Ocotillo Foot & Ankle Centers

Mary Peters, DPM Frank Maben, DPM Vanousheh Ghandhari, DPM Ricardo Navarrete Jr., DPM

270 W Chandler Heights Rd #5
Chandler, AZ 85248
Phone: 480-895-0276
Fax: 877-389-9169

13838 S. 46TH Pl #105
Phone: 480-940-5172

PATIENT INFORMATION

_____ Marital Status: S □ M □ D□ W□
Last First MI

Sex: M □ F □ O □ DOB _____/_____/_____ HT _____ WT _____ Shoe Size _____

Mailing Address:_____
P.O. Box /Street Apt# City State Zip

Phone # ( ) _____-_____ Cell # ( ) _____-_____ Work # ( ) _____-_____

For oral communications, may we leave a message? Yes ☐ No ☐ Work/Home/Cell: _____

With whom may we leave a message with: _____

Patient Employer: _____ Phone # ( ) _____-_____

Family Physician Name: _____ Phone # ( ) _____-_____
(Medicare/HMO Patients Required)

Preferred Pharmacy: _____ Phone # ( ) _____-_____

E-mail Address (For the Patient Portal): _____

Who referred you to our office? _____

INSURANCE INFORMATION Do you have insurance? Yes ☐ or No ☐

PRIMARY INSURANCE: _____ Phone #: _____ Member ID #:_____

Policy Holder'sName: _____ **Relationship to Patient:** _____

Policyholder's S.S. #: _____-_____-_____ **DOB** _____/_____/_____

SECONDARY INSURANCE (if any): _____ Phone #: _____ Member ID #: _____

Policyholder's Name: _____ Relationship to Patient: _____

Policyholder's S.S. #: _____-_____-_____ DOB _____/_____/_____

INSURANCE AUTHORIZATION TO RELEASE INFORMATION AND AUTHORIZATION TO PAY

I hereby authorize Mary Peters, DPM / Frank Maben, DPM / Vanousheh Ghandhari, DPM / Ricardo Navarrete Jr., DPM to release any information, for insurance purposes, required in the course of my examination or treatment. I also hereby authorize payment directly to the business office Mary M. Peters, DPM / Frank Maben, DPM / Vanousheh Ghandhari, DPM / Ricardo Navarrete Jr., DPM for the surgical and/ or medical benefits, if any, and otherwise payable to me for services. I understand that I am financially responsible for the charges not covered by my insurance.

Patient Signature: (or Parent, if minor) _____Date:_____

Ocotillo Foot & Ankle Centers

Mary Peters, DPM Frank Maben, DPM Vanousheh Ghandhari, DPM Ricardo Navarrete Jr., DPM

MEDICAL HISTORY

Patient Name:_____ Present Foot/Ankle Complaint:_____

Please Check (√) if you or an immediate family member have had any of the following conditions:

You	Family Member	Nature of Problem	Date of Onset, Comments/Treatments
		Recent Weight Loss	
		Headaches	
		Vision/Hearing Problems	
		Asthma or Respiratory Issues	
		Thyroid Problems	
		Diabetes	A1c: Last Blood Sugar:
		Heart Disease	Pacemaker Yes □ No □
		Circulation/Bleeding Problems	
		High/Low Blood Pressure	
		Arthritis	
		Stomach Ulcers/Trouble	
		Gout	
		Liver Disease	
		Kidney Disease	
		Keloids/Scarring Problems	
		Drug/Alcohol Abuse	
		Nerve Problems	
		Other Medical Conditions	

Last office visit with primary care provider: _____

Please list any surgeries or serious injuries: _____
_____
_____

Please list medications you are currently taking (including prescription, over-the-counter medications and vitamins):
_____
_____
_____

Please list any allergies: _____

Do you smoke? Yes ☐ No ☐ If yes, how often? _____ Do you take oral contraceptives? Yes ☐ No ☐

Flu Vaccine? Yes □ No □ Covid Vaccine? Yes □ No □ Pneumonia Vaccine? Yes □ No □

Please list any other information we should be aware of: _____
_____

CONSENT I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment.

CONSENT TO OBTAIN ELECTRONIC MEDICATION HISTORY

I understand that my medication history may be obtained utilizing an electronic information exchange and that this protected health information may provide valuable information for my healthcare provider.

I hereby authorize Ocotillo Foot & Ankle Centers to access my medication history without limitation or exclusion as is reasonably advisable to disclose, retrieve, and view medications issued by a provider.

Patient Signature: (or Parent, if minor) _____ Date: _____

Ocotillo Foot & Ankle Centers

Mary Peters, DPM Frank Maben, DPM Vanousheh Ghandhari, DPM Ricardo Navarrete Jr., DPM

INSURANCE POLICY:

Insurance provides for your reimbursement on allowed medical charges. As a courtesy to you we will provide an itemized statement you may send to your insurance company for payment. We will be happy to submit to most insurance carriers, if you have provided us with policy numbers, address, place of employment and any other pertinent information. You are responsible for all deductibles and charges not covered by insurance. Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility.

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

I have read the above and accept financial responsibility in full for this account.

PATIENT SIGNATURE: _____ Date: _____
(or Parent, if minor)

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I authorize the Doctor to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the Doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of the information. (ex: family member, spouse, child)

I_____ authorize release of personal information to _____

PATIENT SIGNATURE :_____ Date:_____

Form Fees: There will be a $50.00 charge for all forms completed without an appointment. This fee is due at the time the time the form is presented to the office. The form will not be completed until the form fee is paid. The majority of forms including Disability Forms, FMLA, Leave of Absence Forms, work and/or school notes. INITIALS:_____

No Show / Same Day Cancellation Policy: No show and same day cancellations make it impossible for our office to provide care to another patient in need. We require a 24-hour notice for cancellations.

- 1st No show or same day cancellation: $25.00 CHARGE
- 2nd No show or same day cancellation: $25.00 CHARGE
- 3rd No show or same day cancellation: $35.00 CHARGE and/or **PATIENT is DISCHARGED from the practice.**

Thank you for your consideration in this matter INITIALS:_____

IN CASE OF EMERGENCY PLEASE CONTACT:

Name:_____
Phone:_____Relationship:_____
Address:_____

PATIENT SIGNATURE:_____Date:_____

Ocotillo Foot & Ankle Centers

Mary Peters, DPM Frank Maben, DPM Vanousheh Ghandhari, DPM Ricardo Navarrete Jr., DPM

HIPAA (Health Insurance Portability and Accountability Act):

The HIPAA privacy standards no longer require an individual's consent or authorization to execute health care treatment, payment or operations. Instead, Section 164.506 gives covered entities express "regulatory permission" to use or disclose protected health information (PHI) under certain circumstances for treatment, payment or health care operations without an individual's prior written permission or authorization.

The December 3, 2002, Office of Civil Right HIPPA Privacy Guidance states, "Payment encompasses the various activities of health care providers to obtain payment or be reimbursed for their services and of a health plan to obtain premiums, to fulfill their coverage responsibilities and provide benefits under the plan, and to obtain or provide reimbursement for the provision of health care." Examples given in the guidance of permitted use or disclosure or PHI for treatment, payment and health care operations include:

1. A hospital may use PHI about an individual to provide health care to the individual and may consult with other health care providers about the individual's treatment.
2. A health care provider may disclose PHI about an individual as part of a claim for payment to a health plan.
3. A health plan may use PHI to provide customer service to its enrollees. We respectfully assert that an individual's prior written permission or authorization is not required in order to fulfill the nature of our request.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

_____ _____

Patient Name (please PRINT) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature