment, it is our policy to charge the patient $65 for the missed office visit fee (fee is subject to change).**

I have read and understand the financial policies as described above.

_____ _____

Signature Date

ALAMITOS-SEAL BEACH PODIATRY GROUP

JEREMY COOK, D.P.M | FAYE IZADI, D.P.M | RYAN ALLEN, D.P.M

Notice of Privacy Practices

OUR LEGAL DUTY We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request. You may request a copay of our notice at any time.

USES AND DISCLOSURES OF HEALTH INFORMATION We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: we may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use or disclose your health information to obtain payment for services we provided to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence of qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credential activities.

YOUR AUTHORIZATION In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization we can not use or disclose your health information for any reason, except those described in this notice.

MARKETING HEALTH-RELATED SERVICES We will not use your health information for marketing communications without your written authorization.

REQUIRED BY LAW We may use or disclose your health information when we are required to do so by law.

ABUSE OR NEGLECT We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety, or the health or safety of others.

NATIONAL SECURITY We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

APPOINTMENT REMINDERS We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, emails, text messages, postcards or letters).

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices, and that I have read (or have had the opportunity to read) and understand the notice.

_____	_____	_____
Patient Name (print)	Signature	Date

ALAMITOS-SEAL BEACH PODIATRY GROUP

JEREMY COOK, D.P.M | FAYE IZADI, D.P.M | RYAN ALLEN, D.P.M

No Show and Cancellation Policy

We understand that you may need to cancel an appointment occasionally. In such circumstances, please contact us no later than 24 hours before your scheduled appointment time. You may do so by calling our office.

If you do not show up for your appointment, or cancel/reschedule within 24 hours of your appointment time, we will consider that a no show. No show appointments may be subject to a **$65 fee**. No show fees are the patient's sole responsibility and must be paid in full before a new appointment will be made.

I have read and understand the no show and cancellation policy as described above.

_____ _____

Signature Date

Consent to E-mail or Text Usage for Appointment Reminders and other Healthcare Communications

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. Frequency of messages may vary. The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan. You may cancel at any time.

I consent to receive text messages or emails from the practice to receive communication as stated above. I authorize the office to send messages for appointment reminders, patient feedback and general health reminders or information to the following:

Cell phone number: _____

Email address: _____

At our medical office, we prioritize patient privacy and confidentiality. We do not share patients' mobile phone numbers with any third parties, including other patients or staff members, without explicit consent.

Patient name (please print): _____

_____ _____

Signature Date