CAPITAL FOOT AND ANKLE
PATIENT REGISTRATION FORM

This information is confidential

PATIENT INFORMATION

Name_____

Address_____

City_____

State_____ Zip_____

Home Phone (____)_____

Work Phone (____)_____Ext_____

Cell Phone (____)_____

Date of Birth_____

E-mail:_____

Primary Physician_____

Phone# _____

Referring Physician_____

☐ Male ☐ Female

☐ Single ☐ Married ☐ Widowed ☐ Divorced

☐ American Indian or Alaska Native ☐ Asian ☐ White

☐ Black or African American ☐ Native Hawaiian

☐ Hispanic Latino ☐ Veteran ☐ Other

Occupation _____

Employer _____

Address _____

_____

Spouse Information (If Applicable)

Name _____

Home Phone _____

Work Phone _____Ext_____

INSURANCE INFORMATION

Primary- Ins. Co. Name_____

Policyholder Name_____

☐ Self ☐ Spouse

Policyholders Date of Birth_____/_____/_____

Employer_____

Secondary- Ins. Co. Name_____

Policyholder Name_____

Policyholders Date of Birth_____/_____/_____

☐ Self ☐ Spouse ☐ Other_____

PHARMACY INFORMATION

Pharmacy Name_____

Phone#: _____Fax#:_____

Address_____

City_____ State_____

EMERGENCY CONTACT (If other than Spouse)

Name_____

Relationship:_____

Telephone (____)_____

Guarantor Information:
Complete if other than patient (MINORS)

Name_____

Address_____

City_____

State_____ Zip_____

Telephone (____)_____ DOB_____

Employer_____

Address_____

Work Phone(____)_____Ext_____

CAPITAL FOOT AND ANKLE
PATIENT REGISTRATION FORM

Is your treatment today due to:

……a work related injury ☐ Yes ☐ No Injury Date_____

Do you have written authorization from your employer and comp carrier to be treated ☐ Yes ☐ No

……a motor vehicle accident ☐ Yes ☐ No Accident Date_____

……a an accident/ liability case ☐ Yes ☐ No Accident Date_____

I hereby authorize Carla Docharty DPM, Mark Drake DPM, Jamie Bakal DPM and Barbara Adams DPM, to perform an examination and or any medical treatment deemed necessary by the treating physicians . This includes, but is not limited to any required medical examinations, x-rays, medical procedures and medical diagnostics or laboratory tests ordered by or performed by the treating physician(s).

Signature X_____ Date_____

I hereby authorize the release of any medical information pertaining to my treatment or information necessary for processing insurance claims and payment of medical benefits to myself or the party who accepts assignments. This authorization will remain valid until revoked by me in writing. I understand that I am legally responsible for all charges whether or not reimbursed by my insurance company.

Signature X_____ Date_____

MEDICARE SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made either to me or on my behalf of **Capital Foot & Ankle** for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider of supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

<table>
<tr><th colspan="2">PATIENT'S NAME (Please Print)</th><th>PROVIDER: Name, Address, and Zip</th></tr>
<tr><td colspan="2"></td><td rowspan="4">Capital Foot & Ankle
3800 J Street, Suite 200
Sacramento, CA 95816

Capital Foot & Ankle
5 Medical Plaza Dr. Suite 110
Roseville, CA 95661</td></tr>
<tr><td colspan="2">PATIENT'S SIGNATURE</td></tr>
<tr><td>PATIENT'S MEDICARE NO.</td><td>DATE</td></tr>
<tr><td></td><td></td></tr>
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Patient Name: _____ **Date:** _____

History & Medical Information

1. **Explain your foot/ankle problem** ☐ Right ☐ Left _____

_____

2. **When did pain/discomfort begin (date):** _____

Describe pain/discomfort: ☐ Burning ☐ Numbness ☐ Sharp ☐ Other _____

3. **What makes the pain/discomfort better:** _____

4. **Have you had a physical trauma?** ☐ Yes ☐ No _____

5. **Have you had an accident?** ☐ Yes ☐ No _____

6. **Past Medical History:**

☐ Anemia	☐ Gout	☐ Kidney Disease	☐ Other Arthritis
☐ Bleeding Disorders	☐ Heart failure	☐ Lung/Respiratory Disorders	☐ Prostate Disorders
☐ Cancer _____	☐ Hepatitis	☐ Mitral Valve Prolapse	☐ Rheumatic Fever
☐ Diabetes	☐ High Cholesterol	☐ Nerve Disorders	☐ Stroke
☐ Epilepsy	☐ HIV / AIDS	☐ Neurological Disorders	☐ Thyroid Disorders
	☐ High blood pressure	☐ Osteoarthritis	☐ Other: _____

7. **List all medications/herbs/vitamins:** ☐ **NONE** _____

_____

8. **Allergies:** (Describe reaction) ☐ **NONE**

☐ Penicillin _____ ☐ Aspirin _____ ☐ Narcotic Agent / Codeine _____
☐ Anesthesia _____ ☐ Shellfish _____ ☐ Sulfa Drugs _____
☐ Nickel / Metal _____ ☐ Radiographic Contrast Dye _____
☐ Other _____

9. **Are you currently pregnant?** ☐ Yes ☐ No _____

10. **What is your shoe size?** _____

11. **Surgical History:** Have you had surgery? ☐ Yes—if yes, describe below ☐ No

Surgery / Date: _____

_____

12. **Social History:** (Only check what is pertinent to you)

☐ Tobacco Use ☐ Alcohol Use ☐ Exercise habits_____
☐ Caffeine Use ☐ Drug use (recreational, IV)

13. **Job:** _____ **Job requirements: %** Sitting _____ **%**Standing _____ **%**Lifting _____

14. **Family History: (List relationship of family member(s) who have had these problems):**

☐ Diabetes_____ ☐ Heart Disease _____ ☐ Kidney Disease _____
☐ Hypertension _____ ☐ Stroke _____ ☐ Mental Illness _____
☐ Rheumatology _____ ☐ Bleeding Disorders _____ ☐ Cancer _____
☐ Other family History: _____

15. **Height:** _____ **Weight:** _____

For office use: B/P _____ Pulse _____ Resp. _____ Temp. _____

Financial Policy

Welcome to Capital Foot & Ankle we are glad you chose our practice for your podiatric care. We would like you to understand our billing policies. We are contracted with most insurance companies, and will bill them in accordance with our contract. Capital Foot & Ankle is not a Medi-Cal provider and we do not bill this insurance. If this is your secondary insurance, you will be responsible for the balance after your primary insurance pays. We will bill all other secondary insurance plans. You will be responsible for co-pays, co-insurance, and deductibles. These are to be paid at the time of service.

You are responsible for any balance not covered by insurance (examples: denied services, or services not covered by your plan, co-pay, co-insurance and deductibles). We require payment when statements are received. If you are having problems with payment, please contact our office immediately. We accept credit cards, checks and cash. We resort to a collection agency when balances are not paid in a timely manner.

You are responsible for letting our practice know if there are any changes to your insurance, address, and telephone number. To bill correctly, we require a copy of your current insurance card.
If you are having surgery, we advise you to know and understand your insurance coverage. We will contact your insurance to determine if you need a prior authorization and obtain one if required. We may require you to pay a deposit, deductible, or co-pay prior to surgery. This is not attached or associated with the deposits the surgery centers collect.

No Shows

Please be advised that if you do not show up for your appointment you will be charged $50 for a No Show Appointment. This fee will not be covered by your insurance company and will be your sole responsibility. Please bear in mind this is only being done to better serve our patients by improving access to appointment times often taken by patients who have scheduled appointment and failed to utilize them.

Forms Completion

It is our office policy to charge $25.00 for any request for correspondence such as disability forms. See the attached form fee. EDD forms will be mailed, we require you pick up all other forms. You will receive a call from us on completion of forms. Processing time is 7 to 10 days for form completion.

Patient Signature: _____Date:_____

Capital Foot & Ankle

Dr. Carla Docharty DPM, Dr. Mark Drake DPM, Dr. Jamie Bakal DPM, Dr. Barbara Adams DPM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (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 among the multiple health care 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 certification

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been giving the right to review such *Notice of Privacy Practices* prior to signing this consent. 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 below to obtain a current copy of the *Notice of Privacy Practices.*

3800 J Street, Suite 200
Sacramento, CA 95816

5 Medical Plaza Drive, Suite 110
Roseville, CA 95661

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care options. 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.

I Understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:_____

Signature:_____

Relationship to Patient:_____

Date:_____