101 Foot and Ankle
450 Rosewood Ave #104
Camarillo, CA 93010
Tel: (805) 388-7809 | Fax: (805) 910-3863

Patient Information

Patient Name: _____ Date of Birth: ____/____/_____ Age:_____

Gender: ☐Male ☐Female ☐Transgender ☐Non-binary ☐Other

Race: ☐African-American/Black ☐American Indian/Alaska Native ☐Asian

☐Native Hawaiian/Pacific Islander ☐White/Caucasian ☐Other ☐Decline to state

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Decline to state

Marital Status: ☐Single ☐Married ☐Partnered ☐Separated ☐Divorced ☐Widowed

SSN:_____ Driver's License #:_____ Preferred language:_____

Home Address:_____

City: _____ State: _____ Zip Code: _____

Home Phone #:_____ Cell Phone #:_____

Work Phone #:_____ E-mail Address:_____

Best method of contact: ☐Home phone ☐Cell phone ☐Work phone ☐E-mail

Preferred Contact Time: ☐Morning ☐Afternoon ☐Evening

Can we leave a detailed message? ☐Yes ☐No

Emergency Contact:_____ Phone #:_____ Relationship:_____

How did you hear about our office? ☐Dr._____ ☐Friend/Family_____

☐Insurance handbook ☐Google ☐Other_____

Insurance

Primary insurance name:_____ Secondary insurance name:_____

ID #:_____ ID#:_____

Name of Policyholder:_____ Name of Policyholder:_____

DOB: _____ SSN:_____ DOB:_____ SSN:_____

Relationship to patient:_____ Relationship to patient:_____

Medical History (If checked, please explain)

☐Diabetes I or II _____
☐Eyes/Ears/Nose/Throat _____
☐High Blood Pressure _____
☐Heart _____
☐Lungs _____
☐Stomach/bowel _____
☐Kidneys _____
☐Arthritis/muscles/joints _____
☐Skin _____
☐Psychological disorder _____
☐Blood/bleeding disorder _____
☐Allergic/immunologic _____
☐Cancer _____
☐HIV+/AIDS _____
☐Circulatory _____
☐Neuropathy _____
☐Liver disease _____
☐Varicose Veins _____
☐Stroke _____
☐Other _____

Family physician name:_____ Phone #:_____

Date last seen:_____

Pharmacy Name:_____ Pharmacy Address:_____

Pharmacy Phone #:_____

Medications *If you have a list, we will make a copy

Medication Name	Dosage/Frequency	Medication Name	Dosage/Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies

☐Medications _____

☐Foods _____ ☐Other_____ ☐No Known Allergies

Surgeries

Type of Surgery	Date	Type of Surgery	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History	Mother	Father	Other family member (specify)
Cancer	☐	☐	_____
Diabetes I or II	☐	☐	_____
Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____
Mental Illness	☐	☐	_____
Stroke	☐	☐	_____
Other_____	☐	☐	_____

Social History

Do you smoke tobacco? ☐ No ☐ Yes ☐ Former smoker _____ years _____ pack(s) per day

Recreational drug use? ☐Yes ☐No ☐Marijuana ☐Narcotics ☐Cocaine ☐Other_____

How often do you drink alcohol? ____ drink(s) per week Drink(s) of choice_____

How often do you exercise? _____ times per week Which activities?_____

Hobbies _____

Occupation_____ Employer_____

Reason for today's visit_____

Height_____ Weight_____ Shoe size_____

Financial Policy

PAYMENT FOR SERVICES: Payment for services is due once services are provided to you. We expect all charges we present to you at your visit will be paid at that visit, including copays and undue balances. You are responsible for copay amounts, coinsurance amounts, program deductibles, unpaid charges to account, and charges for services that are not covered by insurance or government programs, as determined by your insurance plan. Payments must be made by *cash, check, or credit card*. Payment plans can be agreed upon with a credit card on file. This must be discussed with the office. There will be a $25.00 charge for returned checks.

INSURANCE: If your doctor is a participating provider with your insurance plan, we will submit the claim to your insurance company. To do this, we must have accurate insurance information and a copy of your identification card or claim form. Your insurance policy is a contract between you and your insurance company; therefore, you are responsible for payment whether or not your insurance company pays. **Copays are due at the time of the visit.**

NO INSURANCE: If you do not have insurance or the doctor is not a participating provider with your insurance plan, all charges for the services will be paid at the time of the visit.

BILLING COMMUNICATIONS: We will present charges to you by written statements via the mail.

ASSIGNMENT OF BENEFITS: I authorize my insurance benefits to be paid directly to the doctor. I understand that the doctor's office will bill my insurance as a courtesy and that I am responsible for all co-payments, deductibles, unpaid balances, and non-covered services. I authorize the release of information required to process my claims.

COLLECTIONS: A collection fee equal to 40% of balance will be added to all delinquent accounts over 90 days past due that have to be sent to a collection agency.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES HIPAA

I hereby authorize this practice to disclose both orally and in writing all facts pertaining the past, present, and future considerations, treatments, and services rendered with no exceptions. This includes diagnosis, prognosis, care and treatment, reports, testing, and changes. I understand that I may change this authorization in writing at any time. **Grab a copy on the front desk.**

Is there a family member or other person you would like for us to share your medical information?

☐No ☐Yes Name(s):_____

I acknowledge the Financial Policy and Notice of Privacy Practices and I have read and understand them.

_____ _____

Patient Name (Please print) Date

_____

Patient/Guardian Signature

CREDIT CARD ON FILE AGREEMENT – EFFECTIVE APRIL 2023

Recent changes in healthcare markets and payment processes have altered insurance coverages to shift more of the cost of care to our patients. The credit card on file policy is a convenient method to pay for the portion of services that are deemed patient's responsibility such as copay, deductible, and coinsurance. Co-pays are still due at time of visit. At check-in, the credit card information will be obtained and kept confidential and secure until the insurance(s) have paid their portion and notifies 101 Foot and Ankle of the balance due, if any. At that time, the billing department will issue one statement via mail in which the patient will have 30 days to pay the balance or make other payment arrangements. After 30 days, the debit/credit card on file will be automatically charged for any outstanding balance. In the case when a credit card has reached its limit maximum, the billing department will notify the patient via a mailed letter. The patient will have an additional 30 days to arrange payment before the bill is subject to additional collection activity. If you have any questions about the policy, please call us at (805) 388-7809.

I authorize 101 Foot and Ankle to keep my debit/credit card on file and to charge my debit/credit card for any outstanding balances that my health plan has identified as my financial responsibility. If the provided debit/credit card has changes, expired, or is denied for any reason, I agree to immediately give 101 Foot and Ankle a new, valid debit/credit card which I will allow to be charged over the phone. I agree that the new card will be used with the same authorization as the original card I presented.

_____ _____

Patient/Guarantor Signature Date

Notice of Privacy Practices

I understand that under the Health Insurance Portability & Accountability Act of 1998 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up amount the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out:

- Treatment: With your permission, we may use or disclose personal health information about you to provide, coordinate, or manage your care or any related services, including sharing information with others out of 101 Foot and Ankle that we are consulting with or referring you to
- Payment: Information will be used to obtain payment for the treatment and services provided. This will include contacting your health insurance company for prior approval of planned treatment or for billing purposes
- Healthcare operations: We may use information about you to coordinate our business activities. This may include setting up your appointments, reviewing your care, and training staff

I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.