

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

Last First MI DOB: ____/____/____

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 #: _____ SSN: _____

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 hereby 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 financially responsible for the charges not covered by my insurance.

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

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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 Respiratory Issues	
		Thyroid Problems	
		Diabetes	A1c: _____ Last Blood Sugar: _____
		Heart Disease	Pacemaker: Yes <input type="checkbox"/> No <input type="checkbox"/>
		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/VAPE/Marijuana/CBD? Yes No If yes, which one and how often? _____

Do you take Hormone Replacement 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

We are happy to assist you by providing an itemized statement that you may submit to your insurance company for possible reimbursement. As a courtesy, we may also submit claims to most insurance carriers if you provide complete and accurate insurance information, including your policy number insurance address, employer, and any other required details.

Please understand:

- You are responsible for all co-pays, deductible, and any charges not covered by your insurance plan
- We do not participate in extended negotiations or disputes with insurance companies on your behalf

It is your responsibility to verify your insurance coverage prior to receiving services. This includes confirming whether the provider is in-network with your specific plan. Insurance benefits and network requirements vary, and even if provider participated with an insurance company, your individual plan may have different restrictions or preferred providers. We strongly recommend that you contact your insurance company or review your benefits to confirm coverage and network participation using the providers information. If you choose to receive services from an out-of network provider, you may be responsible for some or all of the costs.

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 Fee: There will be a \$50.00 charge for all forms completed by Doctors and/or Staff. 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 disability forms, FMLA, Leave of Absence Forms, work and/or school notes. Please allow at least 72 hours for completion of forms.

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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HIPAA (Health Insurance Portability and Accountability Act):

The HIPAA 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 certain 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 HIPAA 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 of 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