DIABLO FOOT & ANKLE
A Division of BASS Medical Group

PATIENT INFORMATION:

Name_____ Birth Date_____Sex:_____

Social Security Number _____ Marital Status:_____

Race: Ethnicity:

Address: _____
Street **City/State** **Zip**

PRIMARY Phone (____)____-_____ Email:_____

Are you employed? Name of Employer:

Emergency Contact_____ Relationship _____

Home Phone (____)____-_____ Cell Phone ( )____-_____ Other ( )____-_____

PRIMARY CARE DOCTOR:

_____ Phone: (____)____-_____ _____
NAME OF PCP **DATE LAST SEEN**

***Who may we thank for referring you to our office*:** _____

INSURANCE: *Please give **ALL** cards to the receptionist so we may copy them to your patient chart.*

Primary Insurance Company Name _____

Secondary Insurance Company Name _____

RESPONSIBLE PARTY: *The person who supplies the patient's insurance or who is responsible for payment if uninsured*

Name _____ Social Security Number _____ DOB _____

Relation to Patient _____ Phone ( )____-_____ Other ( )____-_____

PHARMACY INFORMATION:

_____ _____
NAME OF PHARMACY **CITY/ZIP CODE** Phone ( )_____-_____

I certify that the above insurance information is current and accurate; I authorize assignment of insurance to Diablo Foot and Ankle. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Diablo Foot and Ankle and its representatives may use my health care information and may disclose such information to the above-named insurance company for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services received. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____ _____
PATIENT NAME (PRINT) **PATIENT SIGNATURE** **DATE**

All information provided on this form will remain confidential in compliance with our HIPAA guidelines

Medical History

Have you ever been treated for (select all that applies):

- ☐ Corns/Calluses
- ☐ Warts
- ☐ Athlete's Foot
- ☐ Fungal Nails
- ☐ Ingrown Nails
- ☐ Neuroma
- ☐ Leg/Foot Ulcers
- ☐ Foot Numbness
- ☐ Bunions
- ☐ Broken Foot/Bone
- ☐ Broken Ankle
- ☐ Ankle Sprain
- ☐ Hammer/Mallet Toe
- ☐ Leg/Foot Cramp
- ☐ Flat Feet
- ☐ Arch pain
- ☐ High Arch Feet
- ☐ Knee Pain
- ☐ Lower Back Pain
- ☐ Heel Pain
- ☐ Rash
- ☐ In-Toeing
- ☐ Toe Walking
- ☐ Gait Problems
- ☐ Childhood Foot Problems

Do you get leg cramps after activity?

Does foot pain limit your desired activities?

Do you have any difficult walking?

Any pain in the calves or buttocks when walking?

Is the pain relieved by stopping & standing still?

List the sports and other actives in which you are involved:

Patient Medical History: Have you ever been treated for:

- ☐ Stroke
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Phlebitis
- ☐ Vascular Disease
- ☐ Heart Condition
- ☐ Anemia
- ☐ Poor Circulation
- ☐ Eyes: Glaucoma
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Keloid/Thick Scar
- ☐ Gout
- ☐ Osteoporosis
- ☐ Alzheimer's
- ☐ Sciatica
- ☐ Lyme's Disease
- ☐ Rheumatic Fever
- ☐ Arthritis
- ☐ Headaches
- ☐ Hearing/Ear Disorder
- ☐ Epilepsy
- ☐ Nerve Disorder
- ☐ Psychiatric Disorder
- ☐ Asthma
- ☐ Lung Disease
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Thyroid Problem
- ☐ Dark Urine
- ☐ Chronic Light Stool
- ☐ Weight Loss
- ☐ Cancer
- ☐ Stomach Ulcer
- ☐ None of the above

Other:

Surgical History: Surgical procedures and complications:

Past Family & Social History

List immediate family members who have had:

Diabetes _____ Foot Problems _____

Arthritis _____ Heart Attack _____

Stroke _____ High Blood Pressure _____

Cancer _____ Birth Defects _____

# of Childbirths ____ Are you currently pregnant?

Are you slow to heal after cuts

Any abnormal bruising, bleeding or scarring?

Do you smoke now?

Did you ever smoke?

If you quit, what year did you do so? _____

Alcohol use? ☐ None ☐ Rarely ☐ Moderately ☐ Daily ☐ Quit

Recreational Drugs?

Are you currently taking any medications?

Are you taking Insulin?

List medications, dose & purpose below:

Are you taking your medications as prescribed?

Allergies: Is there a history of skin reaction or other outward reaction or sickness following an injection, oral or topical administration of:

Latex, Adhesive tape	☐	Penicillin	☐
Other antibiotics	☐	Empirin, Tylenol	☐
Aspirin, Advil, Aleve, Motrin	☐	Celebrex	☐
Other pain remedies	☐	Morphine	☐
Codeine	☐	Other narcotics	☐
Novocaine	☐	Other anesthetics	☐
Sulfa drugs	☐	Shrimp, Iodine or Merthiolate	☐

Clearly list additional medication, drugs, foods, etc.

Review of Systems: Are you currently experiencing any of the following:

General:	☐ Decreased Strength	☐ Weight change	☐ Decreased exercise tolerance	
Head:	☐ Headaches	☐ Vertigo	☐ Injury	
Eyes:	☐ Abnormal vision	☐ Double vision	☐ Diminished vision	☐ Increased drainage ☐ Pain
Ears:	☐ Change in hearing	☐ Tinnitus	☐ Bleeding	☐ Vertigo
Nose:	☐ Nose bleed	☐ Obstruction	☐ Discharge	☐ Inflammation of mucous membrane
Mouth:	☐ Dental difficulties	☐ Gum bleeding	☐ Use of dentures	
Neck:	☐ Stiffness	☐ Pain	☐ Tenderness	☐ Noted masses
Chest:	☐ Shortness of breath	☐ Wheezing	☐ Cough	☐ Spitting up blood
Heart:	☐ Chest pains	☐ Palpitations	☐ Fainting	☐ Breathlessness
Abdomen:	☐ Difficulty Swallowing	☐ Appetite change	☐ Vomiting	☐ Bowel habit changes ☐ Tarry Stool ☐ Pain
Neurologic:	☐ Weakness	☐ Tremor	☐ Seizures	☐ Changes in mentation ☐ Lack of muscle control
Psychiatric:	☐ Depressive symptoms	☐ Change in sleep habits		☐ Changes in thought content

BASS MEDICAL GROUP

Answers to the following questions will help determine if you are at risk for Peripheral Arterial Disease (PAD) and if a vascular examination can help better assess your vascular health status.

1	Do you experience any pain in your legs or feet while at rest?	Yes No
2	Do you have uncomfortable aching, fatigue, tingling, cramping or pain in your feet, calves, buttocks, hip or thigh during walking/exercise?	Yes No
3	If yes to Question 2, does the pain go away when you stop walking/ exercising?	Yes No
4	Do your feet get pale, discolored or bluish at any time during the day?	Yes No
5	Do you have an infection, skin wound or ulcer on your leg or foot that is slow to heal over the past 8-12 weeks?	Yes No
6	Are you over the age of 65	Yes No
7	Are you over the age of 50	Yes No
8	Do you have high cholesterol or other blood lipid (fat) problems or require cholesterol medication?	Yes No
9	Do you have high blood pressure or take medication to reduce blood pressure?	Yes No
10	Do you have diabetes?	Yes No
11	Do you have a history of chronic kidney disease?	Yes No
12	Do you currently or have you ever smoked?	Yes No
13	Do you have a history of stroke or mini-stroke (TIA)?	Yes No
14	Do you have a history of heart disease (heart attack, MI)?	Yes No
15	Do you have a history of carotid stenosis, AA (abdominal aortic aneurysm), and/ or stent placement?	Yes No
16	Do you have numbness, tingling, pain, burning or electrical shocks in your feet and/or ankle?	Yes No
17	Are you unable to distinguish between hot and cold temperatures in your hands or feet?	Yes No
18	Do you feel bloated? Do you sweat when thinking of food? Are you unable to eat a full meal?	Yes No

BASS
MEDICAL GROUP

PATIENT/RESPONSIBLE PARTY FINANCIAL

I, the responsible party, certify that the above information is true and correct to the best of my knowledge. I understand that I am financially responsible for all charges regardless of delays in insurance payment or denial of insurance coverage.

It is my responsibility to understand and have personally verified if my insurance is contracted with this practice and/or the doctor I am seeing.

I hereby authorize Bay Area Surgical Specialists, Inc. to apply for benefits and receive payments directly on my behalf for covered services rendered. They may also disclose any or all parts of my clinical record to any insurance company covering services for the purpose of satisfying charges billed.

I further agree to pay all collection costs, attorney fees and any other collection costs that may be incurred in the attempt to collect outstanding patient responsibility amounts.

I also understand, that if any insurance payments are sent directly to me, it is my responsibility to send these monies directly to Bay Area Surgical Specialists, Inc. immediately upon receipt.

I, the patient or the patient's representative, understand that all medical doctors at Bay Area Surgical Specialists, Inc. are licensed and regulated by the Medical Board of California. I can verify this by contacting the Medical Board at (800) 633-2322 or via the internet at their website: www.mbc.ca.gov.

Signature of Patient, Parent or Legal Guardian	Relationship to Patient	Date

HIPAA / NOTICE OF PRIVACY PRACTICES – Page 1

In accordance with HIPAA laws, this notice describes how your health information may be used or disclosed and how you, the patient, can access this information. Please review the following carefully.

The law permits us to use or disclose your health information to the following:

- Another specialist or physician who is involved in your care.
- Your insurance company, for the purpose of obtaining payment for our services.
- Our staff, for the purpose of entering your information into our computerized system
- Other entities during the course of your treatment, in order to obtain authorizations, referral visits, scheduling of tests, etc. Much of this information is sent via fax which is a permitted use allowed by law. We have on file with these sources verification for the confidentiality of the fax used and its limited access by authorized personnel.
- If this practice is sold, your health information will become the property of the new owner.
- We may release some or all of your health information when required by law. Except as described above, this practice will not use or disclose your health information without your prior written authorization.

Federal and State law allows us to use and disclose our patients' protected health information in order to provide health care services to them, to bill and collect payments for those services, and in connection with our health care operations.

We also use a shared Electronic Medical Record that allows both our physicians and staff and certain of the participating physicians of the Muir Medical Group IPA and their staffs' access to our patients' health information. The purpose for this access is to expedite the referral of patients within the Muir Medical Group IPA systems and to assist in providing and managing their care in a coordinated way. Information in the Electronic Medical Record can be released outside the Muir Medical Group IPA system only with the patient's express authorization or as otherwise specifically permitted or required by law.

The law also establishes patient rights and our responsibility to inform you of those rights. These include:

- You have the right to request in writing any uses or disclosures we make with your health information beyond the normal uses referenced above.
- You have the right to limit the use or restrict the use disclosure of your health information. Our office will follow any restrictions notated by you on the reverse side of this form.
- You have the right to request in writing to inspect and/or receive a copy of your health information.* Our office may charge a reasonable fee to cover copying and mailing of these records to you.
- You have the right to request an alternate means or location to receive communications regarding your health information.*
- You have the right to request in writing an amendment or change to your health information. Our office may agree or disagree with your written request, but we will be happy to include your statement as part of your records. If an agreement to amend or change is acceptable, please be advised that previous documentation is considered a legal document and cannot be deleted or removed. Our office will simply notate the amendment and the reason for it and add it to your records.

* Conditions and limitations may apply; obtain additional information from our Privacy Officer.

HIPAA / NOTICE OF PRIVACY PRACTICES – Page 2

- We may use your information to contact you. For example, we may mail you an appointment reminder card or call you with information regarding your care. If you are not at home, this information may be left on your answering machine or with the person who answered the phone. In an emergency, we may disclose your health information to a family member or another person designated responsible for your care. **Please designate who our offices CAN disclose your health information to by checking the boxes below:**

☐ **OK to Spouse: _____**
☐ **OK to ALL family members: <u>Please list names of family members</u>:**

_____

☐ **OK to Other: _____**
☐ **OK to leave health information on answering machine or voice mail**

☐ **DO NOT RELEASE ANY INFORMATION to anyone other than myself**
☐ **(the patient). DO NOT RELEASE TO_____**

We reserve the right to change our privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an updated notice will be posted and our office will notify you of the changes in writing. You have the right to file a complaint with the Department of Health and Human Services, 200 Independent Avenue, S.W., Room 509F, Washington, DC 20201. Our office will not retaliate against you for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our office, at (925) 932-6330.

This notice goes into effect as of July 28, 2011.

ACKNOWLEDGEMENT

This acknowledges that you have received and read a copy of our Privacy Practices Notice. This document is not a contract, authorization, release, or consent form. This document will remain as part of your records.

Signed:_____Date:_____

Patient's Name:_____Date of Birth:_____

If person signing is not patient please provide:

Name:_____

Relationship to patient: _____

The following sets forth the policies of Bay Area Surgical Specialists, Inc. Please review this information and sign where indicated below.

- I understand that it is my responsibility to furnish Bay Area Surgical Specialists, Inc. with current, accurate insurance information at the time services are rendered and/or notify us in a timely manner of any changes in coverage, which may affect the payment of services already rendered.

- I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a $25.00 NSF Fee. These amounts must be cleared with our financial office prior to your next appointment.

- I understand that a cancellation fee of $25.00 may be billed directly to myself if a 48 hour cancellation notice is not provided to our office. All cancellation fees must be cleared with our financial office prior to your next appointment. Specialty Ultrasound Appointments will have a $50.00 cancellation fee per test scheduled.

- I understand that a surgery cancellation fee of $250.00 may be billed directly to myself if a surgery is cancelled. This fee will also be assessed if cancellation has not been made 7 days prior to scheduled surgery date. This fee must be cleared with our financial office before surgery can be rescheduled.

- I understand that Bay Area Surgical Specialists, Inc. are not providers for any **HMO** insurances unless it is through John Muir Health or Sutter Delta Medical Group, Alta Bates, Hill Physicians, &Affinity.

- We are not **Medi-Cal** providers. You will be responsible for all charges if you elect to see one of our physicians.

- It is the responsibility of each patient to verify with their insurance if this practice and the physician you are seeing is a contracted provider. BASS and/or its representatives will make every effort to assist you but BASS will not be held accountable for understanding every insurance plan.

- I understand that there is a $15.00 fee (per form) to complete disability paperwork associated with my care.

- I understand that the clinic will verify my insurance eligibility for surgery, but until claims are processed deductible amounts and co-insurance amounts prior to surgery cannot be determined. I further understand that a surgery co-pay may be collected upfront and applied to those fees. I further understand that ANY FEES I AM QUOTED ARE ESTIMATED based on 1) anticipated surgery to be performed and 2) current information provided to clinic by my insurance carrier.

- I understand that I will be billed for any amounts due by me (co-payments/co-insurance amounts/deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with three (3) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the third statement being mailed, the third statement will be marked as “Final Notice” and may result in my account being sent to an outside collection service if I still do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with those collection efforts.

- I understand that the clinic will obtain the necessary authorizations prior to surgery. I further

- understand that prior authorization is not a guarantee of payment, and that I am responsible for all charges not paid by my insurance carrier. This also applies if your insurance company delays payment over 90 days after billing or denial of insurance coverage. If your insurance company demands a refund of any monies paid to us, you become financially responsible for those charges.

- I understand that the clinic may also take a verbal request by me over the phone to make a credit card payment on my account. I give authorization for the clinic to bill my card for the amount specified and acknowledge that verbal requests can only be made by the responsible party since no credit card information is kept on file.

My signature below confirms that I have read these billing policies and my financial obligations as pertains to the physicians of Bay Area Surgical Specialists, Inc..

_____ _____

Legal Signature Date

_____

Print Patient's Name

_____

Relationship to Patient