Advance Foot & Ankle Associates Appt Date: _____

Dr. Gunasayan / Dr. Abernathy

Templeton: 1310 Las Tablas Rd, Ste. #205, Templeton, CA 93465 Phone 805.226.4060
San Luis Obispo: 862 Meinecke Ave., Ste. #204, S.L.O., CA 93405 Phone 805.540.5770

Patient Name: _____Gender: _____ Date of Birth: _____

How would you like the staff to address you?(nickname)_____

Address_____City_____State:_____ZipCode_____

Home Phone:_____ Cell Phone: _____ Work Phone:_____

Employer: _____ Employed ☐ Retired ☐ Student ☐

Message Choice(s): Voice ☐ Text ☐ Email ☐ Social Sec.# _____

Marital Status: S☐ M☐ D☐ W☐ Email:_____

Spouse/Parent Name: _____Date of Birth _____Social Sec.# _____

Emergency Contact:_____Relationship:_____Phone#_____

Name of Insured (if other than self) _____ Insured's DOB_____
Patient is: Spouse ☐ Child/Dependent ☐

Notice: We need a copy of your photo ID and current insurance card(s) on file in order to bill your insurance for you. If we do not have this information, you will be billed directly and are solely responsible for all charges. Payment is due at the time of service.

Primary Insurance: _____ Secondary Insurance: _____

Primary Care Physician: _____

Pharmacy: _____ Phone_____

Address_____

Notice: Release of Benefits- I authorize my insurance benefits to be paid directly to Advance Foot & Ankle Associates. I understand that the provider's office will bill my insurance as a courtesy and that I am responsible for all co-payments, deductible, and non-covered services. I authorize the release of information required to process my claims. (If not signed, payment for each visit is due at the time of service.)

ALL CO-PAYS AND PREVIOUS BALANCES ARE DUE ON THE DAY OF SERVICE.

Patient Signature: _____ Date: _____

Relationship to the patient if not self: _____

Dr. Gunasayan / Dr. Abernathy

Patient Medical History

Age: _____ **Weight:** _____ **Height:** _____**Shoe Size:** _____

What condition are you being seen for today? _____
How long have you had it? _____
What started it or makes it worse? _____
What treatment have you had for it? _____
Is this work related?_____

ALLERGIES (check all that apply & list reaction):

- ☐ Aspirin _____
- ☐ Codeine
- ☐ Iodine
- ☐ Metal
- ☐ Other -Antibiotics_____
- ☐ Penicillin
- ☐ Tape/Band Aids
- ☐ Sulfa
- ☐ Other: (Food, fabric, etc.)_____
- ☐ Anesthesia _____

Do you have a history of the following?
(check all that apply) or NONE ___

- ☐ Arthritis Location_____
  _____
- ☐ Asthma
- ☐ Cancer Location: _____

- ☐ Circulatory
- ☐ Diabetes - Type 1☐ Type2☐
- ☐ Eye Condition
- ☐ Fractures: Location_____

- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Problems_____
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Injuries: _____
- ☐ Paralysis
- ☐ Psychiatric History
- ☐ Rheumatic Fever
- ☐ Stomach or Bowel Problems
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Seizures
- ☐ Varicose Veins
- ☐ Other:_____

Current Conditions:
(check all that apply) or NONE ___

- ☐ Anemia
- ☐ Anxiety
- ☐ Back Pain
- ☐ Bleeding Problems
- ☐ Chest Pain
- ☐ Cough
- ☐ Currently Pregnant
- ☐ Depression
- ☐ Digestive Problems
- ☐ Fatigue
- ☐ Frequent Sore Throats
- ☐ Frequent thirst
- ☐ Frequent urination
- ☐ Headaches
- ☐ Hearing Problems
- ☐ Immune Problems
- ☐ Joint pain/stiffness
- ☐ Large weight changes

- ☐ Leg cramps
- ☐ Muscle weakness

- ☐ Neurological Problems
- ☐ Numbness
- ☐ Poor Healing

- ☐ Rash
- ☐ Shortness of Breath
- ☐ Sinus

Patient Medical History

Surgeries: List all previous surgeries and approximate dates:

_____

_____

_____

Other problems or conditions not previously listed

_____

_____

SOCIAL HISTORY:

Exercise, Sports or recreational activities _____ How Often Each Week _____
Alcohol Use: Never ☐ Social ☐ Mild ☐ Moderate ☐ Heavy ☐ Daily ☐ Quit ☐
Tobacco Use: Every day ☐ Sometimes ☐ Never ☐ Former ☐
Recreational/Street Drug Use: Never ☐ Rare ☐ Daily ☐

Family History:
Please list any diseases common to your family including heart disease, diabetes type 1 or type 2, rheumatoid arthritis, etc..
Father: _____
Mother: _____
Brothers: _____
Sisters: _____
No history ☐ or (adopted) ☐

Last Flu Vaccine _____ Last vaccine for Pneumonia _____

Medications: Please list **ALL.** **(check if list was provided to office ☐)**

Name	**Dosage**	**How often taken**	**Why?**

PATEINT ACKNOWLEDGEMENT OF USE/DISCLOSURE OR PROTECTED HEALTH INFORMATION

Patient Name: _____Birth Date: _____
Primary Phone Number_____ Email: _____

I understand that my health information is private and confidential. I understand that the practice of Advance Foot & Ankle Associates and staff work hard to protect my privacy and preserve the confidentiality of my health information.

The practice of Advance Foot & Ankle Associates has a detailed document called the "Notice of Privacy Practices." It contains more detailed information about how they may use and disclose patient health care information. I understand I have the legal right to read the "notice of Privacy Practices" before I sign this consent. The "practice" may update this "Notice of Privacy Practices." If I ask, I will be given a copy of the current "Notice of Privacy Practices."

I may cancel this consent in writing at any time by doing the following:

1. Signing and dating a form the "practice" staff will give me called "Revocation of Consent for Use and Disclosure of Healthcare Information.

OR

2. Writing, signing, and dating a letter to Advance Foot & Ankle Associates It must state, "I want to revoke my consent to authorize the use and disclosure of my health information for treatment, payment, and healthcare operations".

If I revoke this consent, Dr. Gunasayan / Dr. Abernathy does not have to provide any further health care services to me.

My signature below indicates that I have been given the chance to review a current copy of the "practice's" "Notice of privacy Practices." My signature means that I agree and consent to allow Advance Foot & Ankle Associates to use and disclose my protected health information to carry out treatment, payment, insurance claims, and healthcare operations including to my primary care/referring to other physicians & facilities.

Communicating with you is a necessary part of our continued care of your medical health. We may need to communicate with you for various reasons including but not limited to lab results, appointment reminders, billing questions, etc.

Please indicate any person that you give us permission to leave your health information with. If you would like to provide us with permission to give your health information to additional individuals please ask for our "Medical Information Release" form.

Name: _____Relation:_____
Name: _____ Relation: _____
Name: _____Relation: _____

NOTE: We cannot guarantee that cell phone calls and e-mails are confidential due to the nature of these lines of communication. If you choose to list your cell phone number/email, you do so knowing we cannot protect your confidentiality.

_____

Patient or Legally Authorized individual Signature Date

_____

Relationship to patient if signed by anyone other than the patient.

Financial Policy of Advance Foot & Ankle Associates

Thank you for choosing Dr. Gunasayan / Dr. Abernathy. We are committed to the highest standards and excellence in your treatment. The financial aspects of providing Health Care are complex and difficult both for patients and physicians. Therefore, we have instituted the following financial agreement in order to continue to meet our patients' expectations of the highest standards. Please review this binding document carefully and acknowledge agreement with your signature.

Please initial by each line item acknowledging you have read and understand our policies.

____ **PATIENTS ARE RESPONSIBLE FOR SERVICES RENDERED**

1. We accept cash, personal checks, Visa, MasterCard, and Discover.
2. **As a courtesy** we will file a claim to your primary insurance carrier: Current insurance cards and information are required by our office. **There is a $15.00 fee per date of service for rebilling your insurance if incorrect information is given.**

Our billing company will gladly file a claim with your PRIMARY INSURANCE CARRIER.

3. Your insurance is a contract between you and your health plan. It is your responsibility to know your health plan and its benefits. We will not become involved in disputes between you and your insurance company, other than to supply factual information when necessary.
4. We will allow 60 days from the date of service for your health plan to pay. **After that time the unpaid balance is your responsibility.**

_____**CO-PAYS, CO-INSURANCE AND DEDUCTIBLES**

1. Co-payments are a predetermined amount and will be collected on the date of service.
2. Co-insurance and deductibles may be calculated and payable on the date of service. Please contact your insurance carrier if you have any questions regarding your coverage.
3. If you are not prepared to pay the appropriate fees at the time of service your appointment may be rescheduled.
4. Due to the current high deductibles plans many insurances offer, our office will collect the estimated share of cost from the current fee schedule at the time of service.

_____**HMO**

1 Your insurance carrier requires that you obtain a referral from your Primary Care Physician (PCP) before receiving services.
2. Any services you receive without a referral or prior authorization will be your responsibility.

____**ORTHOTICS/DIABETIC SHOES**

1. **Full payment is required prior to ordering custom items such as orthotics and diabetic shoes when applicable.**

____ **SUPPLIES**

1. For the convenience of our patients we carry footcare items. These are self-pay items. They will not be billed to your insurance.

____**SURGERY PATIENTS**

1. We will verify coverage on surgery procedures for the patient's convenience. Please keep in mind surgical authorizations are for professional service of the doctor ONLY.
2. After verification, deductibles, co-pays and/or deposits will be collected when a patient consents to surgery.
3. **Due to the many changes within the insurance industry, we will collect the estimated charges prior to surgery. Payment may be made at the time of the Pre-Op appointment.**

_____**MINOR PATIENTS**

1. We require a minor patient to be accompanied by a parent or legal guardian.
2. The adult accompanying the minor patient is required to pay in accordance with our policies.
3. We **DO NOT** acknowledge or enforce the terms of a divorce decree or other civil settlements.

____**CANCELED / MISSED APPOINTMENT**

1. Patients who fail to keep their scheduled appointments **without giving 24 hours notice will be charged $25.00 for a missed visit.** *REMINDER CALLS / TEXT ARE A COURTESY, NOT A GUARANTEE.* **You are responsible for your appointment.**

_____**DELIQUENT ACCOUNTS**

1. Accounts past due are placed on a cash-only status. All balances must be paid in full at each visit.
2. A fee of $5.00 will be charged for each additional statement if your account is overdue.
3. Accounts are past due if not paid in full within 30 days of the statement date. Payment plans may be arranged in advance. Full payment is expected.
4. Patients with delinquent accounts that necessitate involvement of an outside collection agency may be discharged from the practice.
5. ***I understand my credit card on file will be charged if my account is 30 days past due. I understand that a receipt will be emailed or mailed to me.***

"A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable."

_____ **Cen-Cal / Medi-Cal**

This practice is not contracted with CenCal or Medi-Cal. Patients are required to pay the balance not paid by CenCal/Medi-Cal and may be asked to pay at the time of service.

_____ **NON-COVERED BENEFITS**

1. Occasionally patients request certain professional services that are not covered by health plans.
2. These services are billed at our current fee for service rate.

They include but are not limited to the following:

a. Completion of prior authorization forms for non-HMO plans $25.00 per auth
b. Disability forms (DMV, FMLA, EDD, or other employer requested forms) $25.00 per auth
c. Authorizations requiring doctor phone conversation $25.00 per request

**** As a courtesy our office will mail or fax applications or forms. We will not take responsibility for your forms after they leave our office. It is your responsibility to check with the recipient to insure receipt of forms. *****

+ I HAVE READ AND UNDERSTAND THIS BINDING FINANCIAL DOCUMENT AND AGREE TO ABIDE TO ITS TERMS,
+ I UNDERSTAND THAT CHARGES NOT COVERED BY MY HEALTH CARE PLAN, AS WELL AS ANY APPLICIABLE FEES, CO-PAYS, AND DEDUCTIBLES ARE MY RESPONSIBILITY. THIS BINDING DOCUMENT PRESIDED OVER ANY PAST OR CURRENT AGREEMENT BETWEEN ME AND MY HEALTH PLAN.
+ I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO Advance Foot & Ankle Associates, WHENEVER NECESSARY. I AUTHORIZE Advance Foot & Ankle Associates TO RELEASE PERTINENT MEDICAL INFORMATION TO MY INSURANCE COMPANY WHEN REQUESTED TO FACILITATE PAYMENT OF A CLAIM.
+ ALL QUESTIONS ABOUT THIS POLICY HAVE BEEN ANSWERED TO MY STATISFACTION.

PATIENT NAME (PLEASE PRINT)_____

_____

SIGNATURE (PATIENT OR RESPONSIBLE PARTY) **DATE**