PACIFIC POINT PODIATRY
TEA NGUYEN, DPM
P 831-288-3400 | F 831-319-4637 | 243 GREEN VALLEY RD #A, FREEDOM, CA 95019 | 831FEET.COM

NEW PATIENT REGISTRATION
INFORMACIÓN DE PACIENTE

Your Primary Doctor/Médico de cabecera _____

Referred by/¿Quién lo refirió? _____/ Google

Name (First, Last)/Nombre, Apellido _____

Birthdate/Fecha de nacimiento _____ SS # _____

Sex/Sexo: **Male,** Masculino / **Female**, Femenina / **Other**

Marital status/Estado civil: **Single,** Soltero / **Married,** Casado / **Divorced**, Divorciado / **Widowed,** Viudo

Home address/Domicilio _____

City/Ciudad _____ **State**/Estado _____**Zip**/Código Postal _____

Mobile/celular #_____ **Alternative**/numero alternativo #_____

Email/Correo electrónico _____

☐ **Please check this box if you agree to receive automated text, voice messages and/or email to the provided information. We use this to send you important updates about the office, your appointment and offer promotions. We do not spam.** / Por favor de seleccionar esta opción si acepta recibir texto automatizado, mensajes de voz y correo electrónico. *Usamos esta información para enviarle actualizaciones importantes sobre la oficina, su scita, y ofrecer promociones.*

Occupation/Ocupación: _____**Employer**/Empleador: _____

If patient is a minor (under age 18), parent or guardian to fill out
Si el paciente es menor de (18 años), favor de completar por los padres o guardianes

Parent or Guardian Name/Nombre de un pariente o amigo local _____

Relationship to the patient/Relación al paciente _____

Primary #/Número de teléfono (casa) _____

Secondary #/Número de Teléfono (celular) _____

EMERGENCY CONTACT
EN CASO DE EMERGENCIA

Name/Nombre _____

Relationship to the patient/Relación al paciente _____

Primary #/Número de teléfono (casa) _____

Secondary #/Número de Teléfono (celular) _____

PACIFIC POINT PODIATRY
TEA NGUYEN, DPM
P 831-288-3400 | F 831-319-4637 | 243 GREEN VALLEY RD #A, FREEDOM, CA 95019 | 831FEET.COM

PAST MEDICAL HISTORY (Circle if you have/had):

AIDS / HIV	Bleeding, clot disorder	Gout	Kidney problems
Arthritis	Cancer	Headaches/migraines	Liver disease
Anemia	Chest pain	Hepatitis A / B / C	Neuropathy
Artificial heart	Circulation problems	High or low blood	Psychiatric care
valve/heart disease	Diabetes Type 1	pressure	Stroke
Asthma or shortness	Diabetes Type 2	Sexually transmitted	Tuberculosis
of breath	Epilepsy/seizure	disease (STD)	Other:
Back problems	Eye problems	Stomach ulcers	

HOSPITALIZATIONS / SURGICAL HISTORY:

FAMILY MEDICAL HISTORY (Immediate family**):**

PREFERRED PHARMACY: Name / Street / City

ALLERGIES (circle): Codeine Contrast dye Latex Penicillin Sulfa Shellfish

Other: _____

MEDICATION / SUBSTANCE USE

Tobacco or nicotine use, # of years _____Recreational drug use _____

Former smoker quit date _____Alcohol use (# drinks/week) _____

List of medication, herbal supplement (or provide a copy of your list) with dosage and frequency.

IS THERE ANYTHING ELSE YOU WOULD LIKE THE DOCTOR TO KNOW?

PACIFIC POINT PODIATRY
TEA NGUYEN, DPM
P 831-288-3400 | F 831-319-4637 | 243 GREEN VALLEY RD #A, FREEDOM, CA 95019 | 831FEET.COM

OFFICE POLICIES & FEES

We realize there are many choices and are pleased you have chosen Pacific Point Podiatry for your foot and ankle care. Our staff strives to make your experience as pleasant as possible. In order to maintain a high level of care, we have to implement the following policies, which allow us to better utilize available appointments for our patients in need of medical attention.

Office Hours For appointments, prescription refills and test results, please calls our office during normal business hours. Abnormal test results will only be discussed in person. Prescription refills may take 1-2 days, so be sure to plan ahead. Antibiotics and narcotics will not be prescribed over the phone. We do not prescribe narcotics routinely, you may need to see a pain specialist instead.

Urgent Care We offer walk-ins on a first come first serve basis, schedule permitting .If we are unable to accommodate you, you should go to the nearest urgent care center or emergency room for true emergencies. Pain medication refills are not considered true emergencies so plan ahead and make arrangements with your primary care doctor or pain specialist who can better serve your needs.

Appointments Occasionally, we encounter office emergencies or patients requiring more time. We hope you understand and accommodate for these rare instances that may delay your appointment time. We encourage you to reschedule so that you can have the time and attention you deserve.

Cancellation/No-Show We understand cancellations may happen from time to time. In order to be respectful to other patients requiring medical attention, please call to cancel or reschedule promptly. Due to planning that is involved with your appointment, you will be billed an administrative fee of **$50** for not canceling 24 hours in advance or you do not show to your appointment. Your insurance will not pay for this. Repeated no-shows may result in your care being transferred elsewhere.

Other We encourage a respectful and professional environment for all who come through. We reserve the right to refuse care in patients who are rude or threatening to any staff member of Pacific Point Podiatry.

Your Financial Responsibility

If You Have Health Insurance

- Cost/payment cannot be guaranteed since insurance policies are always changing. Your insurance policy is a contract between you and your insurance company. *Our relationship is with you, the patient, and not the insurance company*. Therefore, if you have questions about your policy, contact your insurance carrier.
- You will be responsible for understanding your coverage including co-payments, deductibles and non-covered services. Check with your insurance that our office is in-network. Additional charges may be applied by your insurance if we are out-of-network.
- Please inform us of any changes in coverage, including your address or phone number. Obsolete information resulting in denial of claims may be subject to a **$25** administration fee.
- Some insurances require a referral from your primary care doctor to see us to receive the maximum benefit of your insurance.

PACIFIC POINT PODIATRY
TEA NGUYEN, DPM
P 831-288-3400 | F 831-319-4637 | 243 GREEN VALLEY RD #A, FREEDOM, CA 95019 | 831FEET.COM

- If your annual out of pocket expenses (deductible) have not been met, **we may collect up to 60% of the visit's charges on the day of your appointment**. This will be applied to your account and a statement will be sent reflecting any additional monies owed and a response from your insurance carrier. If it has been stated by your insurance carrier that a deductible deposit cannot be collected at the time of service, a valid credit card will be required and stored securely. Upon a claim response, your credit card will be charged and a detailed statement will be provided along with a paid receipt.

If You Do Not Have Health Insurance Payment is due at the time of service. A cash fee schedule is available.

Payment/Collection/Fees We accept cash, check, Visa or MasterCard. We will make all reasonable attempts to collect outstanding balances, including convenient payment arrangements. Accounts not paid within 30 days are subject to a 10% annual finance charge. To improve our efficiencies, the following administrative fees will be added to your balance and is not covered by your insurance:

- As a courtesy, we will bill your insurance for the services rendered. Should any part of it be denied, the full balance is due immediately. Balances not received within 30 days will be charged **$15.** If it is not paid for more than 90 days it will be sent to a third-party collection agency plus an additional **$35**.
- Returned checks: **$20**.
- Surgery cancellation made within 10 days of scheduled date: **$200.**

Forms/Letters Various forms as related to your medical care require time so please allow 7-10 days upon your request to be completed. This includes short-term disability forms for our surgical patients. Long-term issues should be addressed with your primary care doctor. Disability forms or other requested documentation: **$15 each**.

Medical Records Per HIPAA guidelines, copies of your medical records need to be requested in writing using our Release of Medical Information form. The first set of copies is free of charge, additional copies will have a fee of a minimum of $**10.**

Insurance Release The entirety of the above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician and to use my signature on all insurance submissions required to process claims. I understand I am financially responsible for any balance.

Please initial

- _____ I have read the above and agree to comply with the office policies and consent to treatment. I agree to pay all finance charges, all collection fees (third party collection fees included), attorney fees, and any other cost that may be incurred to enforce collection of any amount outstanding on my account.

- _____ I have read the HIPAA form and acknowledge that I can request a copy of this form.

_____ _____
Signature Today's Date

_____
Print your full name

Thank you for your understanding and cooperation. We are delighted to serve you.

PACIFIC POINT PODIATRY
TEA NGUYEN, DPM
P 831-288-3400 | F 831-319-4637 | 243 GREEN VALLEY RD #A, FREEDOM, CA 95019 | 831FEET.COM

MEDICAL RECORDS RELEASE

Information to be released (check one)

☐ Complete records OR

☐ Restricted records (specify information you are requesting):

_____

_____

Who in your family/friends can we discuss your medical care with?

Name _____

Relationship _____

Address _____

Phone _____

Which medical doctor(s) can we share your medical records with?

Name _____

Address _____

Fax _____

Phone _____

_____ _____

Signature Today's Date

_____

Print your full name

PACIFIC POINT PODIATRY
TEA NGUYEN, DPM
P 831-288-3400 | F 831-319-4637 | 243 GREEN VALLEY RD #A, FREEDOM, CA 95019 | 831FEET.COM

CONSENT FOR PHOTOS

I give my consent to have photographs, videotaped images, or other images made of myself. I understand and agree that these images may be used by **Pacific Point Podiatry** or authorized persons for the purpose outlined here: Teaching purposes, includes being shown to other patients, advertisements, placement on websites, social media, scientific and/or research publications. I provide unrestricted rights to all materials produced.

Initial only one:

_____ I initial here to give consent

OR
_____ I initial here to **not** give the above consent

_____ _____
Signature Today's Date

_____
Print your full name