VICTORIA M. FOLEY, DPM
CONSTANCE J. ORNELAS, DPM

❑ 3747 Worsham Ave Suite 201 Long Beach CA 90808
562-420-9800

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

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Please check YES or NO

HISTORY

Surgical History **YES/NO**
If yes, please list: _____
_____
_____
_____
_____

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_____
_____
_____

Allergy History **YES/NO**
Iodine ____/____
Latex ____/____
Tape ____/____
Other Allergies _____
_____
_____

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:

_____

_____

_____

_____

_____

Height ___ ft. ___ in. Weight___lbs.

Current Medications

_____

_____

_____

_____

_____

Allergies to Medicine

_____

_____

_____

_____

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 2025

Thank you for choosing Dr. Victoria Foley and Dr. Constance Ornelas as your foot and ankle care providers. Please read the following office payment policy, initial each section and sign at the bottom stating that you agree to the terms. A copy will be provided to you upon request.

Please initial each line indicating your understanding of our policies:

____**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 coverage.

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

____**Non-covered/Cash pay products and services:** Please be aware that some and perhaps all of the services you receive may not be covered or considered not reasonable or medically necessary by Medicare and 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 prior to seeing a doctor. We must obtain a copy of your driver's license (or alternative current photo ID) and current valid insurance card to provide proof of coverage. If you fail to provide us with 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 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. Insurance benefits are detailed in the 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.

____**Non-payment:** 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 a doctor. 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 the 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 physicians will only be able to provide you with emergency care.

____**Missed appointments:** It is our policy to charge $40 for missed appointments and those cancelled less than 24 hours prior to scheduled time. These charges will be your responsibility and billed to you directly. Please help us to serve our patients better by keeping your scheduled appointment.

____**Forms and Documents:** It is our policy to charge $25 for completion of all forms such as disability applications, DMV, 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.

_____ _____

Signature of patient or responsible party Date

Print 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.

SMS Terms of Service

By opting into SMS, you are agreeing to receive SMS messages from Superior Foot and Ankle Care Center. This includes SMS messages for appointment scheduling, appointment reminders, post-visit instructions, lab notifications, and billing notifications. Message frequency varies. Message and data rates may apply. See privacy policy at www.doctorvikki.com.

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: _____