

# Advanced Foot And Ankle Center of San Diego

## REGISTRATION FORM

(Please print clearly)

Preferred Communication \_\_\_ E-mail \_\_\_ Home \_\_\_ Cell \_\_\_ Work

Today's Date     /     /

PLEASE FILL IN DATE

### PATIENT INFORMATION

Patient's Last Name		First	Middle	
Street Address		City	State	Zip Code
Home Phone # ( ) - ( ) - ( )	Work Phone # ( ) - ( ) - ( )	Cell Phone # ( ) - ( ) - ( )	Email Address:	
Date of Birth / /	Age	Social Security # / /	Marital Status Single Married Widow Divorced	Gender M F

### INSURANCE INFORMATION

Occupation	Insured's Employer
Insured's Employer's Address	

#### Primary insurance:

Insured's Name	Insured's S. S. #	Insured's ID	Date of Birth
Patient's Relationship to Insured    Self    Spouse    Child    Other:			

#### Secondary insurance:

Insured's Name	Insured's S. S. #	Insured's ID	Date of Birth
Relationship to Insured    Self    Spouse    Child    Other:			

### FAMILY PHYSICIAN INFORMATION

Medical Doctor's Name	Medical Doctor's Phone Number ( ) - ( ) - ( )		
Medical Doctor's Street Address	City	State	Zip Code

### WHO REFERRED YOU TO OUR PRACTICE?

Circle:  
 Physician    Friend    Hospital    Insurance Company    Internet;  
 Please indicate which person, organization or which website so can credit referral: \_\_\_\_\_

### E- PRESCRIPTION PHARMACY INFORMATION

Pharmacy Name	Pharmacy Phone Number ( ) - ( ) - ( )		
Pharmacy Address	City	State	Zip Code

# Advanced Foot And Ankle Center of San Diego

## MEDICAL HISTORY

PATIENT NAME		BIRTH DATE		/ /	
ALLERGIES <i>(LIST KNOWN ALLERGIES TO DRUGS/MEDICATIONS - AND SPECIFIC REACTIONS TO THEM)</i>					
If any allergies, what type of reaction? Difficulty breathing Rash					
MEDICATIONS <i>(CURRENT MEDICATIONS YOU ARE TAKING: PRESCRIPTION AND OVER THE COUNTER)</i>					
MEDICATION	DOSE		MEDICATION	DOSE	
INDICATE WHICH OF THE FOLLOWING YOU HAVE HAD OR HAVE AT PRESENT					
Arthritis/Rheumatism	Yes	No	High Blood Pressure	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	High Cholesterol	Yes	No
Asthma	Yes	No	H.I.V. Positive	Yes	No
Cancer	Yes	No	Kidney Trouble	Yes	No
Diabetes	Yes	No	Liver Disease	Yes	No
Diabetic Foot Ulcers	Yes	No	Neurological Disorder	Yes	No
Fibromyalgia	Yes	No	Psychiatric/Psychological Care	Yes	No
Bleeding Disorders	Yes	No	Stomach Ulcers / Reflux / Heartburn	Yes	No
Heart Disease or Attack	Yes	No	Other:		
Heart Murmur	Yes	No	Other:		
Hepatitis (Indicate) A B C	Yes	No	Other:		
Previous Surgery					
Orthopedic/Podiatric	Yes	No	Circulation (Bypass, Angioplasty)	Yes	No
Heart	Yes	No	Aneurysm	Yes	No
Tumor	Yes	No	Head and Neck	Yes	No
Abdominal	Yes	No	Other:		
Have you ever been put to sleep for surgery? Yes No			Any problems with anesthesia? Yes No		
Do you drink?		Yes No If Yes, Drinks per week			
Do you smoke?		Yes No If Yes, Pack(s)/day			
Are you pregnant?		Yes No			
FAMILY HISTORY					
Relative	Alive	Deceased	Age Deceased	Cause of Death (Heart Problems, Cancer, Diabetes, Etc.)	
Father					
Mother					

*Advanced Foot and Ankle Center of San Diego*  
*Philip Wrotslavsky, DPM, AACFAS*  
**FINANCIAL POLICY AND PATIENT AGREEMENT**

**MEDICARE /PPO:** We have enrolled in numerous insurance PPO programs, as well as Medicare. Due to the constant changes in healthcare today, it is difficult for us to monitor all the individual insurance companies we have contracts with, as well as the individual requirements of the plans. Each plan has different stipulations regarding our services, what, where, and how often those services may be performed. Even within the same insurance company, the plans differ depending upon what type of contract you or your employer has negotiated.

Our office has agreed to bill your insurance company for payment of your office visit/s. You, the patient, are responsible for all co-payment, coinsurance and deductibles specified by the insurance company. They are to be paid at the time of service. We will take the minimum that is generally allowed as a payment toward your deductible or coinsurance. If your insurance company allows additional payment or if you have additional procedures/services performed we will automatically charge your credit card for any balance due that is indicated on your explanation of benefits. You are also responsible for any services that your insurance does not cover, or for any balance due if we are out of network. Our office is not currently enrolled in any HMO plans. All HMO patients will be considered as cash patients and will be required to pay for the visit in full at the time of service

***We will attempt to obtain authorization for certain services, but please understand that, you, the patient are responsible for understanding your own insurance plan and for checking if we are in-network with your insurance plan. If you booked an appointment and there is a balance owed, your credit card on file will be charged for the balance due.***

**PAYMENT OPTIONS:** If you need assistance with insurance or referral problems, or wish to discuss your account and/or set up financial arrangement contact our billing department. (888) 451-3770. We accept cash, checks, or credit cards (Visa, MasterCard) as payment. We will take a credit card on file for any payments due. Once you sign this form please be aware that we will charge your credit card for any balance due only as stated on your explanation of benefits without further notice. You will receive a receipt for these charges. There will be a \$25.00 service charge on any returned checks.

I understand and agree that there will be a charge on my credit card for services rendered by the Advanced Foot and Ankle Center after my insurance company sends an explanation of benefits indicating the balance owed: If the amount is over \$500 I will receive a courtesy call to discuss payment plan options.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**COPIES OF RECORDS:** If you are in need of copies of your records, complete a release form, allowing enough time so that the records can be done. **Fees for copying records are \$25.00.**

**DISABILITY FORMS (ANY FORMS):** There is a **\$10.00 charge for completion of forms.** If you need a letter to be written by a physician, please allow 5-7 working days for completion.

**PRESCRIPTIONS:** Please give our office at least 24 hours' notice if you need a refill on your prescription during the workweek. Please call by noon on Friday for refills needed during the weekend. *No Refills After Hours.*

I am aware that the physician may take photographs or videos of my feet/toes/lower extremities. Once, I allow the physician to take photo's or video's in the office, I am aware that they may be utilized in brochures, publications, medical conferences or on the physicians website etc. No names or personal information of any kind will be attached for confidentiality purposes.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Philip Wrotslavsky, DPM, A Professional Corporation**

**ASSIGNMENT OF BENEFITS:** I hereby authorize and direct my insurance carrier to pay directly to this provider of medical services and benefit due me under my insurance plan. I agree to pay the balance of expenses not paid under this plan. I also hereby authorize this provider to use and disclose any of my personal medical information for treatment and payment (including to my insurance company).

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

**AUTHORIZATION FOR RELEASE OF INFORMATION:** I hereby authorize Philip Wrotslavsky, DPM, APC to use and disclose any of my personal, health, treatment, and payment information for health care operations purposes. This includes any and all information requested by the insurance companies which are necessary to collect benefits under these policies which are in effect at the time of treatment or any policies which I subsequently make claim against for hospital services, including related physician's services on this date of service or related date of service. Unless noted below, this authorization includes but is not limited to the release of information related to drug, alcohol, HIV antibody and/or psychiatric treatment and/or testing. I further authorize any physician or institution that attended to this patient previously to furnish medical records to Dr. Wrotslavsky and authorize the release of information which may be requested by Philip Wrotslavsky, DPM A Professional Corporation from any provider related to my medical care and medical billing.

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

**CONSENT FOR MEDICAL AND SURGICAL TREATMENT:** I authorize Philip Wrotslavsky, DPM, APC to furnish the necessary medical or surgical treatment, or procedures, including diagnostic x-ray and laboratory procedures, anesthesia, drugs and supplies as may be ordered by the attending physician(s), his assistants or designees. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of the treatment. I recognize that Dr. Philip Wrotslavsky is an independent physician at 15525 Pomerado Road Suite E-6 San Diego, California 92064. I understand this and have accepted this without any reservation.

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

**IF PATIENT IS UNDER 18:**

I hereby give my permission for \_\_\_\_\_ to be treated at the Philip Wrotslavsky, DPM, A Professional Corporation.

Guardian Name: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Witness: \_\_\_\_\_ Date: \_\_\_\_\_

*The appropriate authorizations must be signed in order to expedite the filing of your insurance claim.*

# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Philip Wrotslavsky, DPM, A Professional Corporation  
15525 Pomerado Road, Suite E-6  
Poway, CA 92064

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 received, read and understand 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 at the address above to obtain a current copy of the *Notice of Private 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 requested restrictions, but if you do agree then you are bound to abide by such restrictions.

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

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

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

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

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## OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Reason: \_\_\_\_\_

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## NOTICE OF PRIVACY PRACTICES (MEDICAL)

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 records 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 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 records 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 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 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 requests 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.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 1, 2008 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA  
or to file a complaint:

The U.S. Department of Health & Human Services  
Office of Civil Rights  
200 Independence Avenue, S.W.  
Washington, D.C. 20201  
(202) 619-0257  
Toll Free: 1-877-696-6775

\* Worker's Compensation

You have signed a waiver starting your worker compensation claim. You have waived your rights in viewing the chart. Contact your Attorney or Insurance adjuster for any copy of records.

WORKERS' COMPENSATION HISTORY

NAME: \_\_\_\_\_ EXAM DATE: \_\_\_\_\_

AGE: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_ DOMINANT HAND: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

MARITAL STATUS:  Married  Single  Divorced  Separated  Widowed

Number of Children: \_\_\_\_\_

Level of Education: \_\_\_\_\_

Hobbies: \_\_\_\_\_

CHIEF COMPLAINTS

Part(s) of body injured: \_\_\_\_\_

HISTORY OF INJURY

Exact date of injury: \_\_\_\_\_

Employer's Name: \_\_\_\_\_

Describe how you hurt yourself (when, where, how, anyone else involved?)

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

Did you report your injury to your employer? If so, when and to whom?

\_\_\_\_\_

Did your employer refer you for treatment? If so, where and by whom?

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

Please list names of all physicians/chiropractors you have seen for this injury, specifying type of doctor, dates of treatment and location.

<u>Name of Doctor</u>	<u>Dates of Treatment</u>	<u>Who referred you</u>

List any x-rays, special tests, surgeries, hospitalizations for this injury (MRI, EMG, CT, etc.)

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Have you had any other work related injuries? If so, please give dates of injury, employer at time of injury, and body parts injured:

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Was there a settlement made? \_\_\_\_\_

Have you ever had an injury or sought treatment for the body part(s) involved in this claim? If so, please give description of injury and type of treatment received. This would include sports injuries, auto accidents, etc.

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Have you had any new injuries or re-injuries?

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# PRESENT COMPLAINTS:

Where is your pain?

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Please rate your pain level today:

Least 0 (No pain) ----- 10 Worst (severe)

Overall, has your condition  Improved  Worsened  Stayed the same

How much of the time during the day are you in pain?

- Less than 1 hour per day
- Between 1 and 4 hours per day
- Between 4 and 8 hours per day
- Almost any time that I am not lying down
- Almost 24 hours per day

Mark with an X the worst and best times of day for your pain:

WORSE

- On awakening
- Morning
- Mid-day
- Afternoon
- Evening
- Lying in bed

BEST

- On awakening
- Morning
- Mid-day
- Afternoon
- Evening
- Lying in bed

List specific activities which increase your pain:

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Describe specific methods or activities which relieve your pain:

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Please describe what activities of daily living as well as recreational activities you no longer can participate in because of your pain:

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FOR NECK/BACK PAIN ONLY:

Do you have any change in bowel or bladder function since the onset of neck or back pain?

Yes  No

Do you have any pain going into your arms?

Yes  No

Do you have any pain going into your legs?

Yes  No

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In your job you are required to lift:

	<u>Never</u>	<u>Occasionally</u>	<u>Frequently</u>	<u>Constantly</u>
Up to 10 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 to 20 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21 to 50 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51 to 100 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Over 100 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Are you required to use your hands for repetitive motions such as:

	<u>Yes</u>	<u>No</u>
Fine manipulation:	<input type="checkbox"/>	<input type="checkbox"/>
Simple grasping:	<input type="checkbox"/>	<input type="checkbox"/>
Pushing/pulling:	<input type="checkbox"/>	<input type="checkbox"/>

Are you required to use your feet for repetitive use:  yes  no

Are you required to do the following:

	<u>Never</u>	<u>Occasionally</u>	<u>Frequently</u>	<u>Constantly</u>
Bending:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squatting:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawling:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking on uneven ground	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching above shoulder level:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching at shoulder level:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**HEALTHCARE LIEN**

Philip Wrotslavsky, DPM, A Professional Corporation  
15525 Pomerado Road, Suite E-6, Poway, Ca. 92064

Patient Name: \_\_\_\_\_  
Patient SSN: \_\_\_\_\_ Patient DOB: \_\_\_\_\_  
Date of Injury: \_\_\_\_\_

Patient authorizes Provider(s) to furnish his/her Attorney and insurance carrier with a full report of examination, diagnosis, course of treatment, prognosis, and any other relevant information concerning his/her care and treatment for the aforementioned injury. Patient further authorizes his/her attorney and insurance company to furnish Provider(s) with information concerning the merits, viability and status of Patient's injury claim.

Patient hereby gives this Lien to Provider against all proceeds (whether by settlement, judgment or award, including all Med-Pay advances), derived from Patient's injury claim to secure payment of all fees owed Provider(s) by Patient for treatment furnished Patient for the aforementioned injury. This Lien, regardless of when executed, shall apply retroactively to all care and treatment furnished Patient by Provider(s) arising out of aforementioned injury.

Patient understands and agrees that this Lien attaches against all proceeds derived from Patient's injury claim as soon as the proceeds are received by either Patient or his/her Attorney. Patient authorizes and directs his/her Attorney and insurance carrier to withhold from any settlement, judgment or award all funds necessary to fully and completely satisfy this Lien. Patient further authorizes and directs his/her Attorney to honor this Lien and make full payment thereon as soon as possible and prior to and in advance of distributing any of the proceeds derived from Patient's injury claim to Attorney or Patient. It is understood and agreed that payment shall be tendered without regard to setoff, unresolved claims against other third parties, or apportionment or pro-rata distributions to other healthcare providers.

Patient and Attorney understand that this Lien is offered for the protection of Provider and in consideration for Provider agreeing to await payment for services rendered to Patient. Patient understands and agrees that payment of Provider's fees is not contingent on Patient's receipt of a favorable settlement, judgment or award and that he/she remains directly and fully responsible to Provider for all services rendered him/her. Patient agrees that if no suit on the injury claim is filed by Attorney within the statutory period provided therefore, that all Provider's fees shall become due and payable immediately upon expiration of the statutory period.

Attorney and Patient hereby agree to immediately notify Provider(s) in the event Patient retains new or different legal counsel. Patient directs his/her new counsel to execute a new copy of this Lien and otherwise honor the terms hereof.

Attorney agrees that his/her status as trustee for those funds recovered on Patient's behalf will change from trustee to debtor if Attorney: (1) does not directly and fully and completely pay Provider for services furnished Patient that is subject to this Lien (absent a written agreement signed by Provider accepting a compromised amount in lieu of full payment); (2) release/forwards the funds from Patient's settlement, judgment or award from his/her trust account prior to satisfaction of this Lien; or (3) refuses to withhold that amount owed Provider from the funds obtained on Patient's behalf by way of settlement, judgment or award.

Patient, Attorney and Provider agree that if enforcement of this Lien, or any portion thereof, is required, all disputes for less than \$5,000. will be submitted to Small Claims Court for resolution while all disputes in an amount in excess thereof will be submitted to binding arbitration with any award therefrom confirmed by a court of competent jurisdiction. Patient, Attorney and Provider further agree that if enforcement of this Lien, or any portion thereof, is required, that the prevailing party shall be entitled to recover attorney's fees, arbitration fees and costs, jointly and severally, from the non-prevailing part(ies).

I/we have read and fully understand this Lien and agree to be bound by its terms.

Dated: \_\_\_\_\_

\_\_\_\_\_  
(Patient Signature)

Dated: \_\_\_\_\_

\_\_\_\_\_  
(Attorney Name)

\_\_\_\_\_  
(Attorney Signature)

**WORK STATUS:**

Are you currently working? \_\_\_\_\_ Same employer or different (circle)

Have you missed time from work due to this injury? \_\_\_\_\_

If so, what was your first day missed? \_\_\_\_\_

Date returned to work \_\_\_\_\_

Is modified work available? \_\_\_\_\_

When was the last day worked full duty? \_\_\_\_\_ modified duty? \_\_\_\_\_

Are you currently involved in vocational rehabilitation? If so, where and by whom? \_\_\_\_\_

**JOB DESCRIPTION:**

Employer: \_\_\_\_\_

Exact Job Title: \_\_\_\_\_

Date of Hire: \_\_\_\_\_

Work Hours: \_\_\_\_\_

Days per Week: \_\_\_\_\_

Did you have any work restrictions when you were hired: \_\_\_\_\_

General Job Description:  
\_\_\_\_\_  
\_\_\_\_\_

In an 8-Hour work day you are required to: (circle number of hours for each activity)

Sitting:     1     2     3     4     5     6     7     8

Standing:   1     2     3     4     5     6     7     8

Walking:    1     2     3     4     5     6     7     8