Fishman Foot Care

Patient Information Form
(Please Print)

Date: ____/_____/_____ Social Security #: _____/_____/_____

Patient Name: _____ _____ ____ Date of Birth: ____/____/____ Age: ____ Sex: M F
Last First MI

Home Address: _____ City/State: _____ Zip: _____

May we leave a message?
Home Phone #: (_____) _____-_____ Yes No

Work Phone #: (_____) _____-_____ Yes No

Cell Phone #: (_____) _____-_____ Yes No

E-mail: _____ Yes No

Primary Language: _____

Race:_____ Ethnicity:_____

MARITAL STATUS: _____

Emergency Contact: _____ Relationship: _____ Phone #: (_____) _____-_____

Primary Care Doctor: _____ Phone: _____

Pharmacy: _____ Location: _____ Phone #: (_____) _____-_____

Who Referred You To Us?_____

Current Problem

What specific problem brings you to our office today? _____

Was this problem caused by an injury? ☐ Yes (describe) _____ ☐ No

If yes, was it a work or motor vehicle related injury? ☐ Yes ☐ No

I, hereby acknowledge that Dr. Michael Fishman, D.P.M. does **NOT** accept Worker's Compensation/ Personal Injury. By signing below, I acknowledge that I am agreeing my services are **NOT** Worker's Compensated/ Personal Injury related, and am agreeing to **NOT** filing a claim after services are rendered.

_____ Date: _____
Patient Signature

Please list all medications you are currently taking (Include prescriptions, over-the-counter meds and herbal supplements):
Name Dose FREQUENCY OF MEDICATIONS?

_____

Allergies: ☐ Medications _____
☐ Anesthesia _____ ☐ Foods _____
☐ Tape ☐ Latex ☐SULFA ☐ Iodine ☐ PENICILLIN
☐ None Known ALLERGIES

Please list all prior surgeries:
Type of Surgery Date Type of Surgery Date
_____
_____
_____ _____
_____ _____

Social History

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 – How long ago? _____ Type _____
☐ Current use - type _____ ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

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 of exercise: _____

Family History

Do you have a family history of: ☐ Diabetes: Type 1 or Type 2 ☐ Cancer ☐ Heart Disease
☐ High Blood Pressure ☐ Stroke ☐ Coronary Artery Disease ☐ Thyroid Disease
☐ Rheumatoid Arthritis
☐ Other _____

PLEASE LIST ANY OTHER MEDICAL CONDITIONS:
_____
_____
_____

Have you ever had any of the following?

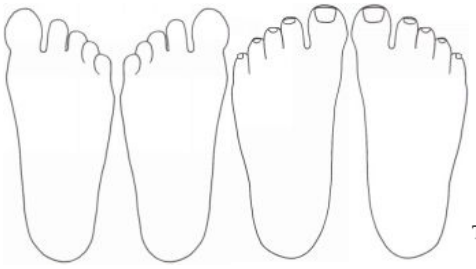
Acid Reflux	Y	N	Fibromyalgia	Y	N	Neuropathy	Y	N
Anemia	Y	N	Gout	Y	N	Open Sores	Y	N
Arthritis	Y	N	Heart Attack	Y	N	ULCERS	Y	N
Asthma	Y	N	Heart Disease/Failure	Y	N	Polio	Y	N
Back Trouble	Y	N	Hepatitis	Y	N	Rheumatic Fever	Y	N
ABNORMAL BLEEDING	Y	N	HIV+/AIDS	Y	N	Sickle Cell Disease	Y	N
BLOOD CLOTS	Y	N	High Blood Pressure	Y	N	Skin Disorder	Y	N
Blood TRANSFUSION	Y	N	Kidney Disease	Y	N	Sleep Apnea	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	Liver Disease	Y	N	Stomach Ulcers	Y	N
CANCER	Y	N	High Blood Pressure	Y	N	Stroke	Y	N
Diabetes: Type 1	Y	N	Migraine Headaches	Y	N	Thyroid Disease	Y	N
Diabetes:Type 2	Y	N	Mitral Valve Prolapse	Y	N	Tuberculosis	Y	N

PLEASE WRITE YOUR PAIN LEVEL FROM 0 MEANING IT DOES NOT BOTHER YOU. 10 MEANING YOU ARE IN EXCRUSIATING PAIN AND NEED TO GO TO THE E.R.

PAIN LEVEL OF: _____

Where is the pain/problem located? Please mark on the pictures below.

Left Foot **Right foot**



Top of Foot Bottom of Foot Bottom of Foot Top of Foo

INSURANCE AUTHORIZATION AND ASSIGNMENT

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO DR. FISHMAN FOR ANY SERVICES THAT DR. FISHMAN PROVIDES. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS OR THE PAYABLE TO RELATED SERVICES. I UNDERSTAND THAT MY SIGNATURE REQUESTS THAT PAYMENT BE MADE AND AUTHORIZES RELEASE OF MEDICAL INFORMATION TO PAY THE CLAIM. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE BALANCE NOT COVERED BY MY INSURANCE. ANY ACCOUNT BALANCES WHICH REMAIN OUTSTANDING ARE SUBJECT TO A $5.00 PER MONTH BILLING CHARGE. IF I FAIL TO MAKE A PAYMENT AND THE BALANCE OF MY ACCOUNT IS PLACED FOR COLLECTION, I WILL BE RESPONSIBLE FOR REASONABLE COLLECTION COSTS, INCLUDING ATTORNEY'S FEES.

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.

_____ _____

PRINT NAME OF PATIENT, PARENT OR GUARDIAN SIGNATURE OF DOCTOR

_____ _____

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

_____

SIGNATURE

_____

DATE

FINANCIAL POLICY

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have
elected to receive which may imply a financial responsibility on your part.

CO-PAYMENTS, CO-INSURANCE, DEDUCTIBLES: All co-payments, co-insurance and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance.

SELF-PAY ACCOUNTS: Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payments of these services.

CLAIM SUBMISSION: We will submit your claims and assist you I any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

PATIENT BILLING: Occasionally after payment and/or explanation of benefits (EOB) are received from your insurance company/companies there is a co-insurance or deductible that we were not aware of at the time of service. You will be sent three notices of your financial responsibility. After the third and final notice, your account may be forwarded to collections. All cost incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due to the office. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payments methods: Cash, Check, VISA, MasterCard, Discover, and American Express. (An additional $30.00 will be added to your statement if the check is returned for insufficient funds.)

I have read the above policy regarding my financial responsibility to Dr. Michael Fishman D.P.M. for medical services provided. I agree to pay Dr. Michael Fishman D.P.M. any balance unpaid by my insurance carrier for myself or the below named person.

ASSIGNMENT OF BENEFITS:

I, the undersigned, certify that I or my dependent) have coverage with my insurance as presented and assign directly to **Dr. Michael Fishman D.P.M.** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, co-insurances, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

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SIGNATURE OF PATIENT **DATE**

PRINT NAME OF PATIENT, PARENT GUARDIAN IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU
The following categories describe different ways that we use and disclosed medical information without your specific written authorization.

- FOR TREATMENT. We may use medical information about you to provide you with medical treatment or services.
- FOR PAYMENT. We may use and disclose medical information about you so that the treatment and services you receive at Michael Fishman D.P.M. may be billed to and payment may be collected from you, an insurance company or health plan or other third party.
- FOR HEALTH CARE OPERATIONS. We may use and disclose medical information about you for Michael P. Fishman D.P.M. operations.
- APPOINTMENTS. We may use your information to provide appointment reminders. Special situations which do not require your written authorization include: (1) Organ and Tissue Donation, (2) Military and Veterans Health Benefits, (3) Worker's Compensation, (4) Public Health Risks, (5) Health Oversight Activities (6) Lawsuits and Disputes (7) Law Enforcement (8) Coroners, Medical examiners and Funeral Directors (9) National Security, Intelligence and federal Protective Service Activities (10) Inmates.

AUTHORIZATIONS FOR OTHER USES AND DISCLOSURES OF MEDICAL INFORMATION
Other uses and disclosures of medical information not covered by the uses of and disclosures stated above will be made only with your written authorization. If you give us an authorization, you may later revoke that permission in writing, at any time.

YOUR RIGHTS REGARDING MEDICAL INFORMATON ABOUT YOU
You have the following rights regarding medical information we maintain about you.

- RIGHT TO INSPECT AND COPY. You have the right to inspect and copy medical information that may be used to make decisions about your care.
- RIGHT TO AMEND. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information.
- RIGHT TO AN ACCOUNTING OF DISCLOSIRES. You have the right to request an "accounting of disclosure."
- RIGHT TO REQUEST RESTRICTIONS. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment.
- RIGHT TO CONFIDENTIAL COMMUNICATIONS. You have the right to request communications of your health information by alternative means or at alternative locations.

RIGHT TO PAPER COPIES OF ELECTRONIC NOTICES. You have the right, where you have agreed to receive electronic notices, to obtain a paper copy of the notice upon request.

OUR LEGAL DUTIES

- We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.
- We are required to abide by the terms of the notice currently in effect.
- We reserve the right to change the terms of this notice and make the new notice provisions effective for all protected health information we maintain. Revised notices will be sent to all our patients within 20 days from the time such revisions are made.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with (Medical Group) or with the Secretary of the Department of Health and Human Services.

CONTACT
To file a complaint with Michael P Fishman D.P.M. contact Kathryn Mabry at (562) 431-2558.

COMPREHENSIVE PRIVACY NOTICE
A more detailed, comprehensive notice regarding our privacy practices is available upon request to the person stated above.

EFFECTIVE DATE:
This notice is effective on April 16, 2003.

Michael Fishman D.P.M.
• Foot & Ankle Specialist • Adult & Pediatric Surgery •
3851 Katella Ave., Suite #255
Los Alamitos, CA 90720
P: (562)431-2558 F: (562)296-8389

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:
We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclosure your health information.

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices of
Michael P. Fishman, D.P.M.

Signature of Patient or Personal Representative.

Print Name of Patient or Personal Representative.

Date

Description of Patient or Personal Representative's Authority

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To Our Patients:

In our efforts to continuously improve our patient service and office efficiency, you will be asked for a credit card number at the time of check in. That information will be held securely until your insurance has paid their portion and have notified both you and us of how much, if any, is your portion. A statement will be mailed to you regarding any remaining balance. If a balance becomes delinquent, the credit card will be charged to avoid the collections process.

This will be an advantage to you because you will no longer have to write out and mail us a check. It will be an advantage to us as well because it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping keep down the cost of health care.

Much like when you check into a Hotel or Rent a Car, you are asked for a Credit Card, which is imprinted and later used to pay your bill. This will in no way compromise your ability to dispute a charge or question your insurance company's determination of payment.

If you have any questions about this payment method, please do not hesitate to ask.

Sincerely yours,

Dr. Michael P. Fishman, D.P.M

I authorize Dr. Michael P. Fishman to charge outstanding patient portion balances for me and my dependents to the following credit cards:

Visa MC DISCOVER AMEX

Account Number _____

Expiration Date: _____ Security Code: _____ Billing Zip Code: _____

Full Name on Credit Card (please print): _____

Signature: _____ Date: _____

ADVANCED BENEFICIARY NOTICE (ABN)

Note: You need to make a choice about receiving these health care items or services.
In the event of injury, severe pain, or new problems, Dr. Fishman has the ability to perform an in office x-ray with his Fluoroscopy machine. We expect that your insurance will pay for the service described, however if they refuse to pay, this would leave you responsible for payment. We cannot guarantee payment of this in office service until it is billed out and processed through your insurance. The fact that the insurance may not pay for this item does not mean that you should not receive it.

We expect that your insurance will not pay for the item(s) or service(s) that are described below. Your insurance does not pay for all your health care costs. Your insurance only pays for covered items and services when items and services rules are met. The fact that the insurance may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, your insurance probably will not pay for:
(76000) **X-Ray exam** (Fluoroscopy)

Because: It may not be a covered benefit on your insurance plan.
The purpose of this for is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

Ask us to explain, if you don't understand why your insurance probably won't pay.
Ask us how much these items or services will cost you. (Estimated Cost: $85)

Choose one option. Please check one box. Sign and date your choice

___ Option 1. Yes, I want to receive these items or services. I understand that my insurance will not decide whether to pay unless I receive these items or services. Please submit my claim to my insurance. I understand that you may bill me for items or services, and that I may have to pay

the bill while my insurance is making its decision. If my insurance does pay, you will refund me any payments I made to you that are due to me. If my insurance denies payment, I agree to be personally and fully responsible for payment. That is, I will personally, either out of pocket or through any other insurance that I have. I understand I can appeal my insurance's decision.

___ Option 2. No, I have decided not to receive these items or services. I understand that you will not be able to submit a claim to my insurance and that I will not be able to appeal your opinion that my insurance won't pay.

_____ _____

Date Signature of patient or person acting on patient behalf

REVIEW OF SYSTEMS
Please check any that apply to you

General/Constitutional
- Chills
- Fatigue
- Fever
- Weakness
- Weight gain/loss

Eyes
- Blurry vision
- Cataracts
- Discharge
- Double vision
- Excessive tearing
- Eye pain
- Glasses/Contacts
- Infections
- Pain with light
- Redness
- Loss of vision

ENT
- Head injury
- Headaches
- Pain
- Sweats
- Discharge
- Frequent colds
- Hay fever
- Infections
- Nasal Obstruction
- Nosebleeds
- Sinus infections
- Bleeding gums
- Hoarseness
- Postnasal drip
- Tongue Burning
- Hearing aid
- Ringing in ears
- Frequent sore throats
- Lumps
- Tenderness
- Tonsils enlarged

Respiratory
- Asthma
- Cough
- Wheezing
- Coughing blood
- Shortness of breath

Cardiovascular
- Chest pains
- Palpitations
- Varicose veins
- Heart murmur
- Leg pain (walking, etc)
- Swelling of legs
- Thrombophlebitis
- Ulcers on legs

Gastrointestinal
- abdominal pain
- Constipation
- Diarrhea
- Heartburn
- Jaundice
- Liver disease
- Rectal bleeding
- Excessive hunger
- Excessive thirst
- Gallbladder disease
- Vomiting/nausea

Musculoskeletal
- Arthritis
- Joint pain
- Gout
- Back problems
- Joint stiffness
- Muscle cramps
- Muscle stiffness
- Paralysis
- Restricted motion
- Weakness

Neurological
- Loss of consciousness
- Blackouts
- Dizziness/fainting
- Headaches/ Memory loss
- Numbness/ Paralysis
- Bell's Palsy
- Stroke
- Tingling/ tremors

Female Genitalia
- Birth control
- Intermittent

Skin
- Eczema
- Itchiness/dryness
- Hives/ lumps
- Mole size increase
- Nail color appearance change
- Rashes

Hematologic/Lymph
- Anemia
- Bleeding easily
- Blood clots
- Bruise easily
- Lumps/ swollen glands
- Transfusion reaction

Allergic/ Immunologic
- Coughing/ with exercise
- Itchy/ watery eyes
- Runny/ stuffy nose
- Wheezing/ with exercise

Urinary
- awakening to urinate
- Bed- wetting
- Blood in urine
- Burning/Pain urinating
- Excessive urination
- Flank pain
- Incontinence
- Infections
- Stones
- Urine odor/discoloration
- Other conditons

_____