Redondo Beach Podiatry Group

2850 Artesia Blvd. Suite #204, Redondo Beach, CA 90278
3440 Lomita Blvd. Suite #137, Torrance, CA 90505

(310) 793-1158 - Ofc (310) 793-1161- Fax

www.RBPodiatry.com

Podiatry Offices of
Phillip Darragh, DPM
Robert Anavian, DPM
Jonathan J. Pirak, DPM

To Our New Patient:

Welcome to Redondo Beach Podiatry Group! We are thrilled that you have chosen our team for your foot and ankle needs. We will do our best to provide you with the most up-to-date and comprehensive podiatric care available. We have a total commitment to keeping your feet healthy – and keeping you happy.

To maximize your time with us, we ask that you bring the following to your first visit: photo identification, medical insurance card(s), written referral (if required by your insurance company), and prior medical records and x-rays (if applicable).

In addition, please complete and sign the New Patient Forms included with this letter. These include our Patient Registration, Comprehensive Health Review (include all current medications and dosages), and Consent to Treat.

Whether you have a serious foot health condition or you're just looking for added comfort, Redondo Beach Podiatry Group is here to provide the best podiatric care possible. We look forward to your appointment with us!

Sincerely,
Redondo Beach Podiatry Group

PS – Please visit us online at **www.RBPodiatry.com** for additional patient information and our Notice of Privacy Policies.

PATIENT REGISTRATION

PATIENT INFORMATION

Patient's Last Name	First	Middle	☐ Mr. ☐ Mrs. ☐ Dr. ☐ Miss ☐ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid
Nickname (Name I preferred to be called)		Birth Date (mm/dd/yyyy)	Sex ☐ M ☐ F	Spouse's Name
Street Address		Social Security #		Home Phone # ( )
City	State	Zip Code	E-Mail	Mobile Phone # ( )
Employer	Employer Address			Employer/Work Phone # ( )
How Did You Hear About Us		Primary Care Physician (PCP) - Name /Phone#		Date PCP Last Seen

PERSON RESPONSIBLE FOR BILL (IF DIFFERENT THAN ABOVE)

Name of Person Responsible for Bill		Birth Date (mm/dd/yyyy)	Sex ☐ M ☐ F	Relationship to Patient ☐ Self ☐ Spouse ☐ Child ☐ Other
Street Address		Social Security #		Home Phone # ( )
City	State	Zip Code	E-Mail	Mobile Phone # ( )
Employer	Employer Address			Employer/Work Phone # ( )

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD AND PHOTO ID TO RECEPTIONIST)

Primary Insurance		Subscriber Name		Birth Date (mm/dd/yyyy)	Social Security #
Insurance ID #	Group #	Policy #	Effective Date	Expiration Date	Co-Payment $

Secondary Insurance		Subscriber Name		Birth Date (mm/dd/yyyy)	Social Security #
Insurance ID #	Group #	Policy #	Effective Date	Expiration Date	Co-Payment $

IN CASE OF EMERGENCY

Name of Nearest Friend or Relative	Relationship to Patient	Home Phone # ( )	Work or Mobile Phone # ( )

PHARMACY INFORMATION

Pharmacy Name & Address: ______________________________

☐ CVS ☐ Rite-Aid ☐ Walgreens ☐ Target Other ____________________ ☐ Phone Number ____________________

The above information is true to the best of my knowledge. I certify that I have insurance with the insurance company(ies) disclosed and assign directly to Redondo Beach Podiatry Group all insurance benefits, if any, otherwise payable to me for service(s) rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature below on all insurance submissions. Redondo Beach Podiatry Group may use my health care information and may disclose such information to the disclosed insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

X

PATIENT/GUARDIAN SIGNATURE DATE

COMPREHENSIVE HEALTH REVIEW

Patient Name:____Date of Birth:__________________Today's Date: __________________

HISTORY OF PRESENT ILLNESS / WHAT BRINGS YOU IN?

What is your specific foot/ankle problem? ________________

____

____

When did the problem begin? ____________________

The problem is: ☐ Improving ☐ Worsening ☐ Unchanged

What aggravates the problem? ____________________

Which foot/ankle is involved? ☐ Right ☐ Left ☐ Both

First visit to a doctor for this problem? ☐ Yes ☐ No

Have you had a similar problem in the past? ☐ Yes ☐ No

How was the problem onset? ☐ Sudden ☐ Gradual

The problem is worst: ☐ AM ☐ PM ☐ At Rest ☐ With Activity

What improves the problem? ______________________________

Is the problem painful? ☐ Yes ☐ No If so, rate your current pain: (none) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Describe the pain: ☐ Sharp ☐ Dull ☐ Aching ☐ Throbbing ☐ Cramping ☐ Itching ☐ Popping
☐ Burning ☐ Tingling ☐ Clicking ☐ Shooting ☐ Stabbing ☐ Other: ____________________

Describe previous treatments: ____

Is this from an injury? ☐ Yes ☐ No If so, is it work-related? ☐ Yes ☐ No ____

PAST MEDICAL HISTORY

☐ Diabetes Type 1 2 Duration _____years Last Blood Sugar______HbA1c______

☐ Acid Reflux

☐ Anemia

☐ Anesthesia Complications

☐ Arthritis (☐ Osteo / ☐ Rheum)

☐ Asthma

☐ Back Problems/Sciatica

☐ Blood Clot/DVT

☐ Cancer: ____________________

☐ Cellulitis/Skin Infection (☐ MRSA?)

☐ Circulation Problem

☐ Dementia/Alzheimer's

☐ Excessive/Easy Bleeding

☐ Fibromyalgia

☐ Foot/Leg Ulcer

☐ Gout

☐ Healing Problems/Keloids

☐ Heart Disease/Heart Attack

☐ High Blood Pressure (☐ Low BP?)

☐ High Cholesterol

☐ Hormone Therapy

☐ Immune Disorder/HIV

☐ Kidney Disease (☐ Dialysis)

☐ Other problems not listed: ____

☐ Liver Disease (☐ Hepatitis)

☐ Leg Cramps/Leg Pain at Rest

☐ Lung Condition:________________

☐ Mitral Valve Prolapse/Murmur

☐ Multiple Sclerosis

☐ Nervous Disorder/Depression

☐ Neuropathy

☐ Osteomyelitis/Bone Infection

☐ Parkinson's Disease

☐ Previous Addiction to:___________

☐ Pulmonary Embolism

☐ Rashes/Skin Condition

☐ Raynauds Disease/Phenomena

☐ Seizure Disorder/Epilepsy

☐ Sickle Cell Disease/Trait

☐ Sleep Apnea

☐ Stomach Ulcers

☐ Stroke ☐ Rt ☐ Lt (year_______)

☐ Thyroid Condition (☐ Hi ☐ Lo)

☐ Varicose Veins

☐ Women – Are You Pregnant or Breast Feeding?

PAST SURGERIES

☐ Foot/Ankle Surgery: ____________________

☐ Joint Replacement: ____________________

☐ Open Heart/Bypass Surgery

☐ Hysterectomy ☐ Tubal ligation ☐ C-Section

☐ Stent Placement: Heart Leg

☐ Cosmetic Surgery: ____________________

☐ Appendix ☐ Gallbladder ☐ Tonsils/Add

☐ Leg Bypass ☐ Open Fracture Repair

☐ Carotid Surgery ☐ Vein Surgery

☐ Hernia repair ☐ Thyroid ☐ Back surgery

☐ Other: ______________________________

FAMILY HISTORY (circle relative)

Mother **F**ather **S**ister **B**rother **G**rand**P**arent

Condition	Relative
☐ Cancer	M F S B GP
☐ Diabetes	M F S B GP
☐ Gout	M F S B GP
☐ Heart Disease	M F S B GP
☐ High Blood Pressure	M F S B GP
☐ Severe Arthritis	M F S B GP
☐ Anesthesia Complications	M F S B GP
☐ Foot Problems	M F S B GP
☐ Other: ______________	M F S B GP

Redondo Beach Podiatry Group

COMPREHENSIVE HEALTH REVIEW

Patient Name: ____

MEDICATIONS (include RX meds, OTC meds, and vitamins)

Medication	*Dosage*	*Medication*	*Dosage*

ALLERGIES

- ☐ **None**
- ☐ Adhesives/Tape
- ☐ Aspirin
- ☐ Codeine
- ☐ Cortisone
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Penicillin
- ☐ Seafood/Shellfish
- ☐ Sulfa Drugs
- ☐ ____________________

SOCIAL HISTORY

Occupation: ____

☐ I Drink Alcoholic Beverages How much/often?_____________

☐ I Use or Have Used Tobacco Products Type:_____________

Packs/Day_________ Years__________When Stopped? ________

☐ I Use or Have Used Drugs that are Illegal ________________

I Live With: ☐ No One ☐ Spouse ☐ Children ☐ Parents ☐ Other

I Stand______% of My Day

I Exercise Each Week: ☐ 0 days ☐ 1-2 days ☐ 3+ days

List Sports/Activities: ____

____

____

☐ My foot/ankle problem limits my activities

REVIEW OF SYSTEMS

CONSTITUTIONAL
- ☐ Recent Weight Changes
- ☐ Fever/Chills
- ☐ Nausea or Vomiting
- ☐ Fatigue

EYES
- ☐ Eye Disease/Injury
- ☐ Wear Glasses/Contacts
- ☐ Blurred or Double vision
- ☐ Glaucoma

EARS/NOSE/MOUTH/THROAT
- ☐ Hearing Loss
- ☐ Nose Bleeds
- ☐ Sore Throat/Voice Change
- ☐ Sinus Problems
- ☐ Difficulty Swallowing

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Arrhythmia/Irregular Heart Beat
- ☐ Leg Pain when Walking
- ☐ Swelling of Hands/Feet

MUSCULOSKELETAL
- ☐ Muscle Pain or Cramps
- ☐ Joint Pain
- ☐ Stiffness/Swelling Joints
- ☐ Low Back Pain
- ☐ Trouble Walking

GASTROINTESTINAL
- ☐ Indigestion/Heartburn
- ☐ Diarrhea
- ☐ Blood in Stools
- ☐ Stomach Pains

RESPIRATORY
- ☐ Shortness of Breath
- ☐ Chronic/Frequent Cough
- ☐ Wheezing

GENITOURINARY
- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Kidney Stones
- ☐ Blood in Urine

INTEGUMENTARY
- ☐ Rash or Itching
- ☐ Dry Skin
- ☐ Change in Hair/Nails

HEMATOLOGICAL
- ☐ Bruise Easily
- ☐ Slow to Heal

ENDOCRINE
- ☐ Hormonal Problem
- ☐ Excessive Thirst
- ☐ Excessive Urination
- ☐ Too Hot/Too Cold

NEUROLOGICAL
- ☐ Migraines
- ☐ Frequent Headaches
- ☐ Numbness/Tingling
- ☐ Dizzy Spells
- ☐ Paralysis/Tremors

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Nervousness
- ☐ Insomnia
- ☐ Confusion/Memory Loss

STATS

Age ______ Height ________ Weight ________ Shoe Size _______

For Office Staff BMI _________

BP_________P___________O2 Sat___________Temp _________

The information I have provided is true to the best of my knowledge. I recognize that the information I have provided will help me receive the best possible care.

X ____________________________________ ________________________

PATIENT/GUARDIAN SIGNATURE DATE

Redondo Beach Podiatry Group

FINANCIAL POLICY

1. All co-payments are due at the time of visit. 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 a violation of the contract you have with your insurance company. Our office accepts cash, checks (post-dated checks are not accepted), credit and debit cards. Patient Initials: ________

2. Co-insurance and unmet deductibles are due prior to scheduled surgeries and procedures. Once benefits are verified and your financial responsibility calculated, you will be notified of the payment amount and due date. Patient Initials: ________

3. You are ultimately responsible for payment of charges for services you receive from our office. Patient Initials: ________

4. In accordance with your insurance member handbook, it is your responsibility to provide accurate insurance information and to present your insurance ID card at the time of your visit. If you do not have insurance or do not present a valid insurance card, you will be responsible for payment at the time of service. We will provide you with a copy of our billing form so that you can obtain reimbursement from your insurance company. Patient Initials: ________

5. It is your responsibility to ensure that our physicians are in your insurance network. Patient Initials: ________

6. If your plan requires a referral, it is your responsibility to obtain this prior to being seen by our provider. Patient Initials: ________

7. Payment is due for rendered services 10 days from receipt of your billing statement. Outstanding balances must be paid in full prior to any additional visit unless arrangements have been made with our billing department. Patient Initials: ________

8. There is a service fee of $35 for each time a check is returned. The bank may return your check up to three times before considering it nonnegotiable. Your insurance company does not cover this fee. Patient Initials: ________

9. A scheduled appointment means that time has been reserved for you. Cancellations for appointments must be received at least 24 hours prior to the scheduled appointment. Cancellations for scheduled surgery and in-office procedures must be received at least 5 days prior to the scheduled surgery date and time. Patient Initials: ________

10. Patients who fail to keep or fail to cancel a scheduled appointment may be charged a $25.00 No Show Fee. There is a $100.00 cancellation fee for scheduled surgeries or in-office procedures that are cancelled less than 5 business days from the date and time of surgery unless cancellation is due to insurance denial or medical necessity. Patient Initials: ________

11. Medical records requests must be received in writing at least 72 hours prior to the date needed. Fees must be received prior to record delivery. No more than 5 pages may be faxed. Patient Initials: ________

12. Administrative Services: There is a $25.00 charge for each required Administrative Service, payable prior to service completion. This Administrative Service Fee covers specific administrative services such as forms completion for family medical leave and disability, letters for insurance authorizations for brand or non-formulary drugs, letters for employers, school, health clubs, and any other administrative items not covered by insurance. Patient Initials: ________

13. In the event your insurance company should happen to send payment to you (the patient), you agree to forward said payment to our office to be applied to your account. Patient Initials: ________

14. SELF-PAY: Payment in full is due at the time of service if you do not have health insurance coverage. Patient Initials: ________

Redondo Beach Podiatry Group

CONSENT TO TREATMENT

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Redondo Beach Podiatry Group Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

Patient Initials: __________

AUTHORIZATION REGARDING PRIVACY POLICY

Due to the recent implementation of the Patient Privacy Act (HIPPA), I hereby authorize Redondo Beach Podiatry Group to leave messages at my home with family members and/or answering machines regarding the following: (1) Confirm or Change Appointment, (2) Results of testing ordered by the physician, and/or (3) Any pertinent information that may be relative to my care.

Patient Initials: __________

ACKNOWLEDGMENT OF RECEIPT OF FINANCIAL POLICY

I acknowledge that I was provided a copy of the Redondo Beach Podiatry Group Financial Policy and that I have read (or had the opportunity to read if I so chose), understand and will comply by the policies stated.

Patient Initials: __________

CONSENT TO VIEW EXTERNAL PRESCRIPTION HISTORY

I authorize Redondo Beach Podiatry Group to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my provider and staff at Redondo Beach Podiatry Group and it may include prescriptions back in time for several years.

Patient Initials: __________

PATIENT CONSENT

I hereby voluntarily consent to outpatient care by a Redondo Beach Podiatry Group Podiatrist, encompassing routine care, diagnostic procedures, examination and medical treatment including, but not limited to, minor surgical procedures, routine laboratory work, x-rays, ultrasound, photographs and administration of medications and injections prescribed by the Redondo Beach Podiatry Group Podiatrist. I agree to ask questions to clarify treatment should I not understand the treatment plan.

Patient Initials: __________

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance with the insurance company(ies) disclosed and assign directly to Redondo Beach Podiatry Group and its Podiatrists, all insurance benefits, if any, otherwise payable to me for service(s) rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I agree that should my account become delinquent and is referred to an attorney or collection agency for collection, I will be charged an additional 33 1/3% of any unpaid balance at the time of referral for all costs of collection and attorney's fees. I authorize the use of my signature below on all insurance submissions.

Patient Initials: __________

Redondo Beach Podiatry Group may use my health care information and may disclose such information to the disclosed insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Patient Initials: __________

DISCLOSURE OF SERVICES

I understand that Redondo Beach Podiatry Group is owned and operated by Dr. Darragh. During my course of treatment, products may be recommended. I understand that I am under no obligation to purchase these products and that i may find alternate sources to purchase these products.

Patient Initials: __________

I have read and fully understand this Consent to Treatment. This authorization is valid as of the date I have signed below and will remain in effect as long as I am a Redondo Beach Podiatry patient. I have read this complete page and agree to all of its contents.

______________________________ Name of Individual/Legal Representative (Print)

______________________________ Signature of Individual/Legal Representative

______________ Date

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HIPAA Notice of Privacy Practices
Written Acknowledgment Form

Our Notice of Privacy Practices (NPP) provides information about how we may use and disclose medical information about you.

I, ______________________, with the date of birth _____________________ have been provided access to a copy of the Redondo Beach Podiatry Group's NPP for review.

This acknowledgment form will be in effect until otherwise revoked by Redondo Beach Podiatry.

I hereby consent to the release of any/all information regarding my medical history, current medical condition, current medical treatment and any/all patient account information to the individual(s) listed below: ***(If you would not like any information to be released please leave blank).***

________________________________ ___________________ __________________
Name Relationship Phone Number

________________________________ ___________________ __________________
Name Relationship Phone Number

________________________________ ___________________ __________________
Name Relationship Phone Number

____ _____________________
Patient Signature Date

____ _____________________
Witness Signature Date