PATIENT REGISTRATION

Last Name: _____ First Name: _____ MI: _____ M F Age ____

By what name would you like to be addressed? _____ Single____ Married___

Patient's Street Address: _____

City, State, Zip: _____

Phone #: _____ SS#: _____ Birth Date: _____

Email: _____

Occupation: _____ Previous Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Name of Insured (if other than self): _____Insured's Birthdate: _____

Insured's Phone #: _____ Patient is: ___Spouse ___Dependent/Child

Note: We are required by law to have a copy of your insurance card and identification card on file in order to bill your insurance for you. If we do not have this information on file, you will be billed directly and are solely responsible for all charges. Payment is due at the time of service.

Whom may we thank for referring you to our office?

Doctor (Name): _____

Friend (Name): _____

Web Search: _____

Other: _____

Who is your primary care physician/Clinic? _____

Preferred Pharmacy? _____ Location: _____

NOTICE: Release of Benefits Information: 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, and non-covered services. I authorize the release of information required to process my claims. (If not signed, payment for each visit is due at the time of service.)

ALL CO-PAYMENTS AND PREVIOUS BALANCES ARE DUE ON THE DAY OF SERVICE.

Patient Signature: _____ Date: _____

PATIENT MEDICAL RECORD

What is your present foot problem or condition?: _____

_____

Is this a result of an injury or accident?: _____ How long have you had this?: _____

What have you already tried to alleviate this?: _____

Have you been seen by another doctor for this?: _____ Who?: _____

What is your height?: _____ Weight?: _____ Shoe size?: _____

Please list allergies: _____

Medications (or a list): _____

_____

_____

Are you on birth control?: _____ Nursing?: _____ Pregnant?: _____

Do you have Diabetes?: _____ Do you have a pacemaker?: _____ Artificial Joint?: _____

Please list any past or current medical problems: _____

_____

_____

_____

_____

Please list your major surgeries with dates, including childbirth: _____

_____

_____

_____

_____

Any anesthetic reactions or complications?: _____

_____

Do you have any family members with a similar foot issue?: _____

Date of last flu shot: _____ Date of last eye exam: _____

Date of last pneumonia vaccination: _____ Do you drink alcohol?: _____

Do you use tobacco?: _____ Have you ever used tobacco?: _____ When did you stop?: _____

I hereby give permission to the doctors to examine, diagnose and treat my feet and ankles medically or surgically and attest that the above information is accurate and true:

Patient (parent/guardian) Signature: _____ Date: _____

You have a right to a paper copy of this notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Central Coast Foot Clinic reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Central Coast Foot Clinic is required by law to comply with this Notice.

Central Coast Foot Clinic is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have any questions about any part of this notice or if you want more information about privacy rights, please contact the Office Administrator by calling our office at 805-481-0881. If the Office Administrator is not available, you may make an appointment for a personal conference, in person or by telephone, within two working days.

Complaints

Complaints about your Privacy rights, or how Central Coast Foot Clinic has handled your health information should be directed to the Office Administrator by calling this office at 805-481-0881. If the Office Administrator is not available, you may make an appointment for a personal conference, in person or by telephone, within two working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DDHS, Office of Civil Rights
200 Independence Avenue, SW
Room 509F, HHH Building
Washington DC 20201

This Notice is effective as of _____/_____/_____

I have read the Privacy Notice and understand my rights contained in this notice.

By way of my signature, I provide Central Coast Foot Clinic with my authorization and consent to use and disclose my protected health care information for the purpose of treatment, payment and health care operations as described in the Privacy Notice

_____

Patient's Name (print)

_____

Patient's Signature Date

_____

Authorized Facility Signature Date

CENTRAL COAST FOOT CLINICS

DR. ADAMS I DR. ECKLUND

Request for Release of Medical Information

Patient: _____ DOB: _____

The above patient authorizes the release of the following medical information.

___Op Reports	Dates: _____
___Lab Reports	Dates: _____
___Progress Notes	Dates: _____
___Radiology Reports	Dates: _____
___X-Rays	Dates: _____

_____

Patient or Guardian Signature

Please forward reports:

☐ To ☐ From: _____

_____

_____

☐ To ☐ From: Central Coast Foot Clinics
310 S. Halcyon Road, Suite 101
Arroyo Grande, CA. 92420
Phone: (805) 481-0881 Fax: (805) 481-0835
Email: info@centralcoastfootclinics.com

CENTRAL COAST FOOT CLINICS

Financial Information

This information is to help you understand your financial obligation to our office.

Please initial each area as you read it:

_____ **GENERAL INFORMATION:**

- Central Coast Foot Clinics will accept cash, personal checks, MasterCard, Visa or Discover Card.
- We encourage you to become familiar with your health insurance plan and its benefits. Any balance unpaid by your insurance company is your responsibility.
- To protect you from imposters, your photo will be taken and kept on file at CCFC.

_____ **CO-PAYMENTS, CO-INSURANCE, AND DEDUCTIBLES:**

- CO-PAY: Co-payments are due and will be collected at the time of your visit.
- CO-INSURANCE: If we know what your co-insurance amount will be at the time of your visit, we will collect the amount at that time. Otherwise, you will be required to pay your co-insurance within fifteen days of receiving your statement from our office.
- DEDUCTIBLES: If you have not met your deductible when your medical services are provided, you will be expected to pay your deductible within fifteen days of receiving your statement from our office.

_____ **SELF PAY:**

- If you do not have healthcare insurance, payment will be collected at the time of service.

_____ **AUTO ACCIDENTS AND PERSONAL INJURIES:**

- If your problem is due to an auto accident or other injury, please let us know immediately so that the correct insurance information can be generated for you. Since your injuries may involve different insurance companies with whom we are not

providers, payments for medical care in our office are due at the time services are rendered. We will give you a copy of the charges so you can submit it to your insurance company for reimbursement to you directly.

- We do not accept liens.
- If you prefer to see a different physician for your auto accident or personal injury claim, we will see you for other medical needs.

_____ **NON-COVERED BENEFITS:**

- Certain professional services may not be covered by health plans and are billed at a cash rate. The following are samples of non-covered services and prices. Please ask in advance about your specific form, letter, or service for a quote of the cost to complete it:

Letters (any reason) $25	Original Disability Forms $35
Work Related Forms: $25	Continuation of Disability $25
School or Work Forms $25	Prescription refills between visits $10
Medical Records-All notes $25	Medical Records – Single note $10
X-rays or copies of X-rays $25	

Prices are subject to change

These charges are in addition to any evaluation by a physician.

_____ **WORKER'S COMPENSATION:**

- Worker's Compensation is defined as any condition which results from or is aggravated by your job. Your regular insurance does not cover this condition.
- Our practice does not provide care for Worker's Compensation cases. Ask your employer for a referral to a Worker's Compensation clinic.

MISSED APPOINTMENTS AND LATE CANCELLATIONS:

- It Is your responsibility to manage your schedule and to keep appointments as we occasionally can't make reminder calls.
- If you need to cancel or reschedule, please contact us at least 24 hours before your scheduled appointment.
- If you fall to keep an appointment without giving notice, your account will be billed $50.00.

DELINQUENT ACCOUNTS:

- If your balance remains unpaid for 60 days, you will receive a notice from our business office. If the balance continues to go unpaid and no arrangements are made to make payments, your account will be sent to a collection agency.

RETURNED CHECKS:

- Any returned check will result In a $25.00 service fee. Returned checks must be redeemed with cash or credit card within 14 days of being returned or the account will be considered delinquent.
- Two returned checks within a 12 month period will place a patient's account on a cash-only status.

PET POLICY:

- Service animals allowed only with a certificate. Can be emailed prior or brought to the office on the day of visit.

Patient Name Printed

Patient Signature

Date