NEW PATIENT INFORMATION

Name: _____
Last First M.I.

Address: _____
Street Apt# City State Zip

Phone: _____ **Social Security #:** _____ DL#: _____

***E-Mail*:** _____ **Date of Birth:** _____ **Sex:** _____

Occupation: _____ **Employer:** _____

Employer Address: _____ **Phone:** _____
Street

_____
City State Zip

Name of Spouse/Parent: _____ **Employer:** _____

Employer Address: _____ **Phone:** _____
Street

_____
City State Zip

NAME OF PRIMARY INSURANCE CO:
_____ **Subscriber:** _____ **DOB:** _____

ID#: _____ **Policy/Group:** _____

(Secondary): _____ **Subscriber:** _____ **DOB:** _____

ID#: _____ **Policy/Group:** _____

CHIEF COMPLAINT:

_____

_____

Who referred you to this office? _____

I consent to receive appointment reminders via: ☐ **Email only** ☐ **Text message only** ☐ **Both email and text message**

I hereby authorize Jeff Brooks, DPM, Andrew To, DPM and Oceanside Foot & Ankle Center to furnish my insurance company all information which said insurance company may request concerning my illness of injury. I hereby assign to Jeff Brooks, DPM, Andrew To, DPM, or Oceanside Foot & Ankle Center all payments to which I am entitled for medical and/or surgical expenses relative to the service reported for my illness or injury. I understand that I am financially responsible to said doctor for charges not covered by this assignment of benefits. A photocopy of this assignment is as valid as the original.

Patient Signature _____ Date: _____

Legal Guardian (if patient is a minor) _____ Date: _____

PATIENT MEDICAL HISTORY

WHO IS YOUR PERSONAL PHYSICIAN? _____

PHARMACY: (*Name, address, city*) _____

HOW IS YOUR GENERAL HEALTH? _____ **HEIGHT:** _____ **WEIGHT:** _____

FAMILY MEDICAL HISTORY: _____

LIST OF SURGERIES: _____

ARE YOU DIABETIC?(*Circle*) Yes No **DO YOU SMOKE?**(*Circle*) Yes No **DO YOU DRINK ALCOHOL?**(*Circle*) Yes No

Please list any medical problems: _____

_____

_____

MEDICATIONS

Please list any medications or drugs you take: _____

_____

_____

ALLERGIES

Please list any medications that you are allergic to: _____

_____

PODIATRIC HISTORY

WHAT IS THE REASON FOR THE VISIT? _____

HOW LONG HAVE YOU HAD THIS CONDITION? _____

HAVE YOU BEEN TREATED FOR THIS CONDITION BEFORE?(Circle) Yes No

DOCTOR'S NAME: _____ **LAST VISIT:** _____

HAVE YOU HAD PREVIOUS FOOT SURGERY?(*Circle*) Yes No _____

Please indicate which foot problems you have had in the past: _____

_____

I certify that the above information is true and correct to the best of my knowledge. I give permission to Jeff Brooks, DPM or Andrew To, DPM to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet (or that of y minor child or dependent).

Print name _____

Patient signature _____ Date: _____

Legal Guardian (if patient is a minor) _____ Date: _____

Oceanside Foot & Ankle Center Financial Policy

We are doing everything possible to hold down the cost of medical care. You can help a great deal by reducing the number of bills we send to you. The following is a summary of our payment policy.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance, copayments or deductibles for participating insurance companies. Oceanside Foot & Ankle Center accepts Cash, Personal Checks (in-state only), Visa, MasterCard, and Discover. There is a minimum service charge of $25 for returned checks.

Patients with an outstanding balance of 60 days or more overdue must make arrangements for payment prior to scheduling appointments. We realize that financial difficulty is a reality. In such circumstances, please speak with one of our staff members to make payment arrangements.

INSURANCE

We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and copayments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance carrier.

If you need assistance or have questions, please contact the billing office between 9:00AM and 5:00PM on Monday through Friday at (973) 947-7756. To make a payment, call (760) 630-9200.

MANAGED CARE

If you are enrolled in a managed care insurance plan (i.e., HMO), you must receive a referral from your primary care doctor before making an appointment. Retroactive referrals are not guaranteed.

MISSED APPOINTMENTS/LATE CANCELLATIONS

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested at least 24 hours prior to the appointment. We reserve the right to charge $50 for missed or late-canceled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

I have read and understand the Oceanside Foot & Ankle Center Financial Policy. I agree to assign insurance benefits to Dr. Brooks, Dr Andrew To and/or Oceanside Foot & Ankle Center whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

Signature:_____

Print Name:_____

Date:_____

Notice of Privacy Practices

To Our Patients

This notice describes how health information about your, as a patient of this practice may be used and disclosed and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the health Insurance Portability and Accountability Act of 1996 (HIPPA).

Our Commitment to Your Privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information.

Use and Disclosure of Your Health Information in Certain Special Circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the treat.
5. If you are a member of US or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For workers compensation and similar programs.

Your Rights Regarding Your Health Information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than at work. We will accommodate reasonable requests.
2. You can request a restriction in our use of disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care, such as a family member or friend. We are not required to agree to your request, however, if we do agree we are bound by our agreement except when otherwise required by law, emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete as long as the information is kept by or for our practice. To request an amendment, you request must be made in writing and submitted to Shin Foot and Ankle Specialists. You must provide us with a reason that supports your request for an amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to provide you with a copy of this notice at any time.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with your practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Your practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please submit your requests to:

Jeff Brooks, DPM or Andrew To, DPM
3230 Waring Court, Suite M Oceanside, CA 92056
(760) 630-9200

Acknowledgement of Receipt of the Notice of Privacy Practices

I acknowledge receipt of the Notice of Privacy Practices provided by the office of Oceanside Foot & Ankle Center and Jeff Brooks, DPM, and Dr. Andrew To in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).Signature: _____ Date: _____ Print Name: _____
If patient is a minor (under 18 years old), relationship to patient: _____

For Office Use Only. (Please do not write below this line)

Acknowledgement not signed due to:
____ Patient refused, ____ Patient unable to sign to due medical condition, ____ Patient left office
Copy mailed on _____ by _____
Other (specify: _____)
Signature of Office Representative: _____

PATIENT TRANSPORTATION RESOURCES

North County Transit District ADA Lift Van (760)-966-6500

This service is low cost and serves the cities of Oceanside, Carlsbad, Escondido, San Marcos, Vista, Solana Beach, Del Mar, Fallbrook, and Valley Center. Capable of transporting patients in wheelchairs, scooters, canes, crutches, and walkers. Advance reservations required. Veterans who meet VA eligibility requirements can get reimbursement from the VA.

Facilitating Access to Coordinated Transportation (FACT) (888)-924-3228, www.factsd.org

FACT offers rides in San Diego County for seniors aged 60+, persons with disabilities, students, veterans, and other residents who need assistance to make essential trips for medical needs.

To arrange a ride, call the phone number between 8:00am-3:00pm M-F, rides are available on first come first served bases and reservations are needed at least 1 day in advance.

San Diego County Senior Transportation Program (855)-638-2279

No cost transportation program in San Diego County for seniors aged 60+ and have household income at or below 80% of San Diego County Area Median Income. To apply, and for questions, call phone number or visit htts://otgrides.org/sd-enrollment to chat with live agent.

Veterans Transportation Services (VTS) 858-552-7572

Free of charge transportation for any Veteran. No rules of eligibility apply. This service can transport Veterans who use manual or power wheelchairs, scooters, canes, crutches, walkers, and those who are ambulatory. Please call to schedule ride 2 to 10 days prior to medical appointment.

Metropolitan Transit Service (MTS) 619-557-4555

Door to door service. Low-cost transportation for all San Diego residents. Capable of transporting persons in manual and power wheelchairs, scooters, canes, crutches, walkers, and those who are ambulatory. Advance reservations required. Veterans who meet VA travel requirements can be reimbursed for the bus fare paid.