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

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.

Redondo Beach Podiatry Group

# 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 # ( ) |
| Primary Care Doctor | | Employer | | Employer/Work Phone # ( ) |
| Specialists | | How Did You Hear About Us | | |

## 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

Redondo Beach Podiatry Group

# 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? _____

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: □ Improving □ Worsening □ Unchanged

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

What aggravates the problem? _____

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)

**M**other **F**ather **S**ister **B**rother **G**rand**P**arent

| | |
|---|---|
| □ 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

# 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 |
|---|---|---|

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. 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: _____

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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 |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

**** Notice of Privacy Practices * ***

Phillip E. Darragh, DPM & Robert Anavian, DPM

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 privacy of your medical information is important to us.

**Our Legal Duty**

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect January 1, 2020, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact our office.

**Uses and Disclosures of Protected Health Information**

We will use and disclose your protected health information about you for treatment, payment, and health care operations.

Following are examples of the types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

**Treatment:** We will use and disclose your protected health information to provide, coordinate or manage your health care and related services. This includes the coordination of management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will disclose protected heath information to other physicians who may be treating you. Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.