Los Gatos Podiatry Group, Inc.
14651 S. Bascom Ave Ste 215, Los Gatos Ca 95032
P. (408) 358-2250 F. (408) 358-2258

PATIENT INTAKE FORM

Last, First, Mid
Patient Name:_____ Nickname: _____ Birthdate:_____

Gender: Female Age:_____ SSN:_____ Marital Status: Single

Address:_____ Apt#: _____ City:_____ State:_____ Zip:_____

Email: Referred by:

Home:_____ Detailed Message ok:

Cell:_____ Detailed Message ok: Text Ok:

Work: _____ Employer: _____ Occupation: _____

Primary Care Physician: _____ Phone: _____ Last Visit: _____

Emergency Contact: _____ Phone: _____ Relation to Patient: _____

INSURANCE INFORMATION

PER HIPPA GUIDELINES, PLEASE COMPLETE ALL FIELDS BELOW

PRIMARY INSURANCE

CARRIER:_____ PLAN TYPE (PPO/HMO/OTHER):_____

MEMBER ID:_____ GROUP ID:_____

SUBSCRIBER NAME:_____ DATE OF BIRTH:_____

SSN:_____ RELATION TO PATIENT:_____

SECONDARY INSURANCE

CARRIER:_____ PLAN TYPE (PPO/HMO/OTHER):_____

MEMBER ID:_____ GROUP ID:_____

SUBSCRIBER NAME:_____ DATE OF BIRTH:_____

SSN:_____ RELATION TO PATIENT:_____

Clinical Assessment

Reason for todays visit:

Please answer all questions to the best of your ability.

☐ Ingrown ☐ Toenail issues ☐ Gait Evaluation Date of Injury

☐ Injury ☐ Pain: ☐ Ankle ☐ Foot ☐ Toe ☐ Surgery Consult

☐ Plantar Wart ☐ Diabetes Management ☐ Other: Duration of pain

Referring Physician: Phone: Fax:

PAST MEDICAL HISTORY

Please check if you have ever been diagnosed with any of the following:

☐ Diabetes A1C	☐ Lung / Respiratory	☐ Cancer	☐ Gout
☐ Heart Disease	☐ Neurological	☐ Hepatitis	☐ HIV / AIDS
☐ High Blood Pressure	☐ Bleeding Disorder	☐ Seizures	☐ GI Ulcers
☐ Circulatory Disease	☐ Kidney Disease	☐ Arthritis	☐ Asthma
☐ High Cholesterol	☐ Thyroid Disorder	☐ Stroke	☐ Blood Clots
☐ Immune Disorders	☐ Alcoholism/Drug Abuse	☐ Alzheimer's	☐ Anxiety/Depression

Other:

PAST SURGICAL HISTORY

Surgeries – List previous hospitalizations, major surgeries, serious injuries and approx. dates:

#1 Date: #2 Date:

#3 Date: #4 Date:

MEDICATION

List all Medications/Vitamins/Supplements you are taking and dosages:

Medication	Dosage (ie. mg)	Times/Day

Do you take a Blood Thinner: ☐ Yes ☑ No If Yes, Name: Dosage:

ALLERGIES:

☐ Penicillin ☐ Aspirin ☐ Sulfa Drugs ☐ Codeine ☐ Novocain ☐ Nuts
☐ Motrin ☐ Iodine ☐ Shellfish ☐ Latex ☐ Egg White
☐ Lactose ☐ Tape ☐ Nickel / Metal ☐ Contrast Dye ☐ No Known Drug Allergies

Please explain other allergic reaction: _____

Preferred Pharmacy: _____ Phone: _____

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

FAMILY HISTORY – *List any health problems in your immediate family:*

	Age	Medical Problem	If Deceased: Cause & Age of Death
Father:			
Mother:			
Siblings:			
Children:			

Family History of clotting disorders or anesthesia complications: No

If yes, Please explain: _____

SOCIAL HISTORY

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Life Partner

Race: ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Asian ☐ Other: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Primary Language: ☐ English ☐ Spanish ☐ French ☐ Chinese ☐ Other: _____

Alcohol use: ☐ Rarely ☐ Moderate ☐ Daily ☐ Socially ☐ Never

Tobacco Use: ☐ No Smoking History
☐ Current Smoker How much per day:
☐ Former Smoker Year of cessation:

Are you currently pregnant: ☐ Yes ☐ No Due Date:

Are you currently breast feeding: ☐ Yes ☐ No

OBGYN Name: _____ Phone: _____

Are you Blind/Deaf/Disabled? No **Describe:** _____

Do you require a translator/Nurse Assistance? No Please describe: _____

Vitals (last known measurements)

Weight: _____ lbs. Height: _____ ft _____ in Blood Pressure: ____/____ Shoe Size: __

Activity: Do you participate in any activities/hobbies?

What activity: _____ How often: _____

Minors: What grade are you in: _____ Any School Activities: _____

REVIEW OF SYMPTOMS (Check all that apply)

Constitutional: ☐ Recent unexplained weight loss ☐ Fever, Chills, or Sweats ☐ Fatigue

HEENT: ☐ Blurred vision ☐ Hearing loss ☐ Dizziness ☐ Difficulty swallowing

Respiratory: ☐ Asthma or wheezing ☐ Coughing up blood ☐ Chronic cough ☐ Pneumonia

Cardiovascular: ☐ Chest pain ☐ Irregular heartbeat ☐ Palpitations ☐ Heart attack
☐ Shortness of breath ☐ Swelling of feet/ankles/hands ☐ Blood clots

Blood Disorders: ☐ Easy bruising ☐ Frequent bleedin ☐ Enlarged lymph nodes

Endocrine: ☐ Heat or Cold intolerance ☐ Excess thirst or urination ☐ Thyroid problems

Musculoskeletal: ☐ Muscle/joints weakness ☐ Difficulty walking ☐ Back Pain ☐ Leg Pain

Neurological: ☐ Headaches ☐ Numbness/tingling ☐ Weakness/paralysis ☐ Loss of the sensation in feet
☐ Change in memory or concentration ☐ Convulsions/Seizures

Genitourinary: ☐ Blood in urine ☐ Burning with urination ☐ Sexually transmitted disease

Gastrointestinal: ☐ Abdominal Pain ☐ Heartburn ☐ Constipation ☐ Diarrhea ☐ Vomiting
☐ Constipation ☐ Bleeding ulcers

Psychiatric: ☐ Anxiety/Nervousness ☐ Memory loss/Confusion ☐ Depression ☐ Hallucination
☐ Difficulty Sleeping

Skin: ☐ Non-healing wounds/ulcers ☐ Change in nails ☐ Changing moles ☐ Skin Infection ☐ Presence of toe hair

Immunologic: ☐ Low resistance to infection

NOTICE OF PRIVACY PRACTICES

You have the right to inspect and copy your protected health information: Under federal law, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of or us in a civil, criminal or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this, Notice of Privacy Practices. Your request must state the specific restriction requested and to who you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to obtain a paper copy of this notice from us upon request, even if you have previously received a copy from us by alternative means or at an alternative location upon request and even if you agreed to accept this notice alternatively, such as electronically.

You may have the right to have your physician amend your protected health information if we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint. This notice was published and became effective on: June 1, 2012

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to the protected health information (PHI) . If you have any objections to this form please ask to speak with our HIPAA Compliance Officer.

Signature below is only acknowledgment that you received this, Notice of our Privacy Practices.

Name _____ **Relation to Patient**: _____ **Signature**: _____

** I authorized Los Gatos Podiatry Group staff to discuss my medical services, including billing and insurance related matters, with the person named below.

Print Name: _____ **Relation to Patient**: _____

Authorized Person's Phone Number: _____

FINANCIAL AGREEMENT: (Please initial beside each section marked below) Proof of Insurance:

*_____• We require Proof of Insurance (physical ID Card) at the time of appointment. If there's no Proof of Insurance, for any reason, at the time of your appointment you will be charged our Office Cash Price for any services rendered; Payment is due prior to leaving the office. Once Proof of Insurance is received, we will issue a refund for any credit left on the account once a claim determination is received. NOTE: If the Timely Filing limit has passed to file your claim NO Refund will be issued.

Benefits & Network Participation:

*_____• Determining the Provider's Network Participation with your specific Insurance plan is the responsibility of the patient. We will do our best to verify this information as a courtesy to you. However, due to the complexity of today's Insurance Market, we cannot guarantee Network Participation until a claim determination is received.

*_____• We will bill your insurance co. for any billable services rendered to you; however, we cannot guarantee your benefits. Any oral representation we make in good faith to you concerning your insurance are not binding on us and will not, in any way or for any reason, be considered a modification of their billing notice.

Payments & Collections:

*_____• We accept payment based on each Insurance Carrier's Allowable Fee Schedule. Any Copayment, Deductible, Co-insurance, or Non-covered charges determined by your insurance company are the responsibility of the patient.

*_____• For any balance due, we will send a statement to the address on file. After x3 failed attempts to collect you will receive a FINAL NOTICE, which is our last attempt to collect any Delinquent Accounts before being forwarded to: TransWorld Collections. Once in collections, all inquiries regarding the account will need to be addressed with TransWorld directly.

Missed Appointments:

*_____• We ask that you give us **24 hour** notice if you cannot attend or need to re-schedule your appointment. Repeated offenses (more than once) will be charges a Missed Appointment Fee: $75.00 for each appointment missed.

Products & DME:

*_____• Any item or product dispensed to you will either be billed to your insurance co. or paid by cash, unless otherwise stated (ex: Samples). Therefore. it is recommended to always check out with the receptionist at the end of your appointment to see if any payment is due. Prices for items billed to your insurance co. are based on their specific Fee Schedule; we are contractually obligated to accept that fee and collect for any patient responsibility indicated on the Explanation of Benefits.

Additional Fee(s):

*_____• Administrative fee of $15.00 for the completion of disability, job capacities, and work-related form(s).

I have read and understand this policy and acknowledge full responsibility for the payment of services rendered. I authorize all payments to be made directly to my provider on my behalf for any services or supplies furnished by my doctor and for my doctor to act as my agent to help obtain payment. I authorize the release of medical information or documentation in their possession in order to determine benefits payable for related services, now or in the future.

Signature: _____ **Print Name**: _____ **Date**: _____

Los Gatos Podiatry Group

INFORMED CONSENT FOR TELEMEDICINE SERVICES

Patient Name: Date of Birth: Medical Record:

Patient Address:

Physician Name:

INTRODUCTION

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

EXPECTED BENEFITS

- Improved access to medical care by enabling a patient to remain in his/her office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

POSSIBLE RISKS

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment error;

Please initial after reading this page:

BY SIGNING THIS FORM, I ATTEST TO AND UNDERSTAND THE FOLLOWING:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent,
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment,
3. I understand that I have the right to inspect all information obtained and recorded in the course of telemedicine interaction, and may receive copies of this information for a reasonable fee,
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My Physician has explained the alternatives to my satisfaction,
5. I understand that it is my duty to inform my Physician of electronic interactions regarding my care that I may have with other healthcare providers.
6. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured. 8. I attest that I am located in the state of California and will be present in the state of California during all telehealth encounters with my Physician.

PATIENT CONSENT TO THE USE OF TELEMEDICINE

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize _____(*name of Physician*) to use telemedicine in the course of my diagnosis and treatment.

PATIENT'S SIGNATURE **DATE**

PARENT/GUARDIAN TO PATIENT SIGNATURE **DATE**

WITNESS **DATE**

PHYSICIAN'S SIGNATURE **DATE**

I have been offered a copy of this consent form. (Patient's Initials)