Pristine Foot & Ankle
29839 Santa Margarita Parkway, Suite 100, RSM, CA 92688

TODAY'S DATE: _____

PATIENT

First Name _____ Middle _____

Last _____

Birthdate (**DOB**) _____

Age _____ Sex _____

Social Security # _____

Employer _____

ADDRESS

Street _____

City _____State _____ **Zip** _____

Mailing if Different

Street _____

City _____State _____ Zip _____

CONTACT

Cell Phone _____

Home Phone *(if different from cell)* _____

Email _____

(Provider sends email/text messages for appointment reminders)

EMERGENCY CONTACT

In case of **Emergency / Next of Kin**, notify

First Name _____ Middle _____

Last _____

Phone # (____) _____ Relationship _____

REFERRED BY

❒ Google ❒ Yelp ❒ Instagram ❒ Facebook ❒ Website (pristinefoot.com)

❒ Other_____

PRIMARY CARE PROVIDER (PCP)

Office Name _____

Doctor's name _____

Phone _____

Fax (if known) _____

Last Visit Date _____

PHARMACY

Name _____

Address _____

Phone _____

Fax (if known) _____

PRIMARY INSURANCE INFORMATION:

Primary Insurance Carrier _____

Insurance ID _____

Subscriber (if different from patient) _____

❒ No Insurance

SECONDARY INSURANCE INFORMATION:

Primary Insurance Carrier _____

Insurance ID _____

Subscriber (if different from patient) _____

❒ No Insurance

PATIENT CONSENT FOR AUTHORIZATION AND TREATMENT

This office does not handle Workers' compensation, Motor Vehicle Accidents or Third-party Liabilities

I hereby authorize **Pristine Foot and Ankle** to furnish information to insurance carriers concerning my illness and treatment and I hereby assign to Pristine Foot and Ankle all payments for medical services rendered to myself or my dependents. I am aware that **it is my obligation to know my insurance company's policies,** whether I need a referral or authorization prior to treatment, if the company is in net-work, and that I am responsible for payment and for all non-covered services.

If requested, I will be provided a copy of the Notice of Privacy Practices and I have read or had the opportunity to read and I understand.

Consent for Treatment: I hereby request and voluntarily consent to such office care, including routine diagnostic procedures and medical treatment as may be deemed necessary by Pristine Foot and Ankle, Inc. and its designees.

Signature _____

Print Name_____

Date _____

REASON FOR TODAY'S VISIT

Please describe the issue:

_____

_____

Which Foot: ❒ Right ❒ Left ❒ Both

Has anyone seen you for this condition: ❒ No ❒ Yes

If Yes, please provide contact _____

Shoe Size (US) _____

Current Medications _____

Allergies to medications _____

Surgeries you have had (include year):

_____

Are you pregnant (Females) ❒ Yes ❒ No

ACTIVITY LEVEL

How often do you exercise: ❒ Daily ❒ Weekly ❒ Monthly ❒ Rarely ❒ Never

What do you do for exercise?

SOCIAL HABITS

Do you have a history of substance abuse? ❒ No ❒ Yes

If Yes, please provide details _____

Drink Alcohol? ❒ No ❒ 1-2x/week ❒ 1-2x/month ❒ 1-2x/year

Currently Smoking? ❒ No ❒ Yes

If Yes, Packs per day _____ for _____ years

Quit Smoking? ❒ No ❒ Yes

If Yes, previously smoked _____ packs per day for _____ years

Have you used other tobacco products? ❒ No ❒ Yes

If yes, what products? _____

Are you exposed to tobacco in your household? ❒ No ❒ Yes

PAST MEDICAL HISTORY AND SYSTEM REVIEW

Please check all conditions that apply:

❒ High Blood Pressure ❒ Diabetes. ❒ Pneumonia ❒ Heart Disease / Heart Attack ❒ Chest Pain / Tightness

❒ Palpitations ❒ T.B. ❒ Hepatitis or Jaundice ❒ Thyroid Disease ❒ Headache ❒ Kidney Disease

❒ Vision Problems ❒ Asthma / Wheezing ❒ Ulcers ❒ GI Problems ❒ Persistent Cough

❒ Weight Gain/Loss ❒ Depression ❒ Anemia ❒ Alcohol or Drug Abuse ❒ Stroke/TIA ❒ Gout ❒ Joint Pain

❒ Water pills ❒ Blood in Stool ❒ Low Back Problems ❒ Skin Diseases ❒ HIV/AIDS ❒ Anxiety / Racing Heart

❒ Shortness of Breath ❒ Swollen Ankles ❒ Neck or Back Pain ❒ Light-headedness / Fainting ❒ Skin Rash

❒ Blood Thinner ❒ Liver Disease ❒ Arthritis ❒ Cancer ❒ Neuropathy or Tingling

❒ Blood Disorders/Clotting ❒ Hay Fever ❒ Abdominal Discomfort ❒ Leg Cramps ❒ Nausea / Vomiting

❒ Fever / Chills ❒ Constipation ❒ Kidney Stones

❒ Other _____

Do you have a family history of: (**Mother**):

❒ Rheumatoid Arthritis ❒ Thyroid Disease ❒ Diabetes ❒ Cancer

❒ Heart Disease ❒ Stroke ❒ High Blood Pressure ❒ High Cholesterol ❒ Coronary Artery Disease

❒ Vascular Disease

Do you have a family history of: (**Father**): ❒ Rheumatoid Arthritis ❒ Thyroid Disease ❒ Diabetes ❒ Cancer

❒ Heart Disease ❒ Stroke ❒ High Blood Pressure ❒ High Cholesterol ❒ Coronary Artery Disease

❒ Vascular Disease

What **medications** are you presently taking?

_____

Any other information we need to know?

_____

MEDICATION HISTORY AUTHORIZATION:

By signing below, I authorize Pristine Foot and Ankle to have access to my Medication History.

Signature _____

Print _____

Date _____

PATIENT AGREEMENT: The following is a statement of our Financial Policy which we ask that you read carefully and sign.

AUTHORIZATION FOR TREATMENT & RELEASE OF MEDICAL INFORMATION: For any insurance plan that requires authorization from a primary care physician (e.g. HMO, PPO, OHP, etc.) it is your responsibility as the patient or guardian to be sure that this office receives all necessary referrals or authorizations PRIOR to treatment. Professional services are rendered and billed directly to your insurance carrier; however, you the patient or guardian are directly responsible for services rendered by the doctor. A health insurance policy is a contract between you, the patient or subscriber and your insurance carrier. If for any reason the insurance carrier denies charges, payment for any serves rendered will become the responsibility of the patient. We are not responsible for negotiating a settlement on a disputed claim or denial.

REFFERALS & DEDUCTIBLES/COPAYS: If your insurance requires a referral from your primary care physician, this needs to be completed prior to being seen. The responsibility for the referral is between you and your primary care physician. If for any reason your insurance and/or primary care physician does not authorize your visit, payment for services rendered by Pristine Foot and Ankle will be your responsibility. If you have any doubt about your referral, please contact your primary care physician's office. You are responsible for payment to Pristine Foot and Ankle all copays and deductibles.

MEDICARE PATIENTS: Pristine Foot and Ankle is a participating Medicare provider. Medicare will be billed and upon receipt of payment, we will bill any secondary insurance, if the information is provided. If the secondary payment is not received in 60 days, a bill will be sent to you. Amounts that Medicare assigns as patient responsibility will be billed to you. If you receive payment from a secondary it is your responsibility to forward that payment to our office.

NON-COVERED SERVICES WAIVER/NOTICE OF FINANCIAL LIABILITY: I accept full financial liability for all items or services which are determined by my health care service plan not to be covered. Services not specified as being covered in the patient's contract, charges that occur because of missing referrals, deductibles, copays, coinsurance, or because the patient is considered out of network. I understand and agree that it is my responsibility and obligation to obtain a referral if required, and to follow up with my Primary Care Physician Referral Department to be sure my referral has been sent in a timely manner.

OUTSTANDING BALANCES: Again, it is your responsibility to follow up with the insurance company to ensure we receive payment timely. There is a **$35 fee for bounced, returned or cancelled checks**. Outstanding balances not paid within 61 days may result in further collections actions. If any information regarding your account changes our office needs to be updated as soon as possible; this includes address changes, new insurance information, new PCP, etc.

By signing below, I authorize the release of any medical or other information necessary to process my insurance claim(s). I also authorize payment of my insurance and/or Government Benefits be made directly to Pristine Foot and Ankle which includes but not limited to Sandra Haider, D.P.M. whom accept assignments for services rendered as outlined above.

Signature _____

Print _____

Date _____

NEW & ESTABLISHED PATIENTS

You are required to provide your insurance identification card (to include the billing address and phone number) at the time of your first visit. If you have an HMO or PPO insurance with a co-payment requirement, you will need to make the co-payment at the time of service before you are seen by the doctor. There is a **$25.00** fee if we have to send a bill for your co-pay. If you do not have proof of insurance, you will be required to pay at the time of service. When proof of insurance can be provided, you will be reimbursed. If you have a secondary insurance and would like us to bill this for you, we require all information to do this. Signature below authorizes the release of any medical or other information necessary to bill insurance and authorizes payment to Pristine Foot and Ankle.

MISSED APPOINTMENTS / CANCELLATION AND NO SHOW POLICY: In the event that you are unable to keep your appointment at our office, we must be **notified 24 hours prior to your appointment**. If we do not receive notification of your cancelation, there will be a charge of **$50.00** for any missed appointment. *If you are 15 minutes past your scheduled time, we reserve the right to reschedule your appointment.*

Signature _____

Print _____

Date _____

NOTICE OF HEALTH PRIVACY PRACTICES

I acknowledge that I have been offered and understand **Pristine Foot and Ankle's** NOTICE OF PRIVACY PRACTICES. This notice describes how we use/disclose your healthcare information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected information. I understand that this Notice of Privacy Practices is available should I wish to take one home with me.

Persons with authorization to have access to my medical records:

_____

Signature _____

Print _____

Date _____

CDC FACILITIES COVID-19 SCREENING

PLEASE READ CAREFULLY, READ ALL SYMPTOMS AND CIRCLE

Accessible version available at https://www.cdc.gov/screening

Are you experiencing any of the following symptoms: • fever or chills • cough • shortness of breath or difficulty breathing • fatigue • muscle or body aches • headache • new loss of taste or smell • sore throat • congestion or runny nose • nausea or vomiting • diarrhea	YES	NO
Within the past 14 days, have you been in close physical contact (6 feet or closer for at least 15 minutes) with a person who is known to have laboratory-confirmed COVID-19 or with anyone who has any symptoms consistent with COVID-19?	YES	NO
Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?	YES	NO
Are you currently waiting on the results of a COVID-19 test?	YES	NO

Signature _____

Print _____

Date _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

❒ Individual refused to sign

❒ Communication barriers prohibited obtaining the acknowledgement

❒ An emergency situation prevented us from obtaining acknowledgement

❒ Other (Please Specify) _____