ADVANCED FOOT CARE
FOOT AND ANKLE SPECIALISTS

Patient Registration
All Fields are required

Demographic Information

Last Name: _____ First Name: _____ MI: _____

Date Of Birth: _____(mm/dd/yy) Sex: ☐ Male ☐ Female SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Whom may we thank for referring you to our practice: _____

Contact Information

Home Phone: _____

Cell Phone: _____

Emergency Contact

First Name: _____

Last Name: _____

Phone Number: _____
Relationship: _____

Primary Care Physician

Physician Name: _____

Phone Number: _____

Pharmacy Information

Pharmacy Name: _____

Phone Number: _____

Primary Insurance

Insurance Name: _____

Medical Group: _____

Subscriber ID: _____

Group Number: _____

Secondary Insurance

Insurance Name: _____

Medical Group: _____

Subscriber ID: _____

Group Number: _____

By Signing below, I attest that the information provided above is true and accurate

Signature of Insured/Guardian: _____ Date: _____

OC Advanced Foot Care

MEDICAL HISTORY FORM

MEDICAL HISTORY (Check all that Apply)

Aids/HIV	____	Diabetes	____	High Blood Pressure	____	Thyroid Problems	____
Anemia	____	Epilepsy	____	High Cholesterol	____	Tuberculosis	____
Arthritis	____	GERD	____	Kidney Disease	____	Valve Joint/ Replacement	____
Asthma	____	Gout	____	Liver Disease	____	Varicose Veins	____
Bleeding	____	Heart	____	Stroke	____	Other: _____	
Cancer	____	Hepatitis	____	Stomach Ulcer	____	_____	

CURRENT MEDICATIONS (List ALL Medications, If more space is needed Please Use Back of this form)

Medication Name:	Dosage:	Used For:

HAVE YOU EXPERIENCED THE FOLLOWING?

	YES	NO		YES	NO
Back Problems	___	___	Headaches	___	___
Burning Tingling or Numbness in Toes	___	___	Itchy Skin on Feet	___	___
Dryness of Skin	___	___	Reaction to local anesthetic	___	___
Episodes of Fainting	___	___	Shortness of breath	___	___
Foot / Leg Cramps while sleeping	___	___	swelling of Feet and Ankles	___	___
Foot / Leg Cramps while Walking	___	___	Keloid or thick scars	___	___

ALLERGIES (List Allergies Below) **-OR-** _____ **Check if you have NO Known Drug Allergies**

Allergies:	Reactions:

SURGICAL HISTORY (Have you had any surgeries in the last year?) _____
_____

SOCIAL HISTORY (Mark all that apply)
Current Smoker ___ Former Smoker ___ NON-Smoker ___ Alcohol Use ___ NON-Alcohol Use ___ Drug use ___ NON-Drug Use ___
Smoker? How Long? _____ **Packs A Day?** _____ **Drinker? How many a day?** _____

What is your chief foot/ankle complaint today? _____.
How long has it been bothering you? _____. If applicable, what is the date of injury? _____

_____ _____
Signature **Date**

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General Consent for Care and Treatment

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).
I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative _____ **Date:** _____

Printed Name of Patient or Personal Representative _____ **Relationship to Patient** _____

Lala S. _____ Office Manager _____

Printed Name of Witness _____ Employee Job Title _____

_____ _____

Signature of Witness **Date**

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether bron or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, nit supplant, any other applicable statutory or common law.

Either party shall have the absolute right ti arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in once proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days, or signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical services.

_____
Patient's or Patient Representative's Initials

If any provision if this arbitration agreement is held invalid of unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Patient's or Patient Representative's Signature (Date)

By: _____ _____
Physician's or Authorized Representative's Signature (Date)

By: _____
Print Patient's Name

_____
Print or Stamp Name of Physician, Medical Group or Association Name

_____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to Patient. Original is to be files in Patient's medical records.

Daniel Recalde, D.P.M.

Disorders & Surgery of the Foot

FINANCIAL POLICY

Our office is committed to the successful treatment of your condition. Please understand that payment of your bill is considered part of your treatment. Your clear understanding of our Financial Policy is important to our professional relationship. You can always call our office manager if you have any questions or concerns about a statement or this policy.

* WE ARE HAPPY TO BILL YOUR INSURANCE DIRECTLY; HOWEVER, WE MUST HAVE A COPY OF THE INSURANCE CARD.
* **IF PAYMENT IS NOT RECEIVED FROM THE INSURANCE CARRIER OR OTHER RESPONSIBLE PARTY IN 90 DAYS, WE HAVE THE RIGHT TO BILL YOU DIRECT.**
* IF YOU DO NOT HAVE INSURANCE, OR, IF YOU DO NOT HAVE YOUR INSURANCE CARD, FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECK, VISA/MASTERCARD, AND DISCOVER. *ALL PATIENTS MUST COMPLETE OUR "PATIENT REGISTRATION FORM" AND OTHER RELATED FORMS.
* PLEASE NOTIFY US IMMEDIATELY OF ANY CHANGES IN YOUR INSURANCE OR COVERAGE.
* **48-HOUR NOTICE IS REQUIRED FOR COPIES OF MEDICAL RECORDS OR X-RAYS, AND THERE MAY BE A NOMINAL FEE.**

Medicare

We accept Medicare assignment. As a Medicare patient, you are responsible only for the difference between the approved charge and the amount Medicare pays and, of course, you're deductible. If you have supplemental insurance, we will be happy to bill it directly for you. You will receive a bill after your insurance has paid.

HMO/PPO

ALL CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE. We are members of most, but not all, plans. You are responsible for verifying that we are providers for your plan. If you are an HMO member, you will not be billed as long as we have the necessary referrals. Please note: We must have your referral in the office at the time of the visit, or your plan requires that we ask you to reschedule. PPO patients will only be responsible for their co- payments, deductible and co-insurance, as long as they have verified with their insurance that our physician is in their plan.

Workers' Compensation

If you are here as a result of a work-related injury, we will require information regarding both health insurance and your employer's Workers' Compensation insurance. Before seeing a doctor, we will require a letter or statement from the Workers' Compensation carrier, authorizing your treatment. The letter should include the claim number, address, and adjuster's name and phone number. (Your employer's Human Resources office should be able to assist you with obtaining this information.)

Appointments

There will be a $25.00 charge for any missed appointment or cancellation made less than 24 hours before an already scheduled appointment. We realize that emergencies happen and will take that into consideration.

Financial Agreement

I understand that I am ultimately responsible for all charges not covered by my insurance, and payment is due upon receipt of statement. I understand that if the office agrees to bill insurance as a courtesy, I must submit information as needed to ensure payment for services rendered to me.

Name of Patient (please print)	**Signature of Patient or Responsible Party**	**Date**

Daniel Recalde, D.P.M.
Disorders & Surgery of the Foot

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003 and in accordance with the health Insurance Portability and Accountability Act of 1996 (HIPPA) this office has developed a policy to secure patient privacy with regard to their health care information.

During the care our patients, it may become necessary to fax records, give medical information over the phone to other physicians, pharmacies, hospitals, laboratories, radiology, therapist, insurance companies, or patient themselves.

By signing the authorization below you are giving us your permission to release either by fax, mail, telephone or computer the necessary information so they may care for you or assist in the billing of your services to the insurance company,

This office has always kept your health care information secure and confidential but the new law requires us to explain our policy in writing, give you this notice and follow the terms of this notice. The following explains how your health information may be used and disclosed and how you can access this information. Please read and review carefully. We may use or disclose your health information to those involved in your treatment. (Example: Progress notes to your family doctor or specialist we refer you to)

We may use your information in our daily office operations (Example: staff members entering information into our computers). We may share your medication information with business associates (Example: our billing service which has a contract to protect your privacy). We may use your information to contact you (Example: calling to remind you of appointment, leaving messages with family members or on an answering machine)

In an emergency, we may disclose health information to a family member or person responsible for your care.
We may release some or all of your health information when required by law. (Example: if the practice is sold and your information becomes the property of the new owner)

We will honor your written request not to disclose your health information if you so desire.
You have the right to know of any disclosures we make with your health information beyond the above stated uses.

You have the right to transfer copies of your health information to another practice and we will mail your files to you. With a written request, you have the right to see and receive a copy of your health information, with a few exception. We are permitted to charge you a reasonable fee for a copy of your records.

You have the right to request, in writing, an amendment or change to your health information. You are entitled to add a statement to your file. If we agree to an amendment or change, we will not remove or alter previous information, but will add new information

You are entitled to receive a copy of this notice. If we change any of the details of this notice, we 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 Independence Avenue, SW, Room 509F, and Washington DC 20201 with no fear of retaliation by this office.

However before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer, Lala Sauta at 714-979-0313.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read, if I so chose) and understand the notice.

Date:_____

Patient Name (Printed): _____

Patient or responsible party: _____

Signature:_____

Patient Testimonial, Video, Photo, Audio Release Consent

By signing this form, you are hereby consenting to allow **OC Advanced Foot Care & Associates** to use and disclose your testimonial, audio, photos and/or videos and you acknowledge that they may be distributed to the public.

CONSENT TO RELEASE I hereby authorize **Daniel Recalde & OC Advanced Foot Care** And staff to use my testimonial, photos, videos, audio and any information contained herein in its media/public relations efforts. I understand and approve the disclosure of the testimonial, photo, video, audio information to the media and other individuals and entities that may be involved in the media/public relations efforts of **OC Advanced Foot Care & Associates.** I agree that I will make no monetary or other claim against Oc Advanced Foot Care & Associates for the use of the statement. In addition, I waive any right to inspect or approve the finished product, including written copy, wherein my testimonial appears.

I understand that I am providing the testimonial, photo, video, or audio information to **OC Advanced Foot Care & Associates** and that my treating healthcare provider will not be providing any protected information such as to the media or the public, including private health information in my medical records, the confidentiality of which may be protected by federal and state statutes and regulations, including the Health Insurance Portability and Accountability Act (HIPAA).

I waive the right of prior approval and hereby release **OC Advanced Foot Care & Associates** from any and all claims for damages of any kind based on the use of my testimonial, picture, video, audio or information in the testimonial. By signing below I agree and acknowledge that I have read and understood the above Release and agree to all terms described. I am of legal age and freely sign this Consent to Release my Patient Testimonial and other media I provided to the doctor. I release and waive any claims and rights of compensation or ownership regarding such uses and understand that all such recordings shall remain the property of **OC Advanced Foot Care.**

Name of Patient (Please Print): _____

Patient Signature: _____

Parent/Guardian Signature (If Participant is under 18 years of age): _____

Date: _____

Phone Number: _____ Email: _____

Address: _____

ADVANCED FOOT CARE
FOOT AND ANKLE SPECIALISTS

When Prescribed Opioids for Pain: Informed Consent

Please review the information listed below and sign below when you feel you understand and accept what each statement says:

When I take these medications, I may experience certain reactions or side effects that could be dangerous, including sleepiness or sedation, constipation, nausea, itching, allergic reactions, problems with thinking clearly, slowing of my reactions, or slowing of my breathing.

When I take these medications it may not be safe for me to drive a car, operate machinery, or take care of other people. If I feel sedated, confused, or otherwise impaired by these medications, I should not do things that would put other people at risk for being injured.

Anyone can develop an addiction to opioid pain medications, but people who have had problems with mental illness or with controlling drug or alcohol use in the past are at higher risk. I have told my provider if I or anyone in my family has had any of these types of problems.

Taking too much of my pain medication, or mixing my pain medications with drugs, psychiatric medicine, or other medications that cause sleepiness, such as benzodiazepines, barbiturates, and other sleep aids, could cause me to be dangerously sedated or to overdose and stop breathing.

It is my responsibility to tell any provider that is treating me or prescribing me medications that I am taking opioid pain medications so that they can treat me safely and do not give me any medicines that may interact dangerously with my pain medicines.

_____	_____	_____
Patient Name Printed	Patient Signature	Date