Performance Foot & Ankle

Heraj Patel DPM, FACFAOM
Brooke Gifford DPM, FACFAS

I. Patient Information

Name ____________________

Address (No P.O Boxes) ____________________

City____________________ State____________________ Zip____________________

Home Phone #( )____________________ Mobile Phone #( )____________________

E-Mail address____________________

Age __________ Date of Birth____________________ Marital Status M___ S___ D___ W___ Sex M____ F____

Ethnicity: White__________Latino__________Asian__________Black/AA__________Other__________

If you prefer a language other than English, please list. ____________________

Social Security #____________________ Drivers License #____________________

Employer____________________ Work Phone #( )____________________

Occupation____________________ Responsible for Payments____________________

In Case Of Emergency Contact: ____________________ Phone #( )____________________

II. Referred By:

Dr.____________________ Friend or Relative____________________

Google __________Yahoo __________Other __________Insurance Handbook____________________

III. Primary Insurance:

Insurance Company Name____________________

Deductible Amount ____________________Co-Pay Amount ____________________

Subscriber's Name____________________

Subscriber's Birthdate____________________ Sex _____M _____F

Subscriber's Social Security #____________________

Patient Relationship to Subscriber Self______ Spouse______ Child______ Other______

I give my consent to have photographs taken of my feet. I understand and agree these images may be used by Performance Foot & Ankle Inc, and placed into your medical chart.

Patient Signature____________________ **Date**____________________

(Parent or guardian signature required if patient is a minor)

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Reason for today's visit: (chief complaint)____________________

Weight:__________ **Height** __________ **Shoe Size:**__________

Current medications:____________________

Environmental or Medicine Allergies:____________________

Previous Surgeries:____________________

Medical History: (Review of systems)

	Yes	**No**	**(if yes, explain)**
Diabetes	___	___	___
Eyes	___	___	___
Ears/Nose/Throat/Mouth	___	___	___
High blood pressure	___	___	___
Heart (murmur, artificial valves)	___	___	___
Lungs	___	___	___
Stomach/bowel	___	___	___
Kidneys	___	___	___
Arthritis/muscles/joints	___	___	___
Skin	___	___	___
Psychological disorder	___	___	___
Blood/bleeding disorder	___	___	___
Allergic/immunologic	___	___	___
Cancer	___	___	___
Circulatory problems	___	___	___
Liver disease	___	___	___
Varicose veins	___	___	___
Stroke	___	___	___

Females: are you pregnant ___yes ___no planning to become pregnant ___yes ___no

Family History:

No. of children: __________ age(s)__________

Check the following medical conditions that have occurred within your family history:

Disease	**Mother**	**Father**
Arthritis	___	___
Cancer	___	___
Diabetes	___	___
Heart disease	___	___
High blood pressure	___	___
Lung disease	___	___
Skin cancer	___	___

Social History:

Who is your primary care or family doctor? ____________________ Do you have stairs at home? ___no ___yes

Do you smoke? no ___ yes ___ –frequency__________ Have you ever smoked? no ___ yes ___ (if yes how many years)?__________

Do you drink alcohol? no ___ yes ___ -frequency__________ Do you use recreational drugs? no ___ yes ___ -frequency__________

Occupation____________________ Hobbies/leisure activities ____________________

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this infomation.

When it comes to your health information, you have certain rights:

- **Get an electronic or paper copy of your medical record:** You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. We will provide a copy or a summary of your health information, usually within 30 days of your request. A fee may apply.
- **Ask us to correct your medical record:** You can ask us to correct health information about you that you think is incorrect or incomplete. We may say "no" to your request, but we will tell you why in writing within 60 days.
- **Request confidential communications:** You can ask us to contact you in specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- **Ask us to limit what we use or share:** You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- **Get a list of those with whom we've shared information:** You can ask us for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why. We will include all the disclosures, except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you have us to make). We'll provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask or another one within 12 months.
- **Get a copy of this privacy notice:** You can ask for a paper copy of this notice at any time, even if you hace received the notice electronically. We will provide you with a paper copy promptly.
- **Choose someone to act for you:** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make decisions about your health information on your behalf. We will make sure the person has this authority and can act for you before we take any action.
- **File a complaint if you feel your rights are violated:** You can complain if you feel we have violated our rights by contacting us at the location listed above. You can file a complaint with the U.S. Department of Health and Human Services office for Civil Rights by sending a letter to 200 Independence Avenue SW, Washington, D.C. 20201, calling 1-877-696-6775, or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

For certain health information, you can tell us our choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do and we will follow your instructions.

- In these cases, you have both the right and choice to tell us to: Share information with your family, close friends, or other involved in your care; Share information in a disaster relief situation. *If you are not able to tell us your preference, for example, if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
- In these cases, we never share your information unless you give us written permission: Marketing purposes, Sale of your information.

Our uses and disclosures: We typically use or share your health information in the following ways:

- **Patient treatment:** We can use your health information and share it with other professionals who are treating you.
- **Run our organization:** We can use and share your health information to run our practice, improve your care, and contact you when necessary.
- **Bill for your services:** We can use or share your health information to bill and get payment from health plans or other entities.
- We can use or share your information for health research.
- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services, if it wants to see that we're complying with federal privacy laws.
- We can share health information about you with organ procurement organizations
- We can share health information with a coroner, medical examiner, or funeral director when an individual pass away.
- We can share health information about you to address worker's compensation, law enforcement, and other government requests, as authorized by law.
- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our responsibilities: We are required by law to maintain the privacy and security of your protected health information

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. You must let us know in writing if you change your mind.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Acknowledgement of Notice of Privacy Practices

I have received and read the Notice of Privacy Practices for Performance Foot & Ankle Inc. I authorize PFA to release any information necessary to process my claims for health care benefits. I agree to assign the benefits of my health insurance to PFA. I understand that I am fully responsible for any non-covered services, denied services, health insurance deductibles, co-payments, and co-insurance, due by me. I consent to the use of sharing of my health records for treatment, payment, and operational purposes as described in the Notice of Privacy Practices.

____

Patient Name

____________________________________ ______________________

Patient Signature (Parent or Guardian for minors) Date

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Financial Policy

Thank you for choosing Performance Foot & Ankle Inc. as your health care providers. We are committed to your treatment being successful. The following is a statement of our Financial Policy that we ask you to read, agree to and sign prior to any treatment

Co-pays: Payment is due at the time services are rendered, including co-payment and deductibles. We do bill insurance plans as a courtesy. We will bill PPO & POS plans, we do NOT accept HMO plans. We accept cash, checks, credit cards and debit cards with the Visa or MasterCard logos.

Insurance Claims: To properly bill your insurance, we require that you disclose all insurance information including primary and secondary insurance, and any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately. Denied claims become the patient's responsibility.

Surgery: When possible, prior to scheduling surgery, an estimated surgical cost analysis will be provided. It is your responsibility to pay the deductible, coinsurance or any outstanding balances on your account at least five (5) days prior to the date of your scheduled surgery. There will be a $150 cancellation fee for all non-medical cancellations.

DME Products: All supplies dispensed which are not billable to insurance must be paid for at the time they are dispensed. There are no refunds or exchanges on any supplies dispensed including but not limited to orthotics and splints.

Returned Checks: The charge for a returned check is $25 payable by cash, credit card or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned checks.

Cancelled Appointments: There is a $50 charge for all appointments canceled with less than 24 hours' notice. This fee also applies to 'no show' appointments.

Medical Records: There is a $30 fee for all requested copies of medical records and x-rays. Requests will need to be made in writing and will take 5 business days to process.

Outstanding Balance Policy: It is our office policy that all past due accounts be sent three statements. If payment is not made on this account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account may be subject to collection by an external agency unless financial arrangements can be made with our billing office, (866) 324-7003.

I authorize Performance Foot & Ankle Inc. to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim. I have read, understand and agree to the Financial Policy.

____ ____________________________
Patient Signature (Parent or guardian for minors) Date

3095 Old Conejo Road, Suite 100
Newbury Park, CA 91320
805-273-1415
http://www.performancefa.com

Performance Foot & Ankle

Orthotic Policy

If your doctor determines that orthotics are medically necessary and/or beneficial to you, it is important that you understand our office policy regarding fees and payment for custom functional orthotics. We take great pride in prescribing the finest biomechanical orthotics available. Each orthotic is a custom mold/scan of the foot and therefore are non-refundable.

The cost for orthotics is $550 regardless of insurance coverage or allowable amount. Please note that if we call your insurance company as a courtesy to check benefits, it is only an estimate and is NOT a guarantee of coverage or payment. We however encourage you to call your insurance company to also check your benefits. The insurance company will want to know the billable codes and they are as follows:

S0395 - Scanning Right Foot

S0395 - Scanning Left Foot

L3000 - Orthotics Right Molding

L3000 - Orthotics Left Molding

A letter of medical necessity is sometimes required by your insurance company and we will be happy to provide them with that letter upon request. Although it is our hope, we cannot guarantee that orthotics will resolve your current foot or ankle issue and/or pain.

Please sign below to verify that you understand our policy regarding custom orthotics.

I agree to the above.

____

Patient Name

____ ____________________

Patient Signature Date

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805-273-1415
http://www.performancefa.com

DeepScribe Inc.
Patient Consent for Recordings

Patient Consent for Recordings
DeepScribe Inc.

I, (the "Patient") give my permission, as indicated below, to be audio recorded during my medical visit.

I consent to using DeepScribe Inc.'s medical scribe services to use these Recordings and personal information collected during the Recordings, including health information, for the following services, which includes but is not limited to, medical documentation, medical transcription, quality assurance, training, software improvement, and voice analytics purposes.

I understand that any or all of the information provided by me or my care team during the Recordings may be used and disclosed for the above-indicated purposes, including personal and health information about myself.

____
Patient Signature Date

____