Daly City Podiatry Group / Serramonte Podiatry Group
1800 Sullivan Avenue #401
Daly City, CA 94015
www.dalycitypodiatry.com

PATIENT INFORMATION

Name: _____ Date of Birth: ___/___/___ Age____

Address_____City_____State____Zip_____

Home Phone # (____) _____ Cell Phone # (____) _____

SS (Not Medicare) #_____Email_____

Race_____ Ethnicity_____ Sex ___F ___M

Preferred Language? _____

Marital Status: ___Single ___Married ___Divorced ___Widowed ___Other

Occupation: _____ Place of employment: _____

Height: ____Ft ____Inch Weight: _____ Shoe Size: _____

Do you currently smoke? ___Yes ___No How many packs per day? _____

Did you smoke previously? ___Yes ___No Year quit: _____

Number of caffeine drinks per day? ____ Amount of alcohol consumed per week ___

Primary Care Physician: _____

Referred By: _____

Emergency Contact & Relationship _____

Phone # (___) _____

Please describe your foot and/or ankle problem (include date of injury if applicable)

_____

_____

Pharmacy Information:

Name of pharmacy: _____ Phone number: ( ) _____

Address: _____

(Office Use only) Blood Pressure _____/_____ Pulse_____

Medical Insurance Information:

Primary Insurance Carrier:	
HMO: PPO:	
Subscriber's Name:	Subscriber's Date of Birth:
Insurance ID #:	Group #:

Do you have Secondary Insurance? If so, please fill out next section

Secondary Insurance Carrier:	
HMO: PPO:	
Subscriber's Name:	Subscriber's Date of Birth:
Insurance ID #:	Group #:

Medicare / Health Plan of San Mateo/ Care Advantage /HPSM-Medical Patients only

I request that payment of authorized Medicare benefits, and if applicable, benefits, be made on my behalf to: Daly City Podiatry Group/Serramonte Podiatry Group For any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and HPSM services, my HPSM insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature: _____ **Date:** _____

INSURANCE ASSIGNMENT AND RELEASE
Only If you are an HMO/ Hill Physicians, Brown & Toland and Brand New Day patient

I certify that I have insurance with_____
(Name of Insurance Company(ies)

and assign directly to Daly City Podiatry Group all insurance benefits, if any, payable for services rendered for my treatment. I
understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below, whichever comes first. I also understand that Daly City Podiatry Group is ONLY contracted with HILL PHYSICIANS MEDICAL GROUP as the HMO Plan.

Signature_____ **Date:** _____

Consent of Treatment/ Office Policies

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform treatment of my concerns upon a thorough discussion with the doctor. I hereby authorize the doctor or his assistants to initiate the diagnosis and treatment of my condition with x-ray, examination or photographs of injections as necessary.

1. If you need to reschedule, call within 24 HOURS of scheduled appointment in order to avoid an in-office **$25 non-cancellation fee.** We will not set up F/U appointments until we receive payment. There is a **$50 non-cancellation fee** for a missed procedure appt.
2. If you are late to your appointment by **15 minutes** or more, we have the right to reschedule your appointment. So please call the office ahead of time if you will be late to your appointment.
3. All insurance CO-PAYS and applicable DEDUCTIBLES are due at the time of the visit.
4. IT IS THE PATIENT'S RESPONSIBILITY to update any insurance or changes in your contact information with our staff in order to avoid an out of pocket expense.
5. IT IS THE PATIENT'S RESPONSIBILITY to know what is covered under their insurance plan.
6. If your insurance policy requires a referral to see a specialist, please have it at the time of the visit.
7. Should you receive payment from the insurance company for the doctor, timely reimbursement for your care is imperative.
8. If you are a diabetic please be sure to provide your primary care physician's name and contact information.
9. It is patient's responsibility to remember their appointments. Reminder calls are a curtesy not an obligation.
10. **No Dogs are allowed in the office. Only seeing dogs ect.**
11. Patients must bring insurance card and Photo ID to every visit. No Exceptions!

I have acknowledged and agree to follow the policies of this office.

Signature_____ **Date** _____

PERSONAL MEDICAL HISTORY check all that apply CHECK here if NONE ☐

Check those that apply Frequent Headache / Migraines		Anemia / Blood Disorders	
Rheumatic Fever		Pneumonia	
Kidney Disease		Drug/Alcohol Abuse	
Dialysis M W F or T TH SA		Epilepsy / Seizures	
Diabetes Average Blood Sugar:		Prolonged Bleeding Time	
Tuberculosis		Stomach Disorder / Ulcer	
Emphysema		Thyroid/Parathyroid Disease	
Heart Trouble		High Blood Pressure	
Stroke		Arthritis	
Chest Pain on Mild Exertion		Psychiatric Treatment	
Gout		Emotional Problems / Tension	
BLOOD CLOTS		Asthma / Hay Fever / Shortness of Breath	
Tumor / Abnormal Growth / Cancer		Prostate Disorder	
Ear, Nose, Throat Disorder		Sexually Transmitted Disease	

Has any family member had any of the following (please indicate relationship)

Cancer: _____ Diabetes: _____ Heart Trouble: _____
High Blood Pressure: _____Kidney Disease: _____Stroke: _____
Mental or Emotional Disease: _____ Tuberculosis: _____
Arthritis: _____ Emphysema: _____BLOOD CLOTS: _____ NONE:____

Please complete the following: NONE ☐
Exercise: Type, duration, frequency (Example: Walking 30 minutes 3 x/week)

_____
_____
_____
_____

ALLERGIES If you don't have any allergies please check here ☐

Please check all allergies:
_____Medications:_____
_____Foods:_____
_____Tapes _____Novocain _____Anesthetics _____Silver/Nickel/Costume Jewelry
_____Other:_____ NONE_____

What types or reactions have you experienced?

_____
_____
_____
_____

MEDICATIONS CHECK THIS BOX IF YOU DO NOT TAKE ANY MEDICATION ☐

Please list all prescription and over-the-counter medications and the dosages:

SURGICAL HISTORY CHECK here if NONE ☐

Surgical Procedures / Serious Injuries / Illnesses	Year	Physician	Hospital

HEALTH REVIEW CHECK here if NONE ☐

Please circle any symptoms you have had in the past 3 months.	
General	Fever Chills Fatigue Weight Loss Weight Gain
Head	Headaches Visual Problems Hearing Problems Light Sensitivity
Cardiovascular	Chest Pain Palpitations Dizziness Swelling of Legs Other :
Hematology	Anemia Abnormal bleeding/bruising Blood Clots Other Blood Disorder :
Respiratory	Persistent Cough Wheezing Shortness of Breath
Gastrointestinal	Difficulty swallowing Indigestion/Heartburn Abdominal Pain Change in Bowel Habits
Urinary	Painful urination Frequent Nighttime Urination Bladder leakage Other :
Musculoskeletal	Joint Pain/Swelling/Stiffness Back Pain Arthritis Muscle Weakness
Skin	Skin Rash Suspicious Lesions Itching
Neurological	Numbness of hands/feet Seizures Tremors Paralysis
Psychiatric	Depression Anxiety Problems Sleeping Memory Loss
Endocrine	Heat/Cold Intolerance Hot Flashes Change in hair/skin texture Other:

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Acknowledgment for HIPPA (The pages following pages)

I, _____ have been informed of this office's Notice of Privacy Practices.

Signature _____ **Date:** _____

FOR OFFICE USE ONLY

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

___ Individual refused to sign
___ Communications barriers prohibited obtaining the acknowledgment
___ An emergency situation prevented us from obtaining acknowledgment
___ Other (Please Specify)

_____
_____
_____
_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH AND MEDICAL INFORMATION IS IMPORTANT TO US.

OUR RESPONSIBILITIES

We at Daly City Podiatry Group understand that medical information about you and your health is personal. Applicable federal and state law requires us 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 03/24/2017, and will remain in effect until we replace it. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We reserve the right to change our privacy practices and the terms of this Notice at any time, 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. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

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

To Treat You: We can use or disclose your health information to a physician or other healthcare provider providing treatment to you.

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

Healthcare Operations: We can use and disclose your health information in connection with our healthcare operations which 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 the Patient Rights section of this Notice We may disclose your health information to a family member, friend or another person to the extent 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 locating) a family member, your personal representative or another person responsible for PCIHIPAA.com Page 1 of 3 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 purposes without your written permission.

Required by Law: We may use or disclose your health information when we are required to do so by state or federal law, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a 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 official having lawful custody of protected health information of inmate or patient under certain circumstances.

Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you: For workers' compensation claims For law enforcement purposes or with a law enforcement official With health oversight agencies for activities authorized by law For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

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

PATIENT RIGHTS

Access: You have the right to look at or 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. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies, mailing, and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end PCIHIPAA.com Page 2 of 3 of this FRONT AND BACK Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request

this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

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).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Officer: Office Manager/ Saydi Marquez
Telephone: 6507553338
E-mail: saydi_dcpg@yahoo.com
Address: 1800 Sullivan Ave. #401
Zip Code: 94015
State: California
City: Daly City
PCIHIPAA.com

FRONT AND BACK