

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

- 3840 WOODRUFF AVE SUITE 211 LONG BEACH CA 90808
- 3771 KATELLA AVE SUITE 110 LOS ALAMITOS CA 90720

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? \_\_\_\_\_

**IF YOU HAVE A LIST OF MEDICATIONS, PLEASE GIVE LIST TO RECEPTIONIST TO TAKE A COPY  
OR WRITE MEDICATION(S) ON BACK OF THIS PAGE.**

Patient \_\_\_\_\_

Date \_\_\_\_\_

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

Height \_\_\_\_ ft. \_\_\_\_ in.      Weight \_\_\_\_ lbs.      Temperature. \_\_\_\_ F.      O2 Sat. \_\_\_\_%

BP Systolic/Diastolic \_\_\_\_/\_\_\_\_      Respiratory Rate \_\_\_\_      Pulse \_\_\_\_

**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 check **YES or No** if you have a problem with any of the following:

**Review of Systems**

**YES/NO**

|                                                     |             |
|-----------------------------------------------------|-------------|
| Fevers, chills or recent weight gain or loss        | ____ / ____ |
| Vision change                                       | ____ / ____ |
| Ear, nose, mouth or throat                          | ____ / ____ |
| Chest pain, fast heart rate                         | ____ / ____ |
| Shortness of breath, persistent coughing            | ____ / ____ |
| Stomach upset, diarrhea, constipation               | ____ / ____ |
| Painful urination, increased or decreased frequency | ____ / ____ |
| Skin rashes, lesions, or easy bruising              | ____ / ____ |
| Pin and needle sensation in hands or feet, tremors  | ____ / ____ |
| Depression, mood swings, sleep disturbance          | ____ / ____ |
| Swollen hands and feet, blood in urine or stool     | ____ / ____ |
| Frequent sneezing, watery eyes                      | ____ / ____ |

If **YES** to any of the above, please explain:

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**EXERCISE PROGRAM:**      **YES/NO**

Elliptical                      \_\_\_\_ / \_\_\_\_  
Running                        \_\_\_\_ / \_\_\_\_  
Stationary Bike                \_\_\_\_ / \_\_\_\_  
Swimming                      \_\_\_\_ / \_\_\_\_  
Treadmill                      \_\_\_\_ / \_\_\_\_  
Walking                        \_\_\_\_ / \_\_\_\_  
Other \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**AGE OF SHOES:** \_\_\_\_\_

**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 ORNELAS, D.P.M.

3840 Woodruff Ave. #211  
Long Beach, Ca 90808

3771 Katella Ave. #110  
Los Alamitos, Ca 90720

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

### Payment Policy

Thank you for choosing Dr. Victoria Foley and Dr. Constance Ornelas as your foot care providers. We are committed to providing you with quality and affordable health care. Please read the following office payment policy and feel free to ask us any questions that you may have. Once you accept this policy, kindly sign in the space provided. A copy will be provided to you upon request.

- 1. 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.
- 2. 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. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
- 3. Non-covered services.** Please be aware that some - and perhaps all - of the services you receive may be uncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
- 4. 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.
- 5. 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.
- 6. 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.
- 7. 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. 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.
- 8. Missed appointments.** Our policy is to charge \$25.00 for missed appointments not canceled within a 1 day of scheduled appointment. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.
- 9. Forms and Documents.** It is our policy to charge \$5.00 for completion of all forms, such as disability applications, etc.
- 10. Fees.** Our fees are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

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

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Signature of patient or responsible party

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Date

# PATIENT RECORD OF DISCLOSURES

In general, the *HIPPA* 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

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

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

Other \_\_\_\_\_

- 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 (“HIPPA”) 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. “HIPPA” provides penalties for covered entities that misuse that personal health information.

As required by ”HIPPA”, 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 the, 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 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 OF DOCTOR OR MEDICAL FACILITY & PHONE #

\_\_\_\_\_  
ADDRESS

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

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

Victoria M. Foley, D.P.M  
Constance Ornelas, D.P.M  
3840 Woodruff Ave #211  
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: \_\_\_\_\_