SHADY GROVE PODIATRY
THE FOOT AND ANKLE EXPERTS

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EMAIL: CONTACT@SHADYGROVEPODIATRY.COM
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DR. AMIR ASSILI | DR. DAVID BAEK | DR. HOAN DANG | DR. JON DILLARD | DR. COLIN MIZUO

NEW PATIENT PACKET

BASIC PATIENT INFORMATION		
PATIENT ACCOUNT NUMBER (OFFICE USE ONLY):		**DATE:**
FULL NAME (LAST, FIRST, MIDDLE INITIAL):		
BIRTHDATE:		**AGE:**
SOCIAL SECURITY NUMBER (NOT REQUIRED):		**SEX:**
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
PLEASE PROVIDE YOUR PHONE NUMBERS BELOW AND CHECK OFF WHICH NUMBER IS PRIMARY:		
☐ HOME:	☐ CELL:	☐ WORK:
PLEASE INDICATE YOUR PREFERRED METHODS OF RECEIVING APPOINTMENT REMINDERS:		
☐ PHONE CALL AT CHECKED # ABOVE	☐ TEXT MESSAGE AT CELL # ABOVE	☐ EMAIL ADDRESS (INDICATE BELOW)

OTHER PATIENT INFORMATION			
PRIMARY CARE PHYSICIAN (FULL NAME):			
PHARMACY (NAME, LOCATION):			
EMPLOYER:			
IF PATIENT IS A MINOR, INDICATE GUARDIAN AND RELATION:			
EMAIL:	**WEB ENABLE FOR PATIENT PORTAL?** ☐ YES ☐ NO		
PRIMARY LANGUAGE:	**DO YOU NEED AN INTERPRETER?** ☐ YES ☐ NO		
DO YOU HAVE AN ADVANCE DIRECTIVE (LIVING WILL)?	☐ YES	☐ NO	
DO YOU GIVE PERMISSION TO ACCESS YOUR PRESCRIPTION HISTORY TO BEST PROVIDE TREATMENT?	☐ YES	☐ NO	
ARE YOU HISPANIC OR LATINO?	☐ YES	☐ NO	☐ DECLINED TO SPECIFY
WHICH CATEGORY BEST DESCRIBES YOU? (ONE OR MORE CATEGORIES MAY BE MARKED. THIS IS NOT BY ANY MEANS TO DISCRIMINATE AGAINST ANY SINGLE PERSON AND WILL NOT DETER THE TREATMENT YOU RECEIVE IN OUR OFFICE. THIS INFORMATION IS COLLECTED TO ENSURE THAT WE ARE ABLE TO PROVIDE THE HIGHEST QUALITY OF CARE FOR ALL PATIENTS).	☐ ASIAN ☐ ASIAN INDIAN ☐ BLACK OR AFRICAN AMERICAN ☐ MIDDLE EASTERN OR NORTH AFRICAN ☐ OTHER PACIFIC ISLANDER ☐ WHITE ☐ DECLINED TO SPECIFY		

EMERGENCY CONTACT INFORMATION	
NAME OF EMERGENCY CONTACT:	
RELATIONSHIP OF EMERGENCY CONTACT:	
PHONE NUMBER OF EMERGENCY CONTACT:	

INSURANCE INFORMATION	
PRIMARY INSURANCE:	**SECONDARY INSURANCE:**
POLICY ID #:	**POLICY ID #:**
SUBSCRIBER'S NAME:	**SUBSCRIBER'S NAME:**
SUBSCRIBER'S DATE OF BIRTH:	**SUBSCRIBER'S DATE OF BIRTH:**
SUBSCRIBER'S RELATIONSHIP TO PATIENT:	**SUBSCRIBER'S RELATIONSHIP TO PATIENT:**
SUBSCRIBER'S EMPLOYER:	**SUBSCRIBER'S EMPLOYER:**

PATIENT MEDICAL HISTORY			
WHAT IS THE MAIN REASON FOR YOUR VISIT TODAY?			
APPROXIMATELY WHEN DID YOUR SYMPTOMS START?			
WHO REFERRED YOU TO THIS PRACTICE?			
PLEASE CHECK OFF ALL APPLICABLE CONDITIONS FROM THE LIST BELOW:			
☐ DIABETES / A1C: _____	☐ HEART DISEASE	☐ KIDNEY DISORDER	☐ STOMACH PROBLEM
☐ ARTHRITIS	☐ HEPATITIS	☐ LIVER DISORDER	☐ SLEEP APNEA
☐ ANEMIA	☐ HIGH BLOOD PRESSURE	☐ NEUROLOGICAL PROBLEM	☐ STOMACH PROBLEM
☐ CANCER: _____	☐ HIGH CHOLESTEROL	☐ RESPIRATORY	☐ STROKE
☐ CARDIAC: _____	☐ HIV/AIDS	☐ SEIZURES	☐ THYROID PROBLEM
☐ DIALYSIS	☐ INTESTINAL PROBLEM	☐ OTHER (SPECIFY): _____	
PLEASE PROVIDE ANY ALLERGIES TO MEDICATIONS:			
ARE YOU ALLERGIC TO LATEX? ☐ YES ☐ NO		**ARE YOU ALLERGIC TO ADHESIVES?** ☐ YES ☐ NO	
PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: (LET US KNOW IF YOU HAVE A LIST TO COPY)			
PLEASE PROVIDE YOUR SURGICAL HISTORY: (INCLUDE DATES IF POSSIBLE) IE: 2007 – RIGHT ACL SURGERY			
PLEASE LIST PAST HOSPITALIZATIONS: (INCLUDE DATES, REASON IF POSSIBLE) IE: 2009 – INFECTION			

SOCIAL HISTORY	
ARE YOU A SMOKER? ☐ YES ☐ NO	IF SO, HOW MUCH DO YOU SMOKE?
WERE YOU EVER A SMOKER? ☐ YES ☐ NO	WHEN DID YOU QUIT?
DO YOU DRINK ALCOHOL? ☐ YES ☐ NO	HOW OFTEN DO YOU DRINK?

FAMILY HISTORY				
PLEASE CHECK OFF AND INDICATE WHO IN YOUR IMMEDIATE FAMILY (PARENTS, SIBLINGS, ETC) HAS OR HAD ANY OF THE FOLLOWING:				
☐ ARTHRITIS	☐ DIABETES	☐ HEART DISEASE	☐ CANCER (WHICH)	√ *EXAMPLE*
				SISTER
				MOTHER

PATIENT CONSENT FOR TREATMENT

BY SIGNING BELOW, I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I GIVE PERMISSION TO THE PROVIDERS OF SHADY GROVE PODIATRY, LLC, DRS. ASSILI, BAEK, DANG, DILLARD, AND MIZUO TO ADMINISTER AND PERFORM THE PROCEDURES THEY DEEM NECESSARY UPON DISCUSSION WITH ME IN THE DIAGNOSIS AND/OR TREATMENT WITH MY CONSENT.

X _____

SIGNATURE OF PATIENT/ PARENT GUARDIAN **DATE**

MEDICARE AUTHORIZATION (ONLY IF APPLICABLE)

MEDICARE WILL ONLY PAY FOR SERVICES THAT IT DETERMINES TO BE "REASONABLE AND NECESSARY" UNDER SECTION 1842(A) OF THE MEDICARE LAW. IF MEDICARE DETERMINES THAT A PARTICULAR SERVICE IS NOT REASONABLE AND NECESSARY, PAYMENT WILL BE DENIED. IF MEDICARE SHOULD DENY PAYMENT OF SERVICES RENDERED, I AGREE TO BE PERSONALLY RESPONSIBLE FOR PAYMENT BY SIGNING BELOW. THIS AGREEMENT IS VALID FOR ALL SERVICES. I AUTHORIZE THE RELEASE OF ANY MEDICAL AND OTHER INFORMATION NECESSARY TO PROCESS THE CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS TO SHADY GROVE PODIATRY, LLC.

X _____

SIGNATURE OF PATIENT/ PARENT GUARDIAN **DATE**

CONSENT AND RELEASE

BY SIGNING BELOW, I CERTIFY THAT THE INFORMATION I HAVE REPORTED WITH REGARD TO MY INSURANCE COVERAGE IS CORRECT AND FURTHER AUTHORIZE THE RELEASE OF ANY NECESSARY INFORMATION, INCLUDING THE INFORMATION FOR THIS OR ANY RELATED CLAIM TO MY STATED INSURANCE COMPANY. EITHER MY INSURANCE COMPANY OR I MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING. REGARDLESS OF MY INSURANCE COVERAGE, THERE ARE SOME SERVICES, WHICH ARE NOT COVERED. PAYMENTS FOR THESE NON-COVERED SERVICES ARE MY RESPONSIBILITY AND MUST BE PAID AT THE TIME OF THE VISIT. DURING THE COURSE OF TREATMENT, DURABLE MEDICAL EQUIPMENT MAY BE RECOMMENDED. I AUTHORIZE MY INSURANCE COMPANY TO PAY SHADY GROVE PODIATRY, LLC DIRECTLY. I UNDERSTAND THAT MY INSURANCE WILL COVER THIS ITEM IF IT IS MEDICALLY NECESSARY, BUT THAT I AM RESPONSIBLE FOR ANY NON-COVERED SERVICES, DEDUCTIBLES AND COINSURANCE.

X _____

SIGNATURE OF PATIENT/ PARENT GUARDIAN **DATE**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY AND/OR HAVE REVIEWED THE NOTICE OF PRIVACY PRACTICES OF SHADY GROVE PODIATRY, LLC. THIS NOTICE DESCRIBES HOW SHADY GROVE PODIATRY, LLC MAY USE AND DISCLOSE MY PROTECTED HEALTH INFORMATION, CERTAIN RESTRICTIONS ON THE USE OF AND DISCLOSURE OF MY HEALTHCARE INFORMATION, AND RIGHTS I MAY HAVE REGARDING MY PROTECTED HEALTH INFORMATION. THE FEDERAL GOVERNMENT NOW RESTRICTS SHADY GROVE PODIATRY, LLC FROM DISCUSSING MY HEALTH INFORMATION WITH OTHER FAMILY MEMBERS OR PERSONS UNLESS I SPECIFICALLY GIVE WRITTEN PERMISSION. BY MY SIGNATURE BELOW, I GRANT SHADY GROVE PODIATRY, LLC PERMISSION TO DISCUSS AND RELEASE MY PROTECTED MEDICAL INFORMATION TO THE FOLLOWING INDIVIDUALS. (IF YOU DO NOT WISH TO LIST ANYONE, PLEASE SIGN YOUR NAME BELOW AND LEAVE THE FIRST TWO LINES BLANK.)

AUTHORIZED INDIVIDUAL NAME: _____RELATION: _____

AUTHORIZED INDIVIDUAL NAME: _____RELATION: _____

X _____

SIGNATURE OF PATIENT/ PARENT GUARDIAN **DATE**

CANCELLATION POLICY

IN AN EFFORT TO EFFICIENTLY SCHEDULE APPOINTMENTS AND IN CONSIDERATION OF OUR OTHER PATIENTS, WE REQUIRE 24-HOURS' NOTICE IF YOU HAVE TO CANCEL OR CHANGE AN APPOINTMENT. A $50.00 CHARGE WILL OCCUR FOR THE FIRST MISSED APPOINTMENT AND AN ADDITIONAL $25.00 CHARGE WILL OCCUR FOR SUBSEQUENT MISSED APPOINTMENTS. FOR LATE ARRIVALS, WE OFFER A 15 MINUTE GRACE PERIOD FROM THE SCHEDULED TIME. IF YOU ARRIVE LATER THAN THE GRACE PERIOD, YOU WILL BE CHARGED THE FEE. IF THERE IS AN EMERGENCY, WE UNDERSTAND AND WOULD APPRECIATE A CALL / NOTIFICATION TO THE OFFICE. THANK YOU. BY SIGNING BELOW, I AGREE WITH THE ABOVE.

X _____

SIGNATURE OF PATIENT/ PARENT GUARDIAN **DATE**

FORM FEE GUIDELINES (ONLY IF APPLICABLE)

Shady Grove Podiatry, LLC charges a fee for the completion of any form which requires medical information and/or a physician's signature. A fee will also apply for the release of medical records (to a patient or requesting party) unless being provided to another physician's office. Read the following carefully for the applicable fee(s):

- **Handicapped Parking Placard Form -** $5.00

- **Disability Paperwork** - $10 - $65 (Based on length and required detail)
- **FMLA (Family Medical Leave Act) Forms**: $40 - $65 (Based on length and required detail)
- **Personal Medical Records:** $0.76 per page (pages 1-20), $0.38 / page (pages 21-50) – patient must sign an authorization to release form, x-ray discs are not charged and must be picked up by the patient only.

- Pre-payment is required for our office to mail the forms. There will be an additional $.58 charge for postage and handling.
- If the doctor(s) feels it is necessary to obtain additional information from the patient to complete the form(s), the patient may be required to make an appointment. If this is the case, the office will directly contact you to set this up.
- Shady Grove Podiatry, LLC requires at least five (5) business days for the completion of any form(s). After this time, your form will be available for pick-up at the front desk—call our office to confirm it is completed and read for pickup. If it is completed sooner, we will contact you.
- If official copies of your medical records are required to complete any form(s), the Release of Information form must be completed—speak to a front desk associate if you need an ROI form.

By signing below, I acknowledge that I understand the fee schedules and guidelines stated above and that I will be responsible for the forms and/or release of records as requested by myself.

X _____

SIGNATURE OF PATIENT/ PARENT GUARDIAN **DATE**