NorthBay
Foot and **Ankle** Medical

*Diplomates, American Board of Podiatric Surgery
Certified in Foot and Ankle Surgery

*ROBERT Y. CHOY, DPM

JENNIFER K. FONG, DPM

FAIRFIELD
1620 Pennsylvania Avenue Suite A Fairfield, CA 94533
Phone 707 426-5644 Fax 707 426-3156

VACAVILLE
2601 Nut Tree Road Suite B Vacaville, CA 95687
Phone 707 448-6718 Fax 707 426-3156

Welcome to our office

Personal Information

Today's Date _____

Family Physician _____ Date of last visit _____

Whom may we thank for referring you to our office? _____

Patient Name _____ Responsible party _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Age _____ Birthday _____ Sex ☐ Male ☐ Female

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer Name _____ SSN or CDL _____

Employer Address _____

Insurance Information

Subscriber Name _____ Date of Birth _____

#1 Insurance Coverage – Company Name _____

Insurance Address _____

I.D. Number _____ Group _____ Co-pay _____

Patients relationship to insured _____

#2 Insurance Coverage – Company Name _____

Insurance Address _____

I.D. Number _____ Group _____ Co-pay _____

Patients relationship to insured _____

Please note: Payment for services is required at the time of services unless other arrangements are made with this office. Please be advised that insurance companies are responsible to you, the insured, and not the doctor. Although we make every effort to facilitate your insurance billing, the **patient** is responsible for the charges incurred.

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HEALTH QUESTIONNAIRE

Name _____ Date _____

Reason for seeing the doctor today? _____

How long has this problem bothered you? _____

When was your last physical exam? _____

Has your doctor ever told you that you have any of the following?

Diabetes	☐ Yes	☐ No	If yes for how long? _____				
Hepatitis	☐ Yes	☐ No	Kidney or Liver disease	☐ Yes	☐ No		
Thyroid disorder	☐ Yes	☐ No	Heart trouble or recent chest pain	☐ Yes	☐ No		
Excessive bleeding, bruising	☐ Yes	☐ No	Rheumatic or scarlet fever	☐ Yes	☐ No		
Stomach or intestinal ulcers	☐ Yes	☐ No	Psychiatric and/or nervous disorders	☐ Yes	☐ No		
High Blood Pressure	☐ Yes	☐ No	AIDS/HIV	☐ Yes	☐ No		
Problems with blood circulation, blood clots, varicose veins				☐ Yes	☐ No		
Breathing problems (asthma, emphysema, tuberculosis, shortness of breath, etc)				☐ Yes	☐ No		

Do you have any other major medical conditions?

Have you ever had any serious infections? (Please describe)

Have you had any operations or been in the hospital? (Please list dates and reasons)

Have you had any traumatic injuries or broken bones? (Please list dates and injuries)

Are you taking any medication now? (Please list)

Are you allergic to any of the following?

☐ Adhesive Tapes	☐ Penicillin	☐ Codeine	☐ Iodine
☐ Local Anesthetics	☐ Antibiotics	☐ Pain Medication	☐ Sulfa Medications
☐ Other (please list)			

Do you smoke? ☐ Yes ☐ No If yes how much? _____

Do you drink? ☐ Yes ☐ No If yes how much? _____

Are you parents alive ☐ Yes ☐ No

Please list any medical conditions or diseases they have:

Have you had any complications from childhood diseases? (Please describe)

Are there any other conditions the doctor should know about? (Please describe)

The above information is correct and true to the best of my knowledge

Patient Signature _____

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AUTHORIZATION TO ASSIGN INSURANCE BENEFITS

"This authorizes: _____
(Insurance Company)

To pay direct to:

Jennifer K. Fong, DPM
Robert Choy, DPM
of
NorthBay Podiatric Medical Group Inc.

benefits due me out of indemnity under the terms of my policy issued by your company. Patient is authorized upon your receipt of an itemized statement for services rendered me. This policy was in full force and effect at the time that these services were rendered. Payment of this amount as herein directed, in whole or part, shall be considered the same as if paid by your company to me.

A photocopy of this is to be considered as valid as the original. It is understood that any money received from the above named Insurance Company, over and above my indebtness will be refunded to me when the bill is paid in full. I understand I am financially responsible to the said Doctor for charges not covered by this assignment.

Patient (Printed Name): _____

Signature of Patient: _____ Date: _____
Financially Responsible Party

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OUR FINANCIAL POLICY

Thank you for choosing us as your podiatric health care provider. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of Our Financial Policy which we require you to read and sign prior to any treatment.

Financial arrangements can be made in one of the following two ways:

CASH

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. We accept cash, check, MasterCard, Visa and Debit Cards.

INSURANCE

As a courtesy to you, we will bill your insurance company for services rendered. 90 days are allowed for processing by the insurance company, any unpaid balance or unpaid claims are your financial responsibility. For regular office visits and treatments, we require payment of your co-payment and/or any unpaid deductibles at the time services are rendered.
If you become delinquent, your account(s) are subject to collection procedures,

SUPPLIES

All patients are financially responsible for dispensed supplies/

Patient (Printed Name): _____

Signature of Patient: _____ Date: _____

Financially Responsible Party

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND RULE

1. I hereby acknowledge that I received a copy of this medical practice's NOTICE OF FEDERAL HEALTHCARE PRIVACY RULES. I further acknowledge that a copy of current notice will be posted in the reception area, and I may be offered a copy of any amended Notice of Privacy Rules at each appointment.

2. I herby authorize NorthBay Foot and Ankle Medical Group (Robert Y. Choy, DPM and Jennifer K. Fong, DPM) and or staff to identify themselves from the doctor's office when calling to leave messages regarding my appointments, results or other medical information on any answering device or with another person answering the phone. This authorization will remain in effect as long as I remain a patient of this medical practice.

3. I acknowledge that there is a **$25.00 office fee** for **a no show of any scheduled appointments.** If you call to cancel you appointment at least 24 hours before the scheduled appointment no fee will be charged.

Print Name: _____ Phone: _____

Signed : _____ Date: _____

If not signed by the patient, please indicate:

☐ Parent or Guardian of a minor patient
☐ Guardian or Conservator of an incompetent patient

Name of Patient: _____

Witness: _____

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FEDERAL HEALTH PRIVACY RULE

PRIVACY RULE

The Federal Government has developed regulations in an attempt to ensure the health care privacy of patients. This means that we cannot use or disclose health information for the purposes of treatment, payment or health care operations without your written consent. As part of these regulations, we are required to inform you how this office utilizes, shares and protects the health care information we collect.

WHAT INFORMATION WE SHARE

In the course of treating you, the information gathered regarding your health may be shared with a hospital that will be the setting for your health care, with a medical laboratory that will performing a test on you, with medical supply company that will be providing you with a medical apparatus, with another medical facility that may be performing some form of therapy on you at your request, and with medical students and/or residents who function within our practice. For example, when our office submits the necessary forms to a hospital for a proposed surgery, any medical information that the doctor believes to be relevant to your health care will be included. This information may be seen by various doctors, nurses and support staff in the course of their normal duties.

PROTECTING YOUR HEALTH CARE INFORMATION

Our policies to protect your personal health care information are:

1. Office personnel have been instructed not to discuss any information that is gathered on patients outside the office setting.
2. A meeting is held periodically to review our protection policies and re-educate our personnel as to the importance of patient privacy.
3. All medical records are accounted for at the close of the business day and are secured.
4. No medical records are allowed to be taken from our office, unless accompanied by the treating doctor.
5. No medical records will be sent to another doctor or health care facility without the written approval of the patient.
6. Only the medical information that is necessary will be shared with another health care facility or laboratory in order that they can perform their task.
7. All medical information obtained that is no longer usable, will be shredded prior to being disposed of.

YOUR RIGHTS UNDER THE FEDERAL HEALTH POLICY RULE

1. You may revoke this consent at any time.
2. You may access to your medical records. This must be done in writing and the office must allow you access within 5 working days following receipt of your request. If you request a copy of your records, the office must furnish this to you within 15 days of receiving your request. The office may charge 25 cents per page as well the labor costs associated with the copying the documents and postage.
3. You may request an amendment to your medical record by yourself in a situation where you believe your medical record is incorrect or incomplete. The office must allow this to occur within 60 days after receiving such a request.

COMPLAINTS

If you believe that your right to privacy has been compromised, you may contact our office manager, who will make every attempt to correct the problem, or you may go online at http://www.hhs.gov/ocr/hipaa to learn more about the privacy rule and making a complaint.