Podiatry Hotline Inc.
Thomas Rambacher, D.P.M.

26302 La Paz Rd Suite #101
Mission Viejo, CA. 92691
949-916-0077

Patient Information Form

Please Print

Date: ____________

☐ Male ☐ Female

First Name: ___________________ Last Name: ______________________

Date of Birth: ________________ Age: _____

Parent or Guardian (If patient is a minor): ______________________________

E-mail (Required): ______________________________

Address: ___________________________ APT: ______

City: ______________ State: ______ Zip Code: ___________

Home Phone: ____________________

Work: ______________________

Cell: ______________________

Social Sec.#: ______________________

Employer: ______________________

Primary Language: _____________ Ethnicity: ___________

Emergency Contact: ___________________ Relationship: _______________

Phone: _____________________

Medical History

Reason for Visit: ____

Previous foot, ankle, or leg injuries/surgeries: ____________________________________

____

Please indicate which foot problems you now have:

Cramps/ Numbness in feet or legs ____ Athlete's Foot _____Bunions _____ Corns & Calluses ____

Ankl Pain _____ Flat Feet _____ Foot or leg cramps _____ Heel Pain _____ Ingrown Toenails _____

Plantar's Warts _____Tired Feet ______Swelling _____

Please list any other non foot or ankle related surgeries or operations:

____

Anything else Dr. Rambacher should be aware of:

____

Height: _____ Ft: _____ Inches Weight: __________ LBS. Shoe Size: ___________

Have you ever been to a podiatrist before? Yes ☐ No ☐

Name: ______________________________

Last Seen: ___________________

Pharmacy Name: ______________________________ Phone: ______________________

Have you had or ever been treated for the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Heart Attack	☐	☐	Diabetes	☐	☐	Pneumonia
☐	☐	Gout	☐	☐	Stents in legs	☐	☐	Varicose Veins
☐	☐	AIDS or Related	☐	☐	Poor Circulation	☐	☐	Heart Problems
☐	☐	Blood Clots	☐	☐	Back Pain	☐	☐	Kidney Problems
☐	☐	High Blood Pressure	☐	☐	Foot Injury	☐	☐	Stomach Ulcers/Reflux
☐	☐	Knee/Ankle Injury	☐	☐	Bleeding Tendency	☐	☐	Thyroid Disorder
☐	☐	Alcholism	☐	☐	Asthma	☐	☐	Peripheral Neuropathy
						☐	☐	Arthiritis

Is there any pertinent family history our office should know about? ______________________

____

Do you wear orthotics? Yes ☐ No ☐

Current Medications:

____

____

Allergies to Medications:

☐None ☐Penicillin ☐Codeine ☐Cortisone ☐Anesthetics ☐Vicodin ☐Demerol ☐Aspirin

☐Iodine ☐ Other:_______________________________________

Do you smoke? Yes ☐ No ☐ Never ☐ If yes, how many packs a day and years smoked?

____

How often do you have a drink with alcohol? What type of alcohol?

____

How many hours/days are you on your feet? _________________________________

What are your other frequent activities that require you to be on your feet?

☐Sports ☐Exercise ☐ Walking ☐ Travel ☐ Work

Please list activities in which you participate: ______________________________________

____

Primary Care Physician:____

Date Last Seen:___________________ Address:____

Phone:_________________________

Whom may we thank for referring you?

☐Doctor ______________________ Address _______________________________________

City _________________ ZIP ________________

☐Patient/Friend (Name) ______________________ ☐ PPO Ins Directory ☐ Yellow Pages

☐Internet Search (Specify):☐ Google ☐ Yahoo ☐Facebook ☐ Other: ______________________

Met Dr. Rambacher at (Specify):____

☐ Other:____

Permission To Treat

I, __________________ hereby give permission to Dr. Rambacher to examine, to photograph, to 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.

Signature (Patient or Guardian): ____________________________________ Date: __________

Financial Policy / Assignment of Benefits & Payments

It is always good policy to understand and agree with the financial policy of an office. We appreciate having you as our patient and strive to provide you with the best care possible. Misunderstandings regarding insurance coverage and financial policy make it uncomfortable for everyone. If you ever have any questions or wish to discuss your account with us, please do not hesitate. Your signature indicates your understanding and agreement to the following policies:

Assignment of Benefits and Payments

I authorize payment for services rendered to me or my dependents to be paid directly to Thomas Rambacher, D.P.M. from my insurance company, my attorney, or any other party who may become obligated to pay Dr. Rambacher any sums. I further authorize the endorsement of my name to any draft containing my name to which Dr. Rambacher is legally entitled.

Pre- Authorization by your insurance company:

If my insurance plan requires a pre-authorization from my primary physician, I, as the insured party, am responsible for obtaining the pre-certification number prior to my appointment. If this has not been done, I will be asked to pay for my visit or will be asked to reschedule my appointment until this information is obtained. Of course, I have a right to pay for medical services that are not determined to be coverable by my insurance company.

In-Network:

I realize I am responsible for determining if Dr. Rambacher is in-network with my insurance plan. I have called or gone online to see if Dr. Rambacher is in-network. If Dr. Rambacher is not in-network, I am responsible for out of network benefits or uncovered fees.

Referrals:

If my insurance plan is an HMO and/or requires a referral to see Dr. Rambacher, I realize I am responsible in obtaining the referral from my primary care physician. If service is given without referral, I realize I am responsible for the fee.

Financial Responsibility:

Commercial insurance is filed as a courtesy to the patient, and managed care insurance is filed with the contracted carrier. I understand that I will be held financially responsible for any balances incurred in this office as well as for any charges that are not paid by my insurance company, including, but not limited to, co-pays, deductibles, co-insurance and services or charges not paid by insurance for any reason, after consideration of contractual adjustments.

Outstanding Balances:

In the event that my account goes into default and your office turns it over to an outside collections agency/attorney for collections, it is accepted and agreed that thirty percent (30%) of the principal amount of the balance is due will be added as collection/attorney fees. It is also agreed and accepted that in the event that a lawsuit is filed, I will be liable for any and all court costs expended whether judgement has been entered or not.

Non-Sufficient Funds or Closed Accounts:

For this, there will be a **$30.00 service charge.** I realize that your bank charges you for my NSF check and my bank will charge you for the check as well. I will let you know if I need to make payments over time. I understand that your office will definitely make arrangements with me.

Missed Appointment Charges:

Missed appointments mean that not only were my feet not treated but someone else could have been seen and helped. If I fail to cancel an appointment at least 24 hours prior to my appointment, or if I miss the appointment completely, **I understand there will be a $25.00 charge.** I understand the payment for this charge will be collected at the time of my next appointment, unless I pay the amount beforehand.

Medicare Authorization:

I request that payment of authorized Medicare benefits be made either to me or my on my behalf to Dr. Rambacher for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductibles are based upon the charge determination of the Medicare carrier.

Authorization To Release Information:

I authorize Thomas Rambacher, D.P.M. to release any information regarding the medical history and treatment including disability related information to any third-party payer (including Medicare), or their contracted agents, to validate or determine benefits payable for services rendered to myself or any dependents.

Signature: ______________________________ Date: ____________

Dr Thomas Rambacher / Podiatry Hotline Inc.

Notice Of Privacy Practices

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information.

Please review this notice carefully.

Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called *protected* health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If you have questions about this Notice, please contact:
Dr Thomas Rambacher or Podiatry Hotline Inc.
C. We may use and disclose your PHI in the following ways:
The following categories describe the different ways in which we may use and disclose your PHI.
1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.
2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.
3. Health care operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.
4. Appointment reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.
5. Disclosures required by law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

Your rights regarding your PHI:
You have the following rights regarding the PHI that we maintain about you:

1. Confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at

home, rather than work. In order to request a type of confidential communication, you must make a written request to Dr Thomas Rambacher or Podiatry Hotline Inc. specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to Dr Thomas Rambacher or Podiatry Hotline Inc. Your request must describe in a clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,
- To whom you want the limits to apply.

3. Inspection and copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Dr Thomas Rambacher or Podiatry Hotline Inc. in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Dr Thomas Rambacher or Podiatry Hotline Inc. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Right to a paper copy of this notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Dr Thomas Rambacher or Podiatry Hotline Inc.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Dr Thomas Rambacher or Podiatry Hotline Inc. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time *in writing*. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. *Please note:* we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact Dr Thomas Rambacher or Podiatry Hotline Inc.

I hereby acknowledge that I have been given the right to review this organization's Privacy Practices and give my consent to use my protected health information under the conditions provided.

Patient Signature : ______________________________ Date: ______________
Patient (Guardian)