ALOHA FOOT & ANKLE ASSOCIATES, INC
AN INSTITUTE FOR RECONSTRUCTIVE SURGERY OF THE FOOT AND ANKLE
www.alohafootandankle.com

Today's date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	❑Male ❑ Female
Home Phone:	Cell Phone:		Work Phone:		
Street:	City:		State:	Zip Code:	
Social Security #:	E-Mail:	Age:	Date of Birth: / /		Marital Status :
Employer:		Phone #:			Ext:
Street:	City:		State:	Zip Code:	
Occupation:		May we call you at work? ❑ Yes ❑ No			

INSURANCE INFORMATION

Primary Insurance:	Phone #:		Group #:
Street:	City:	State:	Zip Code:
Insured's Name:	Insured's Date of Birth: / /	Insured's ID#:	Copay $(Required at each visit)
Secondary Insurance:	Phone #:		Group #:
Street:	City:	State:	Zip Code:
Insured's Name:	Insured's Date of Birth: / /	Insured's ID#:	Copay $(Required at each visit)

CONTACT INFORMATION

Emergency Contact:	Phone #:	Relationship:
Referred By First and Last Name:	Relationship:	
Primary Care Physician First and Last Name	Phone #:	
Primary Pharmacy	Phone #:	City

Please bring Insurance card and a Government ID as we will need to make copies for your file.

Please read and sign below: I directly assign all medical and surgical benefits to Aloha Foot and Ankle Associates, INC. I understand that I am financially responsible for all charges whether paid by my insurance provider or not. I authorize Aloha Foot and Ankle Associates to release all my information necessary to secure the payment and benefits. I understand that fees for this service and insurance copays are payable at the time of service, unless other arrangements are made in advance. It is my responsibility to pay any deductable amount or coinsurance. It is the policy of this office to bill your insurance for reimbursement. However, we shall allow no more than thirty (30) day for payment. After thirty (30) days you will be billed for any outstanding balance on your account. All outstanding balances are due upon receipt.

I HEREBY GIVE AUTHORIZATION FOR TREATMENT:

Signature: _____ Date: _____

HISTORY AND MEDICAL INFORMATION

Explain your foot/ankle problem: ❑ Left ❑ Right ❑ Both

When did the problem begin? (date)	Describe any accident/event:	Is this problem work related? ❑ Yes ❑ No

Pain Scale (circle) 1 2 3 4 5 6 7 8 9 10	Quality of pain: ❑ Dull ❑ Sharp ❑ Radiating ❑ Burning ❑ Aching ❑ Cramping ❑ Continuous ❑ Intermittent

List of all medication/herbs/vitamins: ❑ None

Allergies: (describe reactions) ❑ none	

If you have had prior treatment, please bring all imaging films to your first appointment, and if you have prior surgical failure, or post-traumatic deformity, please bring pertinent medical records or discharge summaries.

	Date Taken	Previous Treatments? (Including Self Care & Surgery)		
Previous X-Rays? ❑ Yes ❑ No		❑ Steroid Injection	How Many?	Date of last injection
Previous CT Scan? ❑ Yes ❑ No		❑ Anti-Inflammatory/Pain Pills		Name of Medication:
Previous MRI? ❑ Yes ❑ No		❑ Custom Orthotics ❑ OTC Inserts		Are you currently using them? ❑ Yes ❑ No
Previous Labs? ❑ Yes ❑ No		❑ Cast or Immobilization		For how long?
		❑ Surgery	Date:	What Type?

PAST MEDICAL AND FAMILY HISTORY

	Self	Family		Self	Family		Self	Family
Anemia	❑	❑	High Blood Pressure	❑	❑	Pacemaker	❑	❑
Anesthetic Reaction	❑	❑	HIV/AIDS	❑	❑	Phlebitis	❑	❑
Arthritis	❑	❑	Injury Trauma	❑	❑	Psychiatric Problems	❑	❑
Asthma	❑	❑	Kidney Disease	❑	❑	Pulmonary Disease	❑	❑
Bleeding Disorders	❑	❑	Liver Disease	❑	❑	Rheumatic Disease	❑	❑
Cancer	❑	❑	Mitral Valve Prolapse	❑	❑	Skin Problems	❑	❑
Circulation Problems	❑	❑	MRSA	❑	❑	Sleep Apnea	❑	❑
Diabetes	❑	❑	Multiple Sclerosis	❑	❑	Stomach Problems	❑	❑
Gout	❑	❑	Nail Disorders	❑	❑	Stroke	❑	❑
Heart Disease	❑	❑	Neurological Disorders	❑	❑	Varicose Veins	❑	❑
Hepatitis	❑	❑	Osteoporosis	❑	❑	Other		

Have you had surgery? ❑ Yes ❑ No (If yes, please describe)

OTHER HISTORY

Have you ever been treated for any of the following? If yes, please describe

❑ Ankle Problems	❑ Glaucoma	❑ Neuroma
❑ Arch Pain	❑ Hammertoes	❑ Rash
❑ Broken Bones	❑ Heel Pain	❑ Ulcers
❑ Bunions	❑ Ingrown Nails	❑ Other
❑ Calluses/Corns	❑ Knee Pain	
❑ Flat Feet	❑ Low Back Pain	

Social History

Alcohol Use ❑	Recreational Drug Use ❑	Caffeine use ❑

Do you smoke? ❑ Yes ❑ No	Pack/Day:	Years:	Do you have a History of Smoking? ❑ Yes ❑ No	How many Years?

List any sports/activities you participate in:

Are you currently pregnant or nursing? ❑ Yes ❑ No

Shoe Size:	Height:	Weight:	Blood Pressure:

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NOTICE OF PRIVACY PRACTICES, ACKNOWLEDGEMENT AND CONSENT

We understand that medical information about you and your health is personal. As custodians of the information in your medical record, we are committed to protecting the privacy of your information as required by law, professional accreditation standards and our internal policies and procedures.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") requires that all medical records and other individually identifiable health information used or disclosed by this organization be kept properly confidential. The patient has the right to understand and control how their health information is used or disclosed. We may use and disclose patient medical records only for the following purposes:

❑Treatment: providing, coordinating, or managing health care and related services by one or more health care providers.
❑Payment: activities related to obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. (e.g., billing insurance provider for patient visit)
❑Health care operations: conducting quality assessment and improvement activities, auditing functions, cost-management analysis, customer services and as required by law.
❑ We may create and distribute non-identified health information by removing all references to individually identifiable information.
❑ We may contact patients to provide appointment reminders, information about treatment alternatives or other health-related benefits and services.
❑ Any other uses and disclosures may be made only with patient's written authorization.
❑ We have the right to change our Privacy Practices from time to time. Patients may request a current copy by writing to 26732 Crown Valley Parkway, Suite 317 Mission Viejo, CA 92691.

Patients have the following rights with respect to their protected health information. Patients may exercise these rights by submitting a written request to the address indicated above, attention Privacy officer:

❑ The right to request restriction on certain uses and disclosures of protected health information, including those related to family members, other relatives, close personal friends, or any other person identified by patient.
❑ The right to reasonable requests to receive confidential communications of protects health information from this organization by alternative means or locations.
❑ The right to inspect and copy protected health information.
❑ The right to amend protected health information.
❑ The right to receive an accounting of disclosures of protected health information.
❑ The right to request a paper copy of this notice.

I hereby acknowledge the receipt of the Notice of Privacy Practices. A personal copy of the Privacy Practices will be available per my request.

_____ _____

Patient or Guardian Date

I authorize the release of my patient health information to the following personal contacts (Spouse, Child, etc). I understand it is my responsibility to notify Aloha Foot and Ankle Associates, Inc., of any changes in the information below.

_____

Name Relationship

_____

Name Relationship

ALOHA FOOT & ANKLE ASSOCIATES INC
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Personal message from Dr. Cachia, President and Founder of Aloha Foot and Ankle Associates

It is our goal and mission that you receive the best care possible, and that your care is personalized to meet your specific needs. We treat all problems of the foot and ankle, from simple toenail problems to major reconstructive surgery, treatment of fractures, broken bones and acute tendon ruptures. We specialize in bunion surgery, flat -foot surgery, sports injuries, performance enhancement, ankle fractures, wound management and limb preservation. We utilize the most appropriate technology and equipment, and practice in state-of-the-art facilities. We do our best to assure that every patient is given the personalized care that they deserve.

It is our hope that we will meet your expectations and that you will be eager to refer your friends and family. We want you to feel like family, and leave with your foot and ankle conditions resolved. Thank you for placing your trust in us. We look forward to serving the needs of you, your friends and family.

Sincerely,

Victor V. Cachia, DPM

Aloha Foot and Ankle Associates Office Polices

Prior to your appointment

- Please complete the New Patient paperwork. Be sure to read the Financial Policy and Notice of Privacy Practices prior to completing the acknowledgement. Please gather any pertinent medical records, imaging studies, X-rays, and lab work and bring them with you.
- You will receive a phone call two days prior to your appointment time. If for any reason, you are unable to keep your confirmed appointment, please call our office (949) 364-2525 to re-schedule your visit to suit your needs. Our telephone hours are 9:00am-5:00pm Monday-Thursday and 9:00-4:30pm Friday. As a result of high demands on the appointment schedule, we ask that you give us a 24-hour notice if you cannot keep your appointment. This allows the office to give that time to other patients with urgent needs. Patients who miss appointments without calling at least 24 hours in advance may be charged a $50 fee that is exclusive to any insurance including Workers Compensation.

The day of your appointment

- There are additional steps to the registration process that must be completed at the office on your first visit, so please be sure to arrive at least 15 minutes early with your completed paperwork so that you can make your appointment time. Please gather any pertinent medical records, imaging studies, X-rays, and lab work and bring them with you.
- Remember to bring your insurance card(s) and photo identification.
- Please bring means for satisfying the co-payment required by your insurance company or un-met deductable.

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Thank you for choosing Aloha Foot and Ankle Associates, Inc. as your health care provider. We are committed to providing you with the highest quality medical and surgical care. Your clear understanding of our patient financial policy is important to our professional relationship. Please understand that payment for services is a part of this relationship.

We accept many different insurance plans, however all health plans are not the same and do not cover the same services.

1. Insurance. We participate in most insurance plans, including Medicare. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. It is the responsibility of each patient to know their contract limitations. Please contact your insurance company with any questions you may have regarding your coverage.

2. Referrals. If your insurance company requires a written referral prior to your visit, it is the patient/guardian responsibility to obtain that referral (or have it sent to our office) prior to making an appointment at Aloha Foot and Ankle Associates, Inc. Denials from your insurance company based on lack of appropriate referral will be billed directly to the patient/responsible party.

3. Co-payments and deductibles. All co-payments and past due balances are due at the time of check-in unless previous arrangements have been made. We accept cash, money order, check or credit card. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

4. Non-covered services. Please be aware that some - and perhaps all - of the services you receive may be uncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

5. Claims submission. As a courtesy to our patients, we will submit insurance claims and assist in any reasonable way we can to get claims promptly paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

6. Worker's Compensation. In the case of a worker's compensation injury, you must obtain the claim number, phone number, contact person, authorization, prior medical records, studies and the name and address of the insurance carrier prior to your visit.

7. Self-pay Accounts. Self pay accounts are patients without insurance coverage or patients covered by insurance plans in which the office does not participate. It is always the patient's responsibility to know if our office is participating with their plan. It is never our intension to cause hardship to our patients, only to provide them with the best care possible.

8. Usual and Customary Rates. We are committed to provide the best treatments possible for our patients. Our fees for services rendered are usual and customary for our geographic area.

9. Durable Medical Equipment. Aloha Foot and Ankle Associates, Inc., provides Durable Medical Equipment (DME) as ordered by your physician. Your insurance will be billed in accordance to your insurance coverage guidelines; however, you will be responsible to pay for any unpaid balances and coinsurance amounts. Some DME products are not covered by insurance, in which case, you will be notified of the item and its cost. For better understanding of your DME coverage, contact your insurance provider. DME is intended for single patient only, and for this reason, DME is not subject to return.

10. Missed Appointments. We require 24-hour notice of appointment cancellation. Appointments missed that are not properly canceled may be charged a fee of $50.00 that is exclusive to any insurance including worker's compensation. If you are scheduled for surgery, please notify our office no later than one week prior to your procedure if you need to cancel or reschedule. If you do not give proper notification, a $500.00 charge may be applied to your account.

11. Returned Checks. The charge for a returned check is $25 payable by cash or money order. This will be applied to your account in addition to any insufficient charges.

12. Medical Record Copies. Patients requesting copies of medical records will be charged a $15.00 fee. Copying of digital images is subject to an additional fee of $10.00. Please allow up to 5 business days for records to be compiled.

13. Disability, Insurance Forms, FMLA. There will be a charge of $25.00 for the completion of medical forms. Payment is due at the time that you drop off the forms. Please allow 5 business days for the completion of these forms.

14. Outstanding balance Policy. It is our office policy that all past due accounts to be sent two statements and 5 written letters. If no resolution can be made, accounts may be sent a collection agency. In the event an account is turned over for collections, the person financially responsible may be billed for all collection costs and past due balances.

Thank you for understanding our payment policy. If you have any questions or need clarification of any of the above policies, please feel free to contact us.

I have read, understand and accept all responsibilities associated with this financial policy:

_____ _____

Signature of patient or responsible party Date