PAN ACEA FOOT CENTER, P.A.

Simon T. Pan, DPM, FAPWCA

REGISTRATION FORM

PATIENT INFORMATION

Patient's First Name	Middle	Last:	DOB:	Sex: ☐ Male ☐ Female

Address:	Apt#	City & State	Zip code:

Email address:	Social Number:	Driver license number:
Home phone:	Cell:	Work:
Race:	Ethnic	Language

How did you hear about us? ☐ Newspaper ☐ Yellowpages ☐ Radio ☐ Google ☐Pass by ☐ Insurance
☐ Relatives or Friends ☐PCP Name____________________ ☐Other __________________________________

EMERGENCY CONTACT

Name:	Address:	Relation to patient	Phone Number:

GUARDIAN INFORMATION (for minor patient)

Name:	Address:	Relation to patient	Phone Number:

INSURANCE INFORMATION

PRIMARY Insurance Company Name:	SECONDARY Insurance Company Name:
Member ID # Group #	Member ID # Group #

PHARMACY INFORMATION

Name	Address	Phone:

Patient/Guardian's Signature: ____ Date/ Fecha: ____________________

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RECEIPT OF NOTICE OF PRIVACY PRACTICES. WRITTEN ACKNOWLEGEMENT FORM
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (today's date) ______________________, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at anytime, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclosure your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information and correction with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in this Patient rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extend necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in care: We may use or disclose health information to notify, or assist in the notification of (including identifying or location) a family member, your personal representative, or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment remainders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information). We will charge you a reasonable cost-based fee for expenses such as copies and staff time.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

I have read and understand the PAN ACEA FOOT CENTER, P.A.'s Notice of Privacy Practices

______________________________	______________________
Patient's Name	DOB
______________________________	______________________
Patient / Parent's Signature	Date

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____ ______________________

Patient Name **Date of Birth**

____ ______________________

Name of Parent or Guardian **Relationship to patient**

Office Policies

Authorization for Treatment

I hereby voluntarily consent to medical care for the above stated patient and allencompassing diagnostic procedures and medical treatment by the physician, his assistants and/or designees, as may be necessary in his judgment. I acknowledge that no guarantees have been made to the results of treatment or examination.

Authorization for Medical Release of Information

I authorize Pan Acea Foot Center,P.A., to release to the insurance carrier, Social Security Administration, third party administrators, or any party that may be liable for all or part of my medical charges, any information that may be necessary for the purpose of determining benefits available to the patient, for the services rendered during this period of care.

Insurance Claims

For patients with insurance coverage, we will make our best effort to file a claim with your insurance company for covered services. Any balances on your account for services, after your insurance pays or denies a claim, are your responsibility. In the event your account becomes past due, your account may be referred to a collection agency

Assignment to Benefits

I hereby assign to Pan Acea Foot Center,P.A., all rights, title and interest in the benefits payable to me by an insurance policy(ies) or benefit plan under which I am covered for services rendered by the physician. I understand that I am responsible for all charges not covered by the assignment and hereby promise to pay any remaining balance.

Payment Agreement

I further understand that fees are due and payable on the date of services rendered, and I agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement.

My signature indicates that I have read and understand the above content of this document. A copy of this document can be provided to you upon request.

____________________________________ ______________________

Signature of Patient/ Guardian **Date**

9896 Bellaire Blvd., Ste H. Houston TX 77036 Tel 713-270-8682 ♦ Fax 713-270-8990
www.panfootcenter.com

PAN ACEA FOOT CENTER, P.A.
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Patient's Name/ 姓名/ Nombre del Paciente: ____________________

DOB/ 出生日期/ Fecha de Nacimiento: ____________________

PCP/家庭醫生/Doctor primario: ____________________

PCP Ph #/ 家庭醫生的電話＃/Tel de Dr Primario: ____________________

1) Chief complaint/ 您看潘醫师的原因/ Motivo de consulta

____

____

____

2) Past Medical History/ 您的病歷/ Historial medico pasado

☐ **No Significant Past Medical History**

☐ Arthritis/ 關節炎
☐ Coronary Artery Disease/ 心臟病/Enfermedad de la Arteria Coronaria
☐ Diabetes/ 糖尿病
☐ Gout/ 痛風/Gota
☐ High blood pressure/ 高血壓/Alta Presion
☐ Osteoporosis/ 骨質疏鬆
☐ High Cholesterol/ 高膽固醇/Colesterol Alto
☐ Cancer/ 癌症:
Type of Cancer/癌症類型/ Tipo De Cancer:____________________
☐ Others/其他:____________________
____

3) Allergies/ 您對药的敏感/ Alergico(a) a alguna medicina

☐ **No Known Drug Allergies**

____

____

____

4) Name of Current Medication, Strength and Dosage/ 您現在用的药名/ Medicamentos actuales, Fuerza de Medicamento y Dosis

☐**No Known Current Medication**

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

5) Past Surgical History For The Last 10 Years/ 您十年內動的手術 / Antecedentes quirurgicos en los ultimos 10 años

☐**No Significant Past Surgical History**

	When/ 何時	Doctor/ 醫師
☐ Angioplasty/ 心臟手術	________________	________________
☐ Arthroscopy/ 骨頭手術	________________	________________
☐ Bone fracture repair/骨折手術	________________	________________
☐ Bunionectomy/ 腳部手術	________________	________________

☐ Others: ____

____

____

6) Social History/ Historial Social

Employment type/職業/ Oficio o Profesion / Tipo de empleo: ________________________________

Tobacco use? / 抽煙/ Uso de tabaco (Fumar) ☐Non-smoker ☐<1 pack a day ☐ >1 pack a day

Alcohol use? /飲酒/ Bebidas alcoholicas: ☐Yes ☐ No.

If yes, how often? ☐Daily ☐Weekly ☐Occasionally

Illicit drug use/ 娛樂性藥物/Usa drogas ilicitas: ☐ Yes ☐ No

7) **Family History/家族病史/Historial Familiar:**

☐ **No Significant Family History**

Medical History	Relationship

8) PRIME-MD PHQ (2 Question Screen)

During the past month, how often have you been bothered by any of the following problems?
在过去的一个月，您有没有被以下任何问题困扰
Durante el mes pasado, ¿con qué frecuencia le ha molestado alguno de los siguientes problemas?

1. Have you often been bothered by feeling down, depressed, or hopeless?
   感到情绪低落，沮丧或绝望
   ¿Te ha molestado a menudo sentirse deprimido o desesperado?

   ☐Yes/ Si ☐ No

2. Have you often been bothered by little interest or pleasure in doing things?
   感到没有兴趣去做事或者不乐于做事
   ¿Le ha molestado a menudo poco interés o placer en hacer las cosas?

   ☐Yes/Si ☐ No

Patient or Guardian Signature/ 患者或監護人簽名/ Firma del Paciente

Date/ 日期/ Fecha

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Patient Acknowledgement to Receive Treatment during COVID-19

The CDC recommends postponing all nonessential or elective healthcare visits and group-related activities, and states are mandating the provision of emergency services only.

- While our office complies with Federal, State Health Department, and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees about your health and safety.
- I hereby acknowledge and understand that there may be an increased risk that COVID-19 may be transmitted in any place of public accommodation, which includes my physician's office. I have been informed by my physician of their desire to protect their patients, staff and the community at large.

To the best of our knowledge, Pan Acea Foot Center staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of healthcare services, other persons (including other patients) could be infected, with or without their knowledge.

As a prerequisite to receiving care/treatment, we are asking out patients and their accompanying party(s) to complete the screening attestation form below.

	Patient		**Accompanying Party**	
In the last 48 hours have you experienced:	Yes	No	Yes	No
Fever	☐	☐	☐	☐
Any shortness of breath	☐	☐	☐	☐
Dry cough	☐	☐	☐	☐
Runny nose	☐	☐	☐	☐
Sore throat	☐	☐	☐	☐
Los of taste and/or smell sensation	☐	☐	☐	☐
WITHIN THE LAST 14 DAYS have you:				
Travelled to a foreign country	☐	☐	☐	☐
Have you travelled within the US via:				
Airplane	☐	☐	☐	☐
Cruise ship	☐	☐	☐	☐
Train	☐	☐	☐	☐
Public transportation	☐	☐	☐	☐

If yes, to any of the above questions, please explain: ______________________________

I have been practicing all current CDC guidelines with respect to "social distancing" and have NOT been in contact with a person who had a positive test for COVID-19 or suspected to be positive.

I hereby consent to the treatment proposed by my physician.

Patient's name: ______________________ **Patient's D.O.B:** ______________

Patient's signature: ______________________ **Date**: ______________

I have been practicing all current CDC guidelines with respect to "social distancing" and have NOT been in contact with a person who had a positive test for COVID-19 or suspected to be positive.

Accompanying Party name: ______________________ **Accompanying Party signature:** ______________

Date: ______________