PATIENT REGISTRATION FORM

EAST BAY FOOT & ANKLE CLINIC, INC

PLEASE PRINT

TODAYS DATE:	

PATIENT INFORMATION

LAST NAME:		FIRST NAME:	
MIDDLE NAME:		TITLE:	[ ] MR. [ ] MRS. [ ] MISS [ ] DR.
STREET ADDRESS:			
CITY:		STATE, ZIP:	
HOME PHONE:		CELLULAR PHONE:	
EMAIL ADDRESS:		DATE OF BIRTH:	
GENDER:	**[ ]** MALE **[ ]** FEMALE	MARITAL STATUS:	[ ] SINGLE [ ] MAR [ ] WID [ ] DIV
SOCIAL SEC. NUMBER:		PRIMARY CARE MD.	
OCCUPATION:		DRIVERS LICENSE #:	
EMPLOYER NAME:		EMPLOYER ADDRESS:	
CITY, STATE, ZIP:		EMPLOYER PHONE:	
PHARMACY NAME:		PHARMACY STREET, CITY:	

WHO REFERRED YOU TO OUR OFFICE

[ ] DR. _____ [ ] FAMILY [ ] FRIEND [ ] INSURANCE PLAN [ ] YELLOW PAGES [ ] INTERNET [ ] YELP

INSURANCE INFORMATION (PLEASE GIVE INSURANCE CARD TO RECEPTIONIST)

PRIMARY INSURANCE: [ ] MEDICARE [ ] MEDICARE HMO [ ] PPO [ ] HMO [ ] WORK COMP [ ] OTHER_____

SUBSCRIBER NAME:		SUBSCRIBER DOB:	

IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT?

NAME OF LOCAL FRIEND OR RELATIVE:			
HOME PHONE:		WORK PHONE:	
RELATIONSHIP TO PATIENT:			

TREATMENT AUTHORIZATION, ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL INFORMATION

I hereby authorize providers of East Bay Foot & Ankle Clinic to administer necessary treatment for my current medical condition(s) and to release information regarding my treatment to my insurance company(s) or its representatives. I authorize payment to be made directly East Bay Foot & Ankle Clinic in the amount due for all medical and / or surgical charges for myself or my eligible dependent. I hereby accept to receive scheduled appointments reminders via phone or text messages.

I understand that I am financially responsible for any amount not covered or paid by my insurance company(s) including BILLING FEES FOR OVERDUE BALANCES.

[ ] ***Opt out of patient portal*** (Please check this box if you do not want to access the patient portal or do not have an email address)

PATIENT / GUARDIAN SIGNATURE: DATE:

REVIEW OF SYSTEMS FORM

Do You have any of the following symptoms?

Circle Y for yes and N for No

1	Y	N	Fever
2	Y	N	Chills
3	Y	N	Night sweats
4	Y	N	Unexplained weight loss
5	Y	N	Unexplained weight gain
6	Y	N	Chronic fatigue

1	Y	N	Frequent headaches
2	Y	N	Head injury
3	Y	N	Double vision
4	Y	N	Sudden vision loss
5	Y	N	Hearing loss
6	Y	N	Ringing in the ears
7	Y	N	Nose bleeds
8	Y	N	Difficult swallowing
9	Y	N	Bleeding gums

1	Y	N	Chest pain
2	Y	N	Palpitations
3	Y	N	Heart murmur
4	Y	N	Fainting spells
5	Y	N	Short of breath lying down
6	Y	N	Short of breath walking
7	Y	N	Short of breath at night
8	Y	N	Short of breath at rest
9	Y	N	Chronic leg swelling
10	Y	N	Leg pain when walking

1	Y	N	Painful breathing
2	Y	N	Shortness of breath
3	Y	N	Wheezing
4	Y	N	Coughing up blood
5	Y	N	Chronic cough
6	Y	N	Cough producing phlegm

1	Y	N	Abdominal pain
2	Y	N	Chronic constipation
3	Y	N	Chronic diarrhea
4	Y	N	Heartburn
5	Y	N	Hepatitis or jaundice
6	Y	N	Blood in stools
7	Y	N	Black, tarry stools

1	Y	N	Painful urination
2	Y	N	Frequent need to urinate
3	Y	N	Blood in urine
4	Y	N	Incontinence
5	Y	N	Recurring urine infection
6	Y	N	Night urination twice or more
7	Y	N	Slow urine stream
8	Y	N	Straining to urinate

1	Y	N	Numbness in feet
2	Y	N	Tingling, burning in feet
3	Y	N	Dizziness
4	Y	N	Convulsions
5	Y	N	Stroke / TIA
6	Y	N	Migraine headaches
7	Y	N	Vertigo

1	Y	N	Back pain
2	Y	N	Muscle weakness
3	Y	N	Joint pain
4	Y	N	Joint stiffness
5	Y	N	Joint swelling
6	Y	N	Muscle pain
7	Y	N	Arthritis
8	Y	N	Frequent muscle cramps
9	Y	N	Difficulty walking

1	Y	N	Depression
2	Y	N	Anxiety
3	Y	N	Panic attacks
4	Y	N	Memory loss
5	Y	N	Frequent difficulty sleeping
6	Y	N	Frequent confusion

1	Y	N	Skin cancer
2	Y	N	Eczema
3	Y	N	Psoriasis
4	Y	N	Change in moles
5	Y	N	Hives
6	Y	N	Non-healing sores / legs

Medical Conditions Do you have any of the following medical conditions? Please check all that apply.

	Anxiety disorder		Diverticulitis		Kidney disease
	Arthritis		Fibromyalgia		Kidney stones
	Asthma		Gout		Leg / foot ulcers
	Bleeding disorders		Pacemaker / defibrillator		Liver disease
	Blood clots or DVT		Heart attack		Osteoporosis
	Cancer		Heart murmur		Polio
	Coronary artery disease		Hiatal hernia or reflux		Pulmonary embolism
	Claustrophobia		HIV or AIDS		Stomach ulcers
	Diabetes on insulin		High Cholesterol		Stroke / TIA
	Diabetes, not on insulin		High blood pressure		Tuberculosis
	Dialysis		Thyroid problems		Other

Family History Do any of your blood relatives have any of these health conditions? Please check all that apply.

	Arthritis	Blood disorder	Cancer	Diabetes	Heart disease	Hyper-tension	Stroke
RELATIVE							

Allergy Please list any allergies to medication

Name of medication	What was the reaction?

Medications Please list all prescription medications

NAME OF MEDICATION AND STRENGTH	DIRECTIONS FOR TAKING IT

Surgeries Please list any surgeries and the approximate dates

NAME OF THE SURGERY	PROCEDURE DATE

Do you smoke? [ ] Yes [ ] No [ ] Never How many years have you smoked? _____When did you quit?_____

Do you drink alcohol? [ ] Yes [ ] No [ ] Never How often? _____ When did you quit? _____

Do you use [ ] Marijuana [ ] Cocaine [ ] Narcotics [ ] Amphetamines [ ] Other ? _____

Marital status: [ ] SINGLE [ ] MARRIED [ ] WIDOWED [ ] DIVORCED

Occupation: _____

PETER A TERNUS, D.P.M.
CIARAN JACKA, D.P.M.
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PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), 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 among the multiple healthcare providers who may be involved in the treatment directly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessment and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. 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 at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you resist how my private information is used to disclose to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Name _____ Birth date _____

Signature _____

Date _____

_____ OFFICE USE ONLY _____

I ATTEMPTED TO OBTAIN THE PATIENT'S SIGNATURE IN ACKNOWLEDGEMENT ON THIS NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT, BUT WAS UNABLE TO DO SO AS DOCUMENTED BELOW:

FINANCIAL POLICY OF East Bay Foot & Ankle Clinic

PATIENTS WITHOUT INSURANCE

Self-Pay

Our fees cannot always be determined in advance since they depend on services rendered so we may not be able to give you an accurate quote prior to being seen. **FULL PAYMENT IS DUE AT THE TIME OF SERVICE.**

PATIENTS WITH INSURANCE

We require you to show your current insurance cards at each visit.

Although we bill your insurance company or Medical Group for services rendered, you are financially responsible for all services rendered. If payment has not been received within sixty (60) days of billing your health plan or Medical Group, we will contact you for assistance. Should your health plan or Medical Group deny coverage for any reason, you will be responsible for payment in full within thirty (30) days of your billing statement.

MEDICARE

We will bill Medicare, secondary and tertiary health plans for you. You must, however, supply us with the most up-to-date and correct information at the time of your visit. You will be responsible for your deductible and co-pays. If you do not have a supplemental insurance, or if you do not bring your card, you will be required to pay the 20% that Medicare does not cover at the time of your visit. If you are a patient with Medicare and Medi-Cal, we will see you with no out of pocket expenses charged to you for any Medicare covered services.

PRIVATE INSURANCE

Insurance is a contract between you and your insurance company. We file insurance claims as a courtesy to our patients. We cannot become involved in disputes between you and you insurance company regarding deductibles, co-payments, etc. other than to supply factual information as necessary. You are responsible for the timely payment of your account. If you have a co-pay or deductible, plan to pay it at the time of your visit.

HMO/PPO

CO-PAYMENT AND DEDUCTIBLES ARE DUE AT THE TIME OF YOUR VISIT. There will be a $10 charge if not paid at the time of your visit. YOU MUST HAVE A CURRENT AUTHORIZATION/REFERRAL AT THE TIME OF YOUR VISIT.

Medicaid, State Medi-Cal or County CCHP

We are not Medicaid/Medi-Cal providers. If you agree to be seen, you will be financially responsible for all unpaid Medicare allowed amounts and all non-covered charges.

LATE FEES

There will be an additional 10% charged for unpaid balances after 90 days and an additional 15% after 120 days. After 150 days the balance will go to collections. These charges are enforced after payments are received from your insurance.

MISSED APPOINTMENTS

I understand that there will be a minimum $25.00 charge for any missed office appointments without a 24 hour notice

SURGERY CANCELLATION FEES

There is a $250 cancellation fee if you need to cancel or reschedule a surgery within 1 week of the surgery. This fee is waived if it is cancelled by your physician for medical reasons. Scheduling surgeries is extremely time consuming, **therefore we ask that you are sure of your dates prior to committing to them.**

FORMS AND MISCELLANEOUS FEES

Due to the large number of form requests received by our office we have been forced to charge for their completion. An example of charges is listed below…

FORMS:	**FEE**
Private or Miscellaneous forms…(ie Disability Form).....	$10.00
Specialty letters per patient request (Grievance, appeals, or letters of medical necessity)	$25.00
PRIOR AUHTORIZATION for denial of prescription medications…….	$15.00
Medical Records……	$25.00

Fees for copies of your record are found in the HIPPA Policy. This includes sending copies to other doctors

RE-BLLING FEES

If we are not provided with the most current insurance information and we have to re-bill, there will be an additional $20.00 charge.

We accept cash, checks, and most major credit cards.

Thank you for understanding our financial policy.

Please let us know if you have any questions or concerns.

BY SIGNING AND CHECKING THE ACKNOWLEDGEMENT BOX ON THE REGISTRATION FORM, YOU ARE ACKNOWLEDGING THAT YOU HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE INFROMATION.

_____

PATIENT / GUARDIAN SIGNATURE: DATE: