HAPPY FEET PODIATRY

DR. ROBERT LORDS

601 E YORBA LINDA BLVD #6

PLACENTIA, CA 92870

PHONE: (714)996-7601 | FAX: (714)996-0745

Name _____ Date of Birth _____

Last First MI (MM / DD / YEAR)

Sex: M ☐ F ☐ Patient Email: _____

Address: _____

STREET NAME

_____

CITY STATE ZIP

Primary Phone: (_____) _____ - _____ Secondary Phone: (_____) _____ - _____

Referring Physician / Referring Source: Primary Doctor:

_____ _____

EMERGENCY CONTACT

_____ _____ (_____) _____ - _____

Emergency Contact Name Relationship Emergency Contact Number

PHARMACY _____

_____ _____ _____

Pharmacy Name City Cross Streets

INSURANCE INFORMATION

(Please provide insurance cards to front desk)

(Primary Insurance)
Insurance Company _____

(Secondary/Supplement)
Insurance Company _____

AUTHORIZATION FOR TREATMENT AND ASSIGNMENT OF BENEFITS

I hereby authorize Happy Feet Podiatry to perform such medical services, which in their medical judgment are necessary for the welfare of the patient identified above. I authorize Happy Feet Podiatry to furnish insurance carriers with information concerning this illness and/or injury. I hereby irrevocably assign all benefits, including major medical benefits, for medical services rendered to be paid directly to Happy Feet Podiatry in accordance with California Insurance Code, Section 10133. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges, whether or not paid by said insurance.

Signature: _____ **Date:** _____

FEE AGREEMENT

Happy Feet Podiatry ("We") commits to providing the undersigned ("You") with the best possible care, and will discuss our professional fees with you upon request. Your clear understanding of our financial policy is important to our professional relationship.

You are responsible for full payment of the fees billed by us. If you have health coverage, your coverage is a contract between you and your health plan ("health plan"). We do not get involved in disputes between you and your health plan regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, "medical necessity," or any other issues. We will supply factual and medical information as necessary and as requested.

As a courtesy, we will often attempt to collect payment from your health plan, and for this purpose, you agree that any amount billed to your health plan will be assigned to us for payment.

Because cancellations and no shows adversely affect our ability to serve our patients appropriately, we charge $50 for no shows or appointments that are canceled or rescheduled with less than twenty-four hours' notice. This fee is not billable to your insurance company, and you will be responsible for this payment.

Private Pay

If you do not have health coverage, you must make suitable arrangements prior to the appointment; otherwise, we expect payment in full at the time of service.

Non-Contracting Health Plan**

If we are not a preferred provider for your health plan, you must pay in full at the time of service. We will courtesy bill your health plan and request that it reimburse you directly.

Preferred Provider Organization (PPO) Coverage

If we are a preferred provider for your health plan, you will be responsible for your co-payment at the time of services. We will bill your health plan for the allowable amount, and we will bill you for the balance. While we contract with numerous PPOs and insurance companies, we do not guarantee that we are - or that we will remain - a contracting provider for your health plan. Some of our contracts may change. You should contact your health plan to verify that we are a contracting provider at the time of service.

_____ Please initial if we are NOT a contracted provider for your PPO**

Point of Service (POS) Options

If you have chosen to exercise your POS option, this may result in: 1) reduced benefits from your insurance plan; 2) a deductible or co-payment; or 3) an inability to return to your primary care provider (PCP) for referral for procedures or surgery. Once you have decided to use the POS level of benefits, your health plan will most likely process all future bills from this office at the POS level, including fees for diagnostic tests and surgery. "Retro-Authorizations" from your PCP usually cannot be accepted. You may wish to check these rules with your health insurer.

Medicare

We accept Medicare assignment.

Medicare will only pay for services that it determines are "reasonable and necessary" under section 1862 (a)(1) of the Medicare law. If Medicare determines that a particular service is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service, even if that service might otherwise be covered. Our determination in consultation with you that a service is reasonable and necessary may not be the same as Medicare's. Medicare also does not currently reimburse the costs of hearing aids and examinations for hearing aids (including audiograms).

If your health plan denies coverage for any reason or otherwise fails to make payment in full within forty-five (45) days, you agree to pay all bills in full.

If you delay, refuse to pay, or refute your bills, we may refer the bills to a credit collection agency or an attorney, and we may report the unpaid bill to a local credit-reporting bureau.

You agree that you will pay your bills in full on time. You agree that if we reasonably need to seek the services of a collection agency or an attorney because of a dispute or non-timely payment of a bill, you will reimburse us for the reasonable costs of collection and that the prevailing party in any dispute will be entitled to reasonable attorneys' fees. You also agree that if it is necessary to bring a legal proceeding to resolve a fee dispute, such action must be brought in a court in Orange County, California.

By signing below, you acknowledge that you understand and agree to the above terms.

Signature: _____ Print: _____

Medical Records Release

I hereby authorize the release of my pertinent medical records to:

Happy Feet Podiatry
601 E. Yorba Linda Blvd. Suite 6
Placentia, CA 92870

Patient Name: _____ **Date of Birth:** _____
(MM / DD / YEAR)

Signature: _____

Today's Date: _____ Witness (office): _____

Privacy Attestation

By initialing and dating the form below, I acknowledge that I have been given access to the Happy Feet Podiatry Corporate Privacy Notice. (Located at www.ocfootdoc.com)

Signature: _____ **Date:** _____

_____ **Initial Here** to consent to receive personally identifiable mailings from us (announcements, etc.)

_____ **Initial Here** to consent to receive personally identifiable phone calls and voicemails from us (appointment reminders, follow-ups, etc.)

_____ **Initial Here** to consent to receive e-mail correspondence from us with personally identifiable information (lab results, follow-ups, notifications, reminders, advice, etc.)

Cancellation Policy

We kindly request that all appointment cancellations be made by calling the office 24 hours in advance. Same-day cancellations and no-shows will be subject to a $50 fee. The fee may be waived under special consideration only.

Signature: _____ **Date:** _____

Your Medical History

ALLERGIES: NO KNOWN ALLERGIES ☐

MEDICATION(S) _____	☐				
FOOD(S) _____	☐				
ANESTHESIA / LOCAL ANESTHETIC	☐	ADHESIVE / TAPE	☐	LATEX	☐
ENVIRONMENTAL / SEASONAL	☐	INSECT STINGS / BITES	☐	SHELLFISH	☐
IODINE / POVIDONE-IODINE / BETADINE	☐	CONTRAST MEDIA / DYE	☐	METALS	☐
☐	OTHER: _____				

HAVE YOU EVER HAD ANY OF THE FOLLOWING: I HAVE NO PRIOR MEDICAL CONDITIONS ☐

ACID REFLUX	☐	FIBROMYALGIA	☐	NEUROPATHY	☐
ANEMIA	☐	GOUT	☐	OPEN SORES	☐
ARTHRITIS	☐	HEART ATTACK	☐	PNEUMONIA	☐
ASTHMA	☐	HEART DISEASE/FAILURE	☐	POLIO	☐
BACK TROUBLE	☐	HEPATITIS	☐	RHEUMATIC FEVER	☐
BLADDER INFECTIONS	☐	HIV+/AIDS	☐	SICKLE CELL DISEASE	☐
ABNORMAL BLEEDING	☐	HIGH BLOOD PRESSURE	☐	SKIN DISORDER	☐
BLOOD CLOTS	☐	KIDNEY DISEASE	☐	SLEEP APNEA	☐
BLOOD TRANSFUSION	☐	LIVER DISEASE	☐	STOMACH ULCERS	☐
BRONCHITIS/EMPHYSEMA	☐	LOW BLOOD PRESSURE	☐	STROKE	☐
CANCER	☐	MIGRAINE HEADACHES	☐	THYROID DISEASE	☐
DIABETES TYPE 1 ☐ DIABETES TYPE 2 ☐		MITRAL VALVE PROLAPSE	☐	TUBERCULOSIS	☐
☐	OTHER CONDITIONS: _____				

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY?

_____

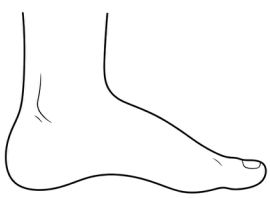
_____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE **MARK** ON THE PICTURES BELOW.

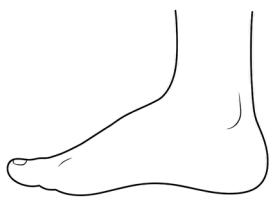
LEFT FOOT

TOP OF FOOT

BOTTOM OF FOOT



INSIDE OF FOOT



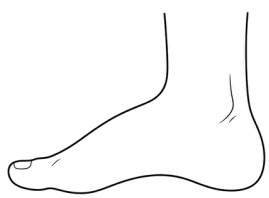
OUTSIDE OF FOOT

RIGHT FOOT

BOTTOM OF FOOT

TOP OF FOOT

OUTSIDE OF FOOT



INSIDE OF FOOT

CURRENT MEDICATIONS Include prescription, over-the-counter medications, and herbal supplements.

MEDICATION NAME	DOSE	HOW OFTEN TAKEN

PRIOR SURGERIES

SURGERY / PROCEDURE	DATE	SURGERY / PROCEDURE	DATE

PRIOR HOSPITALIZATIONS (OTHER THAN SURGERY)

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE

SOCIAL HISTORY

MARITAL STATUS:
☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

EMPLOYER: _____ **OCCUPATION:** _____

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE: _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT - HOW LONG AGO? _____
☐ SMOKE PACKS/DAY: _____ FOR _____ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT ☐ CURRENT USE
☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY TYPE: _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY
☐ SEVERAL TIMES A WEEK ☐ DAILY TYPES: _____

Family Medical History

TYPE 1 DIABETES	☐	CANCER - TYPE: _____	☐
TYPE 2 DIABETES	☐	HIGH BLOOD PRESSURE	☐
HEART / CORONARY ARTERY DISEASE	☐	THYROID DISEASE	☐
STROKE	☐	GOUT	☐
RHEUMATOID ARTHRITIS	☐	POOR CIRCULATION	☐
KIDNEY DISEASE	☐	HIGH CHOLESTEROL	☐
BLOOD CLOTS / CLOTTING DISORDER	☐	LIVER DISEASE	☐

☐ OTHER CONDITIONS: _____

RELATIVE(S): _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

HOW WOULD YOU DESCRIBE YOUR PAIN?

NO PAIN	☐	SHARP	☐
DULL	☐	ACHING	☐
BURNING	☐	RADIATING	☐
ITCHING	☐	STABBING	☐
☐	OTHER: _____		

DID YOUR PAIN OR PROBLEM:

☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOPED OVERTIME

HOW LONG HAVE YOU HAD THIS PAIN OR PROBLEM?

DURATION:_____ ☐ DAY(S) ☐ WEEK(S) ☐ MONTH(S) ☐ YEAR(S)

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT:

☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE?

WALKING	☐	STANDING	☐
DAILY ACTIVITIES	☐	RESTING	☐
DRESS SHOES	☐	HIGH HEELS	☐
FLAT SHOES	☐	ANY CLOSED TOE SHOE	☐
RUNNING	☐	OTHER: _____	☐

ADDITIONAL DETAILS

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER?

_____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM?

_____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK?

_____

WAS THIS PROBLEM CAUSED BY AN INJURY?

☐ NO ☐ YES (DESCRIBE): _____

IF YES, WAS IT A WORK-RELATED INJURY? ☐ NO ☐ YES

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

X _____

PRINT NAME

X _____

SIGNATURE

_____ **X** _____

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE