Patient's Name (Last, First):_____

TUSTIN PODIATRY CLINIC

PATIENT INFORMATION

Name you prefer to be called (Mr. Smith, Mrs. Jones, Bob, etc):_____
Date of Birth:_____ Sex: ☐ M ☐ F
Patient's Address:_____
City, State, Zip:_____ E-mail address:_____
Home Phone Number:_____Cell Phone Number:_____
Social Security #:_____Driver's License #:_____
Occupation_____
How did you hear about our practice/ whom may we thank for referring you?
☐ Google ☐ Yelp ☐ Doctor_____ ☐ Existing Pt_____
☐ Other_____

SPOUSE/ PARENT/ GUARDIAN INFORMATION
Name (Last, First):_____ Date of Birth:_____
Phone Number:_____

EMERGENCY CONTACT (If Different from Guarantor)
Name_____Relationship:_____
Phone Number:_____

PHARMACY INFORMATION
Pharmacy Name_____Phone #:_____
Address:_____
City, State, Zip:_____

I hereby authorize Dr. Charles Baik and his associates to examine, photograph, administer treatment, and to perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot/ankle problem.

I assign the right to payment for all medical benefits directly to Dr. Charles Baik in consideration for medical services and supplies provided pursuant to my health insurance plan.

I give consent to Dr. Baik to release medical information to other healthcare providers for the purpose of treatment, when necessary for my care. I give consent to Dr. Baik to send medical information, as necessary to my insurance plan. I agree that a photo copy of this form may be used in lieu of the original.

I certify the patient information form is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Signature:_____ Date:_____
If Legal Representative, Relationship to Patient:_____

Patient's Name (Last, First)_____

TUSTIN PODIATRY CLINIC

PATIENT HEALTH HISTORY

Height: _____ Weight: _____

Briefly describe your foot/ankle problem _____
_____

If female, are you pregnant? ▫ Yes ▫ No If so, How many months? _____
Last menstrual period: _____

Family Doctor: Name_____ Phone #_____

Review of Systems (Please check if any of the following currently exist):

Constitutional:	O Chills	O Fever	O Weight loss
Head:	O Dizziness	O Headaches	O Fainting
Musculoskeletal:	O Arthritis	O Gout	O Muscle cramps

Allergies: O None, O Penicillins, O Sulfa, O Local Anesthetics, O Codeine,
O Aspirin, O Adhesive Tapes, O Iodine, O Other: _____

Medications: Are you taking any (Prescription, Birth Control Pills, or Over-the-Counter)? If yes, what are they? (Please include dosage and strength if known)

_____
_____
Do you give us permission to access your medication history electronically?
O Yes O No

Medical History: *Please check if any of the following problems exist or have occurred in the past*

O Diabetes – Type I	O Osteoarthritis	O Stomach Ulcers
O Diabetes – Type II	O Rheumatoid Arthritis	O Foot Ulcers
O Rheumatic Fever	O High Blood Pressure	O Tuberculosis
O Stroke	O Gout	O Collagen/Vasc. Disease
O Kidney Disease	O Heart Trouble	O Epilepsy
O Liver Disease	O Heart Murmur	O Ankle Sprains
O Asthma	O Varicose Veins	O Infections
O Hepatitis	O Sickle Cell Anemia	O Cancer _____Remission?___
O AIDS or HIV exposure	O Bleeding problems	O Low Back Pain
O Lymphedema	O Anemia	O Leg Cramps
O Thyroid Disease	O Phlebitis	O Numbness to Feet/Legs
		O Other_____

Family History:
Father: Positive history for:_____ ▯ Alive ▯ Deceased

Mother: Positive history for: _____ ▯ Alive ▯ Deceased

Social History:
O Current Smoker O Former Smoker?
If YES to either, how many Cigarettes per day?_____For how long?_____YRS/MO
O Alcohol? If so, how many drinks per day?_____

Surgical History:

_____

CHARLES BAIK, DPM

NOTICE OF PRIVACY PRACTICES

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 **April 14, 2003**, 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 the 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 us at our office.

Uses and Disclosures of Protected Health Information

We may 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 may use and disclose your protected health information to provide, coordinate or manage your healthcare and any related services. This includes the coordination or 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 also disclose protected health information to other physicians who may be treating you. For example, 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.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. THese activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk, where you will be asked to sign your name. We may also call you by your name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your protected health information with third party “business associates" that perform various activities (e.g., laboratory) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. For example, your name and address will be used to send you a newsletter about our practice and other services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact us to request that these materials be sent to you.

Uses and Disclosures Based On Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person’s involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

Marketing: We may use your protected health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further such information by telling us at our office.

Research; Death; Organ Donation: We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Required by Law: We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

Process and Proceedings: We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

Law Enforcement: We may disclose limited information to law enforcement officials concerning the protected health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Patient Rights

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to your doctor to obtain access to your protected health information. You may also request access by sending us a letter to the office. We will charge fpr postages if you want copies mailed to you.

Accounting of disclosure: You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes other than treatment, payment, healthcare operations and certain other activities after April 14, 20003. After April 14, 2009, the accounting will be provided for the past six (6) years. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us at our office for a full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential communication: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation, You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of that information.

Questions & Complaints

If you want information about our privacy practices or have questions or concerts, please contact us at our office by mail, telephone or fax.

If you believe that we have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us by completing our Patient Complaint form. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

I acknowledge that I received this Notice of Privacy Practices, and have read (or had the opportunity to read if I so choose) and understood the Notice.

_____ _____

Patient Name (please print) Parent or Authorized Representative (if applicable)

_____ _____

Signature Date

TUSTIN PODIATRY CLINIC

FINANCIAL POLICY

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. ***Please read each section carefully.*** If you have any questions, do not hesitate to ask a member of our staff.

Financial Responsibility

1) According to your insurance plan, you are responsible for ***any and all*** **co-payments**, **deductibles**, and **coinsurances**.
2) We will bill your insurance company as a courtesy to you. **All co-payments are due at the time of your visit**.
3) Self-pay patients are expected to pay for services in FULL at the time of the visit.
4) Patient balances are billed on receipt of your insurance plan's explanation of benefits. Your remittance is due within **10** business days of your receipt of your bill. **Balances must be paid in full by your next office visit or the office visit may be cancelled.**
5) If previous arrangements have *not* been made with our finance office, any account balance **outstanding longer than 90 days** will be forwarded to a collection agency and a **35% fee of the balance due will be added** to cover collection costs.
6) We accept cash, checks, Visa, MasterCard, and "Care Credit".
7) A $25 fee will be charged for any checks returned for insufficient funds.
8) A 24-hour notice is requested for cancellations of appointments. If you fail to show for an appointment you personally may be charged a $25 no-show fee. We will try to accommodate you in rescheduling your appointment as soon as possible.

Please call if you have a question about your bill. Most problems can be settled quickly and easily, and your call will prevent any misunderstandings. If you are having trouble paying your bill, please discuss the situation with us. Satisfactory arrangements can almost always be made. We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact our office promptly for payment arrangements & assistance in the management of your account.

The Financial Agreement

We must emphasize that as a provider, our relationship is with you, not your insurance company. While the verification of insurance benefits and submission of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility if payment from insurance companies is not received due to either inaccurate/ untimely information or from failure of insurance companies to pay for covered services that were previously verified by our office staff.

Termination Policy

While we will do our best to deliver the best healthcare with respect, we do not tolerate any type of **physical or verbal abuse** to our staff which is **grounds for immediate termination** of our relationship with you.

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s)_____

Responsible Party Member's Name_____**Relationship**_____

Responsible Party Member's Signature _____**Date** _____

Patient's name: _____
Date: _____ **Temperature:** _____ **(taken by):**_____

Tustin Podiatry Clinic
Patient Acknowledgement to Receive Treatment during COVID-19

While our office complies with Federal, State Health Department, and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees about your health and safety.

I hereby acknowledge and understand that there may be an increased risk that COVID-19 may be transmitted in any place of public accommodation, which includes my physician's office. I have been informed by my physician of their desire to protect their patients, staff and the community at large.

To the best of our knowledge, Tustin Podiatry Clinic staff are symptom-free and, to the best of their knowledge, and are not contagious for the virus. However, since we are a place of healthcare services, other persons (including other patients) could be infected, with or without their knowledge.

As a prerequisite to receiving care/treatment, we are asking out patients and their accompanying party(s) to complete the screening attestation form below.

Attestation: Circle if you are: **Patient or Accompanying Party**
Each complete their own Attestation

1. Have you previously been diagnosed with COVID-19, or do you think you've had/have COVID-19?

   YES ☐ NO ☐

2. Do you currently have (or have you experienced) any of the following symptoms in the past 14 days? Fever, Cough, Difficulty Breathing, Runny Nose, Sore Throat, Loss of taste/ sense of smell?

   YES ☐ NO ☐

3. Have you been in **close contact** with anyone who had a positive test for COVID-19 or suspected to be positive in the past 14 days?

   YES ☐ NO ☐

If yes, to any of the above questions, please explain: _____
_____

(You will be asked the previous questions on every office visit to ensure safety of all others)

I have been practicing all current CDC guidelines with respect to "social distancing"

Accompanying Party name: _____ **Accompanying Party signature:** _____

Date: _____

I hereby consent to the treatment proposed by my physician.

Patient's name: _____ **Patient's signature:** _____

Date: _____

Physician's name: _____ **Physician's signature:** _____

Date: _____

If you develop any symptoms of COVID-19 within next 14 days, please inform our office ASAP.