


ADVANCED FOOT CARE CENTER
301 S FAIR OAKS AVE #207, PASADENA, CA 91105

DATE _____

LAST NAME:	FIRST NAME :	MI:	SEX
------------	--------------	-----	-----

ADDRESS	CITY	STATE	ZIP
---------	------	-------	-----

PRIMARY PHONE NUMBER:	CELL PHONE:	EMAIL ADDRESS:
-----------------------	-------------	----------------

DATE OF BIRTH:	AGE:	SOCIAL SECURITY NUMBER:	MARITAL STATUS:
----------------	------	-------------------------	-----------------

EMPLOYER (IF MINOR, PUT PARENT/PERSON RESPONSIBLE)	OCCUPATION:
----------------------------------------------------	-------------

ADDRESS:	CITY:	STATE:	ZIP
----------	-------	--------	-----

PRIMARY CARE DOCTOR:	ADDRESS:	PHONE NUMBER
----------------------	----------	--------------

WHO WERE YOU REFERRED BY? _____

(IF OTHER THAN PRIMARY DOCTOR) RELATIONSHIP	PHONE NUMBER
---------------------------------------------	--------------

PREFERRED PHARMACY _____

ADDRESS OR CROSS STREETS PHONE NUMBER _____

WHO DO WE CONTACT IN CASE OF AN EMERGENCY? _____

RELATIONSHIP PHONE NUMBER _____

PRIMARY INSURANCE: _____

INSURED'S NAME & DATE OF BIRTH _____

ID/GROUP NUMBER _____

SECONDARY INSURANCE: _____

ID/GROUP NUMBER : _____

I hereby instruct and direct that _____ Insurance company to pay by check made out and mailed to:
 Morse Upshaw, DPM/Ibrahim Akkari, DPM/Steve Tung, DPM at 301 S Fair Oaks Ave #207, Pasadena, CA 91105

If my current policy prohibits direct payment to my doctor, then I hereby also instruct and direct you to make out the check to me and mail it to the above address.

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I understand that I am financially responsible for payment of services rendered. My insurance company is responsible to me, not to the physician.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Signature of patient/policy holder: _____ **Signature of witness:** _____

Patient Name: _____ DOB: _____ Date: _____

PLEASE DESCRIBE YOUR CURRENT FOOT PROBLEM

Please check all that apply

Cardiovascular:

- Ankle swelling
- Calf cramping
- Change in color/temp legs
- Chest pain or tightness
- Shortness of breath

Endocrine:

- Cuts take longer to heal
- Excessive urination
- High blood sugar
- Low blood sugar
- Unusual fatigue

Musculoskeletal:

- Back pain
- Decreased range
- Heel pain
- Joint pain
- Morning stiffness
- Weakness

Surgery/Hospitalizations: _____

Medical conditions: _____

Medications (prescription and over the counter, including dosage): _____

Family health history: _____

Allergies: (circle) Penicillin Aspirin Iodine Tape Sulfa Codeine Shellfish Latex IVP Dye

Other _____ No known drug allergies

Do you smoke: Yes No Packs per day: _____ How many years: _____ Alcohol: Yes No How many per day _____

Illicit Drug Use: Yes No

MEDICAL INFORMATION RELEASE FORM

(HIPAA RELEASE FORM)

Patient's name: _____ DOB: _____

RELEASE OF INFORMATION

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Spouse _____

Child(ren) _____

Other _____

Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

MESSAGES

Please call my home my work my cell number: _____

If unable to reach me:

you may leave a detailed message

please leave a message asking me to return your call

Signed: _____ Date: _____

Witness: _____ Date: _____

Advanced Foot Care Center

Missed Appointment / Late Cancellation Policy

Dear Valued Patient,

At Advanced Foot Care Center, we are committed to providing timely and quality care to all of our patients. Due to the high volume of appointments and an increasing number of missed or last-minute cancellations, we are implementing the following policy:

Effective immediately, a \$50 fee will be charged for any missed appointments or cancellations made less than 24 hours in advance.

This policy is necessary to ensure availability for other patients in need of care and to maintain the efficiency of our scheduling system. We appreciate your understanding and cooperation.

Please acknowledge this policy by signing below.

Patient Acknowledgement

I have read and understand the above policy. I agree to notify Advanced Foot Care Center at least 24 hours in advance if I need to cancel or reschedule my appointment to avoid a \$50 charge.

Patient Name (Print): _____ Date: _____

Signature: _____

Thank you for your cooperation.