DR. SALMA AZIZ, DPM
FOOT AND ANKLE SPECIALTY GROUP

Welcome to our Office

Please Print

PATIENT INFORMATION

Date _____ Home Phone ( ) _____ Email _____
Last Name _____ First Name _____ Middle Initial____ Sex M F
Street _____ City _____ State _____ Zip _____
Social Security # _____ Driver's License _____ Age ____ Date of Birth ____/____/___
Marital Status _____ Children? _____ Ages _____
Employer _____ Phone ( ) _____
Street _____ City _____ State _____ Zip _____
Occupation _____ May we call you at work Y N Work hours_____

Spouse/Domestic Partner Information (If appropriate)

Home Phone ( ) _____
Last Name _____ First Name _____ Middle Initial____ Sex M F
Street _____ City _____ State _____ Zip _____
Social Security # _____ Driver's License _____ Age ____ Date of Birth ____/____/___
Employer _____ Phone ( ) _____
Street _____ City _____ State _____ Zip _____

Financial Responsible Party (If different from patient)

Home Phone ( ) _____
Last Name _____ First Name _____ Middle Initial____ Sex M F
Street _____ City _____ State ____ Zip _____
Social Security # _____ Driver's License _____ Age _____ Date of Birth ____/____/___
Employer _____ Phone ( ) _____
Street _____ City _____ State_____ Zip _____
Occupation _____ May we call you at work Y N Work hours _____

Insurance Information

Primary Insurer _____ Phone _____ Group # _____
Street _____ City _____ State _____ Zip _____
Insurance Id _____
Secondary Insurer _____ Phone _____ Group # _____
Street _____ City _____ State _____ Zip _____
Insurance Id _____

In case of an emergency

Who Should we contact? _____ relationship_____ Phone_____

Who may we thank for referring you? _____

Please read and sign below: I directly assign all medical and surgical benefits to Dr. Aziz. I understand that I am financially responsible for all charges whether paid by my insurance provider or not. I authorize Dr. Aziz to release all information necessary to secure the payment of benefits. I understand that fees for service are payable at the time of service, unless other arrangements are made in advance. It is my responsibility to pay any deductible amount or co-insurance.
It is the policy of this office to bill your insurance for reimbursement. However, we shall allow no more than sixty (60) days for payment. After sixty (60) days you will be billed for any outstanding balance on your account. All outstanding balances are due thirty (30) days from the statement date.

I HEREBY GIVE AUTHORIZATION FOR TREATMENT.

_____ _____
Signature Required Date

2 Patient Medical History - Overview

Patient Name: _____

What is your foot/ankle problem? _____

_____

_____

When did problem begin? Date: _____

Describe any accident/event: _____

_____

Is this problem work related? ☐ Yes ☐ No

First visit to a Doctor for this problem? ☐ Yes ☐ No

Previous x-rays? ☐ Yes ☐ No If Yes, Date: _____

Where are they now? _____

Describe any previous treatment or home remedies?

_____

_____

Have you been treated for:

☐ Low back pain	☐ Intoeing	☐ Heel pain
☐ Broken foot bone(s)	☐ Callouses	☐ Rash
☐ Hammertoes	☐ Neuroma	☐ Corns
☐ Ankle injury	☐ Knee pain	☐ Arch pain
☐ High arch feet	☐ Bunions	☐ Flat feet
☐ Ingrown nails	☐ Childhood foot problems	

Do you have or have you ever been treated for:

☐ Diabetes	☐ Anemia	☐ Blood disease
☐ Hepatitis	☐ Phlebitis	☐ Heart trouble
☐ HIV	☐ High Blood Pressure	☐ Sleep Apnea*

*Do you use a CPAP machine? ☐ Yes ☐ No

Are you slow to heal after cuts? ☐ Yes ☐ No

Any abnormal bruising or bleeding? ☐ Yes ☐ No

Any pain in calves or buttocks when walking? ☐ Yes ☐ No

Is the pain relieved by rest? ☐ Yes ☐ No

Do your feet hurt at night? ☐ Yes ☐ No

Currently taking any prescription medications? ☐ Yes ☐ No

List: _____

_____

Height: _____ Weight: _____ Shoe Size: _____

How much are you on your feet at work?

☐ 20% ☐ 40% ☐ 60% ☐ 80% ☐ 100%

List any sports/activities:

_____

Are you taking nutritional or dietary supplimments (e.g. Ginkgo biloba, Ginseng, Echinacea)? ☐ Yes ☐ No

List _____

Allergies to injection, oral or topical administration of:

Penicillin or other antibiotics?	☐ Yes ☐ No ☐ Don't Know
Narcotics?(Morphine, Codeine, Demerol...)	☐ Yes ☐ No ☐ Don't Know
Local anesthetics?	☐ Yes ☐ No ☐ Don't Know
Pain remedies?	☐ Yes ☐ No ☐ Don't Know
Adhesive tape?	☐ Yes ☐ No ☐ Don't Know
Any other drug, medication or treatment?	☐ Yes ☐ No ☐ Don't Know

If "yes" to any of the above, please explain: _____

_____

Do you smoke cigarettes? ☐ Yes ☐ No Packs/Day: ____ Years:

Did you ever smoke? ☐ Yes ☐ No Packs/Day: ____ Years:

Do you drink alcoholic beverages?

☐ None ☐ Rarely ☐ Moderately ☐ Daily ☐ Quit

Do you use "recreational" drugs?

☐ None ☐ Rarely ☐ Moderately ☐ Daily ☐ Quit

List

_____

Have you had a serious illness?	☐ Yes ☐ No
Have you been hospitalized or under lengthy medical care?	☐ Yes ☐ No
Have you had any surgery?	☐ Yes ☐ No
Do you have any implants?	☐ Yes ☐ No
Orthopedic (e.g. knee, hip, etc.)	☐ Yes ☐ No
Cardiac (e.g. valve, pacemaker, graft, etc.)	☐ Yes ☐ No
Cosmetic (e.g. breast, facial, etc.)	☐ Yes ☐ No

If "yes" to any of the above, please explain: _____

_____

_____

3 Patient Physicians

Did your Family Physician (PCP) or other Specialist refer you? ☐ Yes ☐ No

Family Physician: _____

Date last seen: _____ Phone: ( )

City: _____ State: _____ Zip:

Are you here for a consultation? ☐ Yes ☐ No

Are you here for a surgical evaluation? ☐ Yes ☐ No

Specialist Dr: _____ Specialty: _____ Date last seen: _____ Phone: ( ) _____ City: _____ State: _____ Zip: _____

Are you here for a 2nd opinion on surgery? ☐ Yes ☐ No

Did you independently come for an opinion? ☐ Yes ☐ No

4 Family History

Has any blood relative had:

If "Yes," please indicate who

Tuberculosis?	☐ Yes ☐ No	_____
Cancer or tumor?	☐ Yes ☐ No	_____
High blood pressure?	☐ Yes ☐ No	_____
Heart trouble?	☐ Yes ☐ No	_____
Diabetes?	☐ Yes ☐ No	_____
Birth abnormalities?	☐ Yes ☐ No	_____
Arthritis?	☐ Yes ☐ No	_____
Stroke?	☐ Yes ☐ No	_____
Foot problems?	☐ Yes ☐ No	_____

DR. SALMA AZIZ, DPM
FOOT AND ANKLE SPECIALTY GROUP

Date: _____

Patient Name _____

SALMA AZIZ, DPM
FOOT AND ANKLE SPECIALTY GROUP

Web Site: www.yourfootdoc.com
Mission Health Center
22032 El Paseo, Suite 140

NOTIFICATION OF BILLING PROCEDURES

Medicare—Unauthorized/Unbillable Charges

Medicare requires a minimum of 60 days between visits for at risk patient footcare and nail grinding. If the diagnosis changes (for example, fracture, trauma, infections, etc.) the visit may be billed under
the new diagnosis. Any charges occurring outside these guidelines will be the responsibility of the patient.

Non-covered Services

Insurance providers will decline payment for non-covered services or supplies. Post-op shoes, certain ankle braces, orthotic devices and pads are some examples of non-covered supplies.

Unauthorized Visits

Some insurance providers require prior authorization for office visit or procedure. It is the patient's responsibility to obtain authorization before their office visit. If authorization is not obtained, the patient will be responsible for all costs incurred by their office visit.

Deductible

The deductible is the patient's responsibility. The patient's insurance provider will be billed to determine the amount applied toward the patient's deductible. Insurance information must be available on the day of the visit or full payment will be required at that time.

Date: _____

Patient Name: _____

SALMA AZIZ, D.P.M.
Foot and Ankle Specialty Group

Web Site: www.yourfootdoc.com

Mission Health Center
22032 El Paseo, Suite 140
Rancho Santa Margarita, California 92688
Phone: (949) 766-8505
Fax: (949) 766-5782

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*** **("HIPAA")** 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 analysis, customer 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 patients 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 rights 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 to 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 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

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, American Express, cash or check.

- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.

- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.

- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.

- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.

- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.

- Past due accounts are subject to collections proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due to this office.

- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

- There will be a $45.00 fee for ALL missed appointments without a 24 hour courtesy notice.

- There will be a $45.00 fee for any initial EDD paperwork and $15.00 for extensions.

- There will be a $35.00 fee for any copies of medical records given to patients for their personal use.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party: _____ **Date:** _____