Ocotillo Foot & Ankle Centers

270 W. Chandler Heights Rd. #5
Chandler, AZ 85248
480-895-0276 FAX: 877-389-9169

13838 S. 46th Pl. #105
Phoenix, AZ 85044
480-940-5172

_____ DOB: _____/_____/_____
Last First MI

Marital Status: S ☐ M ☐ D ☐ W ☐ **Sex:** M ☐ F ☐ O ☐ **Height:** _____ **Weight:** _____ **Shoe Size:** _____

Mailing Address: _____
(No P.O. Boxes) Street Apt # City State Zip

Cell #: _____ Home #: _____ Work #: _____

Email for Patient Portal: _____

For oral communications, may we leave a message? Y N Preferred #: _____

With whom may we leave a message with? _____Relationship:_____

Patient Employer: _____ Phone #: _____

Preferred Pharmacy: _____ Phone #: _____

How did you hear about us? ☐ My Doctor ☐ Google ☐ Yelp ☐ Facebook
☐ Friends/Family _____ ☐ Other_____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name: _____Phone #: _____ Relationship: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ Phone #: _____

Member ID #: _____ Policy Holder: _____ DOB: _____

Group #: _____ _____Policy Holder's SSN: _____ Relationship to Patient: _____

SECONDARY INSURANCE (If Any): _____ Phone #: _____

Member ID #: _____ Policy Holder: _____ DOB: _____

Policy Holder's SSN: _____ Relationship to Patient: _____

INSURANCE AUTHORIZATION TO RELEASE INFORMATION AND AUTHORIZATION TO PAY

I hearby authorize Ocotillo Foot and Ankle Centers, PLLC to release any information, for insurance purposes, required in the course of examination or treatment. I also hereby authorize payment directly to the business office of Ocotillo Foot and Ankle Centers, PLLC for surgical and/or medical benefits, if any, and otherwise payable to Ocotillo Foot and Ankle Centers, PLLC. I understand that I am finacially responsible for the charges not covered by my insurance.

Patient Signature (or Parent, if minor): _____ Date: _____

Ocotillo Foot & Ankle Centers

Patient Name: _____ Present Foot/Ankle Complaint:_____

Please check (√) if you or an immediate family member have had any of the following conditions:

YOU	Family Member	Nature of Problem	Date of Onset, Comments/Treatments
		Recent Weight Loss	
		Headaches	
		Vision / Hearing Problems	
		Asthma or Respiratoy Issues	
		Thyroid Problems	
		Diabetes	A1c: Last Blood Sugar:
		Heart Disease	Pacemaker: Yes □ No □
		Circulation / Bleeding Problems	Please Specify
		High / Low Blood Pressure	
		Arthritis	
		Stomach Ulcers / Trouble	
		Gout	
		Liver Disease	
		Kidney Disease	
		Keloid / Scarring Problems	
		Drug / Alcohol Abuse	
		Nerve Problems / Neuropathy	Please Specify
		History of Blood Clots / Arterial or Venous	Please Specify
		History of Cancer	Please Specify
		EDS / POTS	
		Other Medical Conditions	Please Specify

Primary Care Provider: _____Phone #: _____ Last Office Visit:_____

Please list any surgeries or serious injuries: _____

_____

_____

_____

Please list medications you are currently taking (Including prescription, over-the-counter medications and vitamins)

_____

_____

_____

Please list any Allergies: _____

_____

_____

Do you smoke? Yes ☐ No ☐ If yes, how often? _____

Do you take Hormone Repacement Therapy? Yes ☐ No ☐ Do you take oral contraceptives? Yes ☐ No ☐

Flu Vaccine? Yes ☐ No ☐ Covid Vaccine? Yes ☐ No ☐ Pneumonia Vaccine? Yes ☐ No ☐

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures and may be deemed necessary in the diagnosis and / or treatment.

Patient Signature (Parent, if Minor): _____ Date: _____

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CONSENT TO OBTAIN ELECTRONIC MEDICATION HISTORY

I understand that my medication history may be obtained utilizing an electronic information exchange and that this protected health information may provide valuable information for my healthcare provider.
I hereby authorize Ocotillo Foot and Ankle Centers, PLLC to access my medication history without limitation or exclusion as is reasonably advisable to disclose, retrieve, and view medications issued by a provider.

INSURANCE POLICY

Insurance provides for your reimbursement on allowed medical charges. As a courtesy to you we will provide an itemized statement you may send to your insurance company for payment. We will be happy to submit to most insurance carriers, if you have provided us with policy numbers, address, place of employment and any other pertinent information. You are responsible for all copays, deductibles and charges not covered by your insurance. Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility.

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

I have read the above and accept financial responsibility in full for this account.

Patient Signature: _____ Date: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize the Doctor to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the Doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person (s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of the information. (ex: family member, spouse, child, etc.)

I, _____authorize release of personal information to _____
(Patient Name) (ex: family member, spouse, child, etc.)

Patient Signature: _____ Date: _____

Form Fees: There will be a $50.00 charge for all forms completed. This fee is due at the time the form is presented to the office. The form will not be completed until the form fee is paid. The majority of forms including diability forms, FMLA, Leave of Absence Forms, work and/or school notes. **INITIALS _____**

No Show / Same Day Cancellation Policy: No show and same day cancellations make it impossible for our office to provide care to another patient in need. We require a 24-hour notice for cancellations.

- 1st No Show or same day cancellation: $25.00
- 2nd No Show or same day cancellation: $25.00
- 3rd No Show or same day cancellation: $35.00 and/or PATIENT DISCHARGED FROM THE PRACTICE

Thank you for your consideration in this matter. **INITIALS _____**

Patient Signature: _____ Date:_____

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HIPPA (Health Insurance Portability and Accountability Act):

The HIPPA privacy standards no longer require an individual's consent or authorization to execute health care treatment, payment or operations. Instead, Section 164.506 gives covered entities express “regulatory permission” to use or disclose protected health information (PHI) under certsin circumstances for treatment, payment or health care operations without an individual's prior written permission or authorization.

The December 3, 2002, Office of Civil Rights HIPPA Privacy Guidance states, “Payment encompasses the various activities of health care providers to obtain payment or be reimbursed for their services and of a health plan to obtain premiums, to fulfill their coverage responsibilities and provide benefits under the plan, and to obtain or provide reimbursement for the provision of health care. “ Examples given in the guidance of permitted use or disclosure or PHI for treatment, payment and health care operations include:

1) A hospital may use PHI about an individual to provide health care to the individual and may consult with other health care providers about the individual's treatment.
2) A health care provider may disclose PHI about an individual as part of a claim for payment to a health plan.
3) A Health plan may use PHI to provide customer service to its enrollees. We respectfully assert that an individual's prior written permission or authorization is not required in order to fulfill the nature of our request.
4) We will NOT sell or release your PHI to any third party that is not a health care entity.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Name (please PRINT) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature