The Foot Center
8631 W. 3RD ST. SUITE 303-E
LOS ANGELES, CA 90048

PATIENT INFORMATION

NAME:_____DATE OF BIRTH_____/_____/_____

RESPONSIBLE PARTY:_____SS#_____

HOME ADDRESS:_____MARITAL STATUS___

CITY_____STATE_____ZIP CODE_____ SEX M F

CELL PHONE:(_____)_____ HOME PHONE(_____)_____

EMAIL ADDRESS:_____

Information in compliance with MU (OBJ-304C); by the US government:

Race: □American Indian/Alaskan Native □Asian □Native Hawaiian /Pacific Islander □Black/African American □White/Caucasian □ Hispanic □Other: _____ □Refuse to report

Ethnicity: □Hispanic/Latino □Non-Hispanic/Latino □Refuse to Report/Answer

Preferred language: □English □Spanish □Other: _____

OCCUPATION:_____EMPLOYER:_____

WORK PHONE:_(_____)_____

WORK ADDRESS_____

REFERRED BY:_____PRIMARY PHYSICIAN:_____

PREVIOUS PODIATRIST:_____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION OR OTHER INFORMATION NEEDED FOR THE PROCESSING OF MEDICAL CLAIMS AND REQUEST THAT PAYMENT BE MADE DIRECTLY TO THE TREATING DOCTOR. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. IT IS UNDERSTOOD THAT THE PATIENT IS RESPOSIBLE FOR THE MEDICAL SERVICES THEY RECEIVE.

I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND I HAVE READ (OR HAD THE OPPORTUNITY TO READ IF I SO CHOOSE) AND UNDERSTOOD THE NOTICE.

I AUTHORIZE HEALTHCARE PROVIDERS AT THE FOOT CENTER TO TREAT MYSELF OR MY CHILD NAMED ABOVE.

SIGNATURE_____DATE_____

(Parent signature if patient is a minor.)

THE FOOT CENTER
MEDICAL INFORMATION Height ____ Weight___

Shoe Size_____

PATIENT NAME:_____

PLEASE PROVIDE BRIEF DESCRIPTION OF THE NATURE OF ILLNESS/INJURY & PRIOR TREATMENTS:

_____

_____

_____

_____

_____

HOW LONG HAVE YOU HAD THIS CONDITION?_____
DATE OF INJURY:_____(if applicable)
PHARMACY INFORMATION:_____
ALLERGIES:_____
CURRENT MEDICATIONS:_____

PERSONAL MEDICAL HISTORY:

Please indicate whether you have had any of the following medical problems

- ❑ Asthma
- ❑ Bleeding or clotting disorder
- ❑ Cancer
- ❑ Chest pain
- ❑ Depression
- ❑ Diabetes
- ❑ Dizziness
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Lung Disease
- ❑ Shortness of Breath
- ❑ Stroke
- ❑ Weakness/Numbness in extremities
- ❑ Other: (please specify)_____

_____

PAST SURGERIES: If yes, please list all prior operations with dates

_____

_____

_____

PAST SOCIAL HISTORY:

	YES	NO	If Yes, How Often?
Tobacco use:	____	____	_____
Alcohol use:	____	____	_____
Drug use:	____	____	_____
Exercise regularly	____	____	_____

If yes to Exercise, list the types of exercise and how much

_____

_____

_____

FAMILY HISTORY: Any illness that runs in the family?
If yes, please list

_____

_____

Signature:_____ Date:_____

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Communications: (Check one or all that applies):

____ Okay to leave voice message with detailed information

____ OK to E-mail detailed information/medical records

Note: When we send you an email, it is a HIPPA compliant email. When an email is received through emails services (ex: Hotmail, Gmail, Yahoo) that do not utilize encrypted email, it may expose your protected health information.
I understand the risk of unencrypted email and do hereby give permission to The Foot Center to send my personal health information via email when necessary.

The Foot Center will not communicate any information to anyone including family members unless he/she names are specified below:

Name:_____ Relationship to the patient:_____

Name:_____ Relationship to the patient:_____

Patient/Guardian Signature:_____ Date:_____

Print Patient/Guardian (if applicable): Name: _____ Date:_____

In general, the HIPAA privacy rule gives individual the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication PHI be made by alternative means, such as sending correspondences to the individual's office instead of the individual's home.

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and request for PHI to be minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made to pursuant to an authorization requested by the individual.

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Welcome to The Foot Center. We hope that our association will be of great relief to you. The following is a description of our office policies relative to payment based on your insurance.

All copays, deductibles, estimated insurance balances and payment for non-covered services are due at the time of service. Non-covered services will not be billed to insurance.

It your responsibility to be aware of your insurance benefits, The Foot Center will make every effort to assist you in understanding the scope of your insurance benefits. It is not the responsibility of The Foot Center to verify your insurance coverage or determine which services are or are not covered.

If your insurance denies payment for any reason, the amount owed is your responsibility and must be paid promptly. As courtesy to our patients, we will bill insurance carriers for services provided by our office, whether or not we are provider for that carrier. Payment of benefit will be subject to all terms, conditions, limitations, and exclusion of your contract at time of service

Any medical supplies purchased in the office must be paid at the date of service. These are not billable and all sales are final.

A **$50** fee will be charged to you for any appointment missed or cancelled with less than 24 hours notice. A $35 fee will be charged for any returned checks or credit cards. Interest of 12% annually will be charged to all balance's unpaid past 90 days.

We would be happy to answer any questions you might have regarding our office policy.

I give my consent to be treated for my condition and to have photographs, videotaped images, or other images made of me. I understand and agree that these images may be used by for the teaching and maybe placed on website, ads, social media.

I have read and understand the above information and accept full responsibility if any insurance does not pay for services rendered.

Patient's
Signature_____Date_____