

PATIENT INFORMATION **(PLEASE PRINT)** **(IMPORTANT CONFIDENTIAL INFORMATION)**

~~~PLEASE USE BLACK INK ONLY~~~

(\*NECESSARY FOR BILLING PURPOSES):

SOCIAL SECURITY # \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

PATIENT'S NAME \_\_\_\_\_ M.I. \_\_\_\_\_

IF PATIENT IS A MINOR, PARENT'S OR GUARDIAN'S NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

PATIENT'S D.O.B \_\_\_\_\_ (please circle) M / F MARITAL STATUS \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

(If minor, parent's email address)

HOME ADDRESS \_\_\_\_\_ APT # \_\_\_\_\_

CITY \_\_\_\_\_ ZIP CODE \_\_\_\_\_

HOME PHONE # \_\_\_\_\_ WORK PHONE # \_\_\_\_\_ CELL # \_\_\_\_\_

PATIENT'S EMPLOYER \_\_\_\_\_

1) NAME OF **PRIMARY** INSURANCE \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_ INSURED NAME \_\_\_\_\_

INSURED SOCIAL SECURITY# \_\_\_\_\_ INSURED DATE OF BIRTH \_\_\_\_\_

INSURED'S EMPLOYER \_\_\_\_\_ EMPLOYER'S PHONE \_\_\_\_\_

2) NAME OF **SECONDARY** INSURANCE (IF APPLICABLE) \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_ INSURED NAME \_\_\_\_\_

INSURED SOCIAL SECURITY# \_\_\_\_\_ INSURED DATE OF BIRTH \_\_\_\_\_

INSURED'S EMPLOYER \_\_\_\_\_ EMPLOYER'S PHONE # \_\_\_\_\_

\*\*\*PERSON TO CONTACT IN CASE OF EMERGENCY \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_ PHONE # \_\_\_\_\_

\*\*\*WHOM CAN WE THANK FOR REFERRING YOU TO OUR OFFICE? \_\_\_\_\_

ADDRESS \_\_\_\_\_

FAMILY PHYSICIAN \_\_\_\_\_ PHONE # \_\_\_\_\_ FAX \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_

FORMER PODIATRIST, (IF ANY) \_\_\_\_\_

WHAT PROBLEM(S) BRINGS YOU INTO OUR OFFICE? \_\_\_\_\_

**Race**

- American Indian or Alaska Native
- Asian
- Black or African American
- Multiracial
- Hawaiian or other Pacific Islander
- White
- Some other Race
- Decline

**Ethnicity**

- Cuban
- Hispanic or Latino
- Mexican
- Puerto Rican
- Not Hispanic or Latino
- Decline

**Preferred Language**

- English
- Spanish
- Vietnamese
- Japanese
- Hindi
- Chinese
- Other (Please write in) \_\_\_\_\_

Patient \_\_\_\_\_

Date \_\_\_\_\_

***VITAL SIGNS (to be filled in by office)***

Temperature. \_\_\_\_F.      O2 Sat. \_\_\_\_%

BP Systolic/Diastolic \_\_\_\_/\_\_\_\_      Pulse \_\_\_\_      HBA1c \_\_\_\_      Smoker current/former/never

**Please check YES or NO**

**HISTORY**

**Surgical History**      **YES/NO**

If yes, please list: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergy History**      **YES/NO**

Iodine      \_\_\_\_/\_\_\_\_

Latex      \_\_\_\_/\_\_\_\_

Tape      \_\_\_\_/\_\_\_\_

Other Allergies \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Medical History**      **YES/NO**

Anemia      \_\_\_\_/\_\_\_\_

Cancer      \_\_\_\_/\_\_\_\_

Cardiac Disease      \_\_\_\_/\_\_\_\_

Chronic Renal Disease      \_\_\_\_/\_\_\_\_

Congestive Heart Failure      \_\_\_\_/\_\_\_\_

COPD      \_\_\_\_/\_\_\_\_

Diabetes Mellitus      \_\_\_\_/\_\_\_\_

Hypertension      \_\_\_\_/\_\_\_\_

Kidney Disease      \_\_\_\_/\_\_\_\_

M.I.      \_\_\_\_/\_\_\_\_

Obesity      \_\_\_\_/\_\_\_\_

Osteoarthritis      \_\_\_\_/\_\_\_\_

Osteoporosis      \_\_\_\_/\_\_\_\_

Peripheral Vascular Disease      \_\_\_\_/\_\_\_\_

Polio      \_\_\_\_/\_\_\_\_

Rheumatoid Arthritis      \_\_\_\_/\_\_\_\_

Rheumatic Fever      \_\_\_\_/\_\_\_\_

Stroke      \_\_\_\_/\_\_\_\_

Tuberculosis      \_\_\_\_/\_\_\_\_

Other \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Current Supplements**

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_

**Social History**      **YES/NO**

Alcohol Use      \_\_\_\_/\_\_\_\_

Alcohol Consumption \_\_\_\_\_

Smoker      \_\_\_\_/\_\_\_\_

Smoking (Pack/Day) \_\_\_\_\_

Illicit/IVDA User      \_\_\_\_/\_\_\_\_

Occupation \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**OB/GYN**      **YES/NO**

Pregnant      \_\_\_\_/\_\_\_\_

Pregnancy Planning      \_\_\_\_/\_\_\_\_

Breast Feeding      \_\_\_\_/\_\_\_\_

**Psychiatric History**      **YES/NO**

Anxiety Disorder      \_\_\_\_/\_\_\_\_

Personality Disorder      \_\_\_\_/\_\_\_\_

Psychotic Disorder      \_\_\_\_/\_\_\_\_

**Family History (of any above)**

Father- \_\_\_\_\_

Mother- \_\_\_\_\_

Brother(s)- \_\_\_\_\_

Sister(s)- \_\_\_\_\_

Patient \_\_\_\_\_ D.O.B \_\_\_\_ / \_\_\_\_ / \_\_\_\_ DATE \_\_\_\_\_

**Please circle if you have any of the following symptoms**

**Review of Systems**

**General:** Fevers, chills, recent weight gain or weight loss, fatigue, excessive thirst

**Eyes:** Change of vision, blurred vision, cataracts, eyeglasses

**Ear:** Hearing aid, infections, ringing. **Nose:** Bleeding, discharge, infection. **Mouth:** Bleeding, post nasal drip, dentures, dry mouth. **Throat:** Hoarseness, tenderness, lumps, sore throat.

**Cardiac:** Chest pain, fast heart rate, high blood pressure, heart murmur, palpitations

**Respiratory:** Shortness of breath, persistent coughing, wheezing

**GI:** Upset Stomach, diarrhea, constipation, heart burn, nausea

**Renal System:** Painful urination, increased or decreased frequency, blood in urine

**Skin:** Rashes, lesions, easy bruising, Anemia, dryness, itching

**Neuro:** tremors, burning, tingling in feet or hands, fainting, numbness

**Muscle:** Arthritis, gout, knee pain, muscle stiffness, back problems, paralysis, weakness, (Gait)balance problems, muscle cramps, swelling in feet

**Psychiatric:** Depression, mood swings, sleep disturbance

**Allergies:** Sneezing, watery or itchy eyes, hives

**IF circled yes to any above, please explain:**

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Height \_\_\_ ft. \_\_\_ in.

Weight \_\_\_ lbs.

**Current Medications**

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**Allergies to Medicine**

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**LOCAL PHARMACY INFO.**

**(NOT MAIL ORDER)**

Patient Name: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

Pharmacy Cross Street (if possible): \_\_\_\_\_

Pharmacy City: \_\_\_\_\_

Pharmacy Phone: \_\_\_\_\_

**PATIENT'S INSURANCE AUTHORIZATION**

I hereby authorize the processing the medical insurance either by electronic or manual method by the listed provider (#7 below). My signature (#2 below) authorizes payment of all major medical and/or surgical benefits to which I am entitled from the listed insurer (#4 below) to pay to the listed provider assignee (#7 below). I further authorize assignee to release all medical and/or insurance claim information necessary to secure the payment(s). I recognize my financial obligation of any co-insurance or deductible, and non-covered services that may be required. This agreement will remain in effect until revoked by me in writing. A photocopy of this document is to be considered as valid as an original.

1. PATIENTS NAME (PLEASE PRINT)

\_\_\_\_\_

2. PATIENT / PARENT OR GUARDIAN'S SIGNATURE

\_\_\_\_\_

3. DATE \_\_\_\_\_

4. INSURANCE COMPANY NAME

\_\_\_\_\_

5. PATIENTS I.D NUMBER

\_\_\_\_\_

6. PATIENTS GROUP/ POLICY NUMBER

\_\_\_\_\_

7. VICTORIA M. FOLEY, D.P.M.  
CONSTANCE J. ORNELAS

3747 Worsham Ave. #201  
Long Beach, Ca 90808

# PAYMENT POLICY FOR DR. VICTORIA FOLEY AND DR. CONSTANCE ORNELAS

## Payment Policy 2023

Thank you for choosing Dr. Victoria Foley and Dr. Constance Ornelas as your foot care provider. Please read the following office payment policy. Once you accept this policy, kindly sign in the space provided. A copy will be provided to you upon request.

\_\_\_ **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. **If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility.** Please contact your insurance company with any questions you may have regarding your coverage.

\_\_\_ **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. **If you have not met your deductible, we will collect a deposit to apply towards your deductible and co-insurance. Any remaining balance after submission to your insurance company is your responsibility.**

\_\_\_ **Non-covered services.** Please be aware that some - and perhaps all - of the services you receive may not be covered or not considered reasonable or medically necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

\_\_\_ **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

\_\_\_ **Claims submission.** We will submit your claims and assist you in 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.

\_\_\_ **Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.**

\_\_\_ **Nonpayment.** Invoices are sent out every 30 days. Your prompt payment will assist us in keeping the cost of healthcare down. If your account is over 60 days past due, you will receive a letter requesting immediate payment. Partial payments will not be accepted unless otherwise approved by Dr. Foley or Dr. Ornelas. Please be aware that if a balance remains unpaid, we may refer your account to small claims court and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative podiatric care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

\_\_\_ **Missed appointments.** It is our policy to charge \$35.00 for missed appointments not canceled within 1 day of scheduled appointment. These charges will be your responsibility and billed directly to you. Please help us to serve our patients better by keeping your regularly scheduled appointment.

\_\_\_ **Forms and Documents.** It is our policy to charge \$25.00 for completion of all forms, such as disability applications, FMLA, etc.

\_\_\_ **Surgery Cancellation:** Failure to provide **5 business days** notice of cancellation prior to scheduled surgery date will incur a **\$500** fee.

**Fees.** Our fees are representative of the usual and customary charges for our area.

The open payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at <http://openpaymentsdata.cms.gov>.

I have read and understand the payment policy and agree to abide by its guidelines:

X \_\_\_\_\_

Signature of patient or responsible party

\_\_\_\_\_ Date

Print Patient Name: \_\_\_\_\_

# PATIENT RECORD OF DISCLOSURES

In general, the *HIPAA* privacy rule gives individuals the right to request restriction on uses and disclosures of their protected health information (*PHI*). The individual is also provided the right to request confidential communications or that the communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner:  
**(PLEASE CHECK ALL THAT APPLY)**

Home # \_\_\_\_\_

- O.k. to leave message with detailed information
- Leave message with call-back number only

Cell # \_\_\_\_\_

- O.k. to leave message with detailed information
- Leave message with call-back number only
- O.k. to text message (SMS) for appointment reminders and messages with staff.

Work # \_\_\_\_\_

- O.k. to leave message with detailed information
- Leave message with call-back number only

Written Communication

- O.k. to mail to my home address
- O.k. to mail to my work/office address

\_\_\_\_\_  
Please print address

\_\_\_\_\_  
Print patients name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient / Guardian Signature

\_\_\_\_\_  
Date



## NOTICE OF PRIVACY PRACTICES (FOR PATIENT TO KEEP)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. “HIPAA” provides penalties for covered entities that misuse that personal health information.

As required by “HIPAA”, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical record only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example of this would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a request to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request

## PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my of request restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name (PLEASE PRINT): \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_

## MEDICAL RECORDS RELEASE

DATE: \_\_\_\_\_

TO: \_\_\_\_\_  
NAME & PHONE # OF DOCTOR OR MEDICAL FACILITY

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
CITY, STATE, ZIP CODE

**I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE MY MEDICAL RECORDS TO:**

Victoria M. Foley, DPM  
Constance J. Ornelas, DPM  
3747 Worsham Ave #201  
Long Beach Ca 90808  
562-420-9800  
562-420-9884 Fax

THE COMPLETE MEDICAL RECORDS IN YOUR POSSESSION, CONCERNING MY ILLNESS AND/OR  
TREATMENT DURING THE PERIOD FROM:

\_\_\_\_\_ TO \_\_\_\_\_.

PATIENTS SIGNATURE: \_\_\_\_\_

PRINT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

SOCIAL SECURITY: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_