

**FOOT AND ANKLE INSTITUTE**  
**OF THE WEST**  
A Podiatry Corporation

Welcome to our office

We are very pleased to offer you a **COMPLIMENTARY** foot and ankle examination.

This examination provides an initial assessment of your foot/ankle problem.

Should your doctor recommend a diagnostic test or treatment, our regular office fees will apply. Please note that our complimentary examination ***does not*** apply to patients referred by another physician for a second opinion.

Studio City  
12660 Riverside Drive  
Suite 305  
Studio City, CA 91607  
(818) 623-4455

Victorville  
14400 Bear Valley Road, Suite 201  
The Mall of Victor Valley  
Victorville, CA 92392  
(760) 951-2000

Irvine  
18952 MacArthur Blvd  
Suite 102  
Irvine, CA 92612  
(949) 833-3406

Agoura Hills  
29525 Canwood St.  
Suite 302  
Agoura Hills, CA 91301  
(818) 623-5333

Please feel free to ask any questions concerning our office policies.

***I acknowledge that the complimentary examination policy has been explained to me and that I understand that I will be charged for any tests or treatment of my condition beyond the initial examination.***

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date



# HEALTH QUESTIONNAIRE

NAME \_\_\_\_\_ AGE \_\_\_\_\_ HT. \_\_\_\_\_ WT \_\_\_\_\_ DATE \_\_\_\_\_

Allergies to Medications:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List all medications you now take:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

All other allergies:

\_\_\_\_\_  
 \_\_\_\_\_

List all medications you have taken in the past year:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List all major medical illnesses you have had:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List all Operations you have had:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Type of Anesthesia:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Approximate Date of Operation:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list any current medical problems/illnesses you have:

\_\_\_\_\_

	NO	YES	COMMENTS
1. Have you ever had a problem with anesthesia?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Has anyone related to you ever had a problem with anesthesia?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Could you be pregnant?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Date of last menstrual cycle if applicable.			_____
5. Do you smoke? If so, how many packs per day? .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Do you have a cough? .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Do you bring anything up when you cough?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Have you had asthma?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Do you have a cold?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Do you get short of breath after walking up two flights of stairs?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Have you had any difficulties with breathing?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Do you have any bleeding tendencies?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. Have you ever been anemic?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
13. Do you have a heart murmur?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
14. Have you ever had a heart attack?..... Year? _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

No Yes Comments

- 16. Have you ever had high blood pressure?.....   \_\_\_\_\_
- 17. Do you ever wake up short of breath at night?.....   \_\_\_\_\_
- 18. Do you have diabetes?.....   \_\_\_\_\_
- 19. Have you had significant weight loss in the past 4 months without dieting?   \_\_\_\_\_
- 20. Have you ever had thyroid problems?.....   \_\_\_\_\_
- 21. Have you ever had an abnormal chest x-ray?.....   \_\_\_\_\_
- 22. Have you ever had a stroke?.....   \_\_\_\_\_
- 23. Have you ever had epilepsy, seizures or fainting?.....   \_\_\_\_\_
- 24. Do you have frequent headaches?.....   \_\_\_\_\_
- 25. Have you ever had eye problems?.....   \_\_\_\_\_
- 26. Do you wear contact lenses?.....   \_\_\_\_\_
- 27. Have you ever had kidney disease?.....   \_\_\_\_\_
- 28. Have you ever had jaundice?.....   \_\_\_\_\_
- 29. Have you ever had hepatitis?.....   \_\_\_\_\_
- 30. Do you have any arm, leg or back problems?.....   \_\_\_\_\_
- 31. Do you have arthritis?.....   \_\_\_\_\_
- 32. Do you have any physical disabilities?.....   \_\_\_\_\_
- 33. Do you have chipped or loose teeth? Dentures, caps, bridgework, braces?   \_\_\_\_\_
- 34. Are you prone to infections?.....   \_\_\_\_\_
- 35. Do you have a problem with prolonged healing time?.....   \_\_\_\_\_
- 36. Are you extremely anxious about your pending surgery if applicable?.....   \_\_\_\_\_
- 37. Any present illness not mentioned above?.....   \_\_\_\_\_
- 38. If surgically necessary, would you allow your doctor to use donor blood, bone, or other foreign objects in the treatment of your condition? .....   \_\_\_\_\_

If no, please state why \_\_\_\_\_

Patient Signature: \_\_\_\_\_

## FINANCIAL POLICY

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### **CASH PATIENTS**

Full payment at time of service. We accept CASH, CHECK, VISA, MASTERCARD and AMERICAN EXPRESS. Payment plans and financing options may be available; please inquire.

### **PRIVATE INSURANCE CARRIERS**

When we are provided with insurance information, we will bill your insurance company. Deductibles and co-payments are due at the time of your visit. Any co-insurance obligations you may have, as determined by your insurance provider, will be billed following the provision of services.

### **MEDICARE, MEDI-CAL AND WORKERS' COMPENSATION**

If you are covered by Medicare, Medi-Cal, Workers Compensation or any other government-sponsored program, we require that you have proof of such coverage for billing purposes.

### **GENERAL INFORMATION**

Insurance coverage is a contract between you and your insurance company. We are not a party to this contract in most cases. Your insurance claim is filed as a courtesy to you. We will not become involved in disputes between you and your insurance carrier regarding deductibles, co-payments, etc., other than to supply factual information as necessary. You are responsible for the timely payment of your account. Should your account become past due, you will be responsible for any finance charge or legal fees necessary to collect on this account.

## CONSENTS

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### **AUTHORIZATION TO RELEASE INFORMATION FOR INSURANCE PURPOSES**

I hereby authorize Foot & Ankle Institute of the West to release any information in the course of my examination and/or treatment to my insurance company(ies) for the purpose of billing. I also authorize the release of information to my employer if my examination and/or treatment are work related.

### **AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN**

I hereby authorize the medical and/or surgical benefit payments to be made directly to Foot & Ankle Institute of the West. It is understood that benefits are not to exceed the reasonable and customary charge for these services and any moneys received from the insurance company over and above any indebtedness will be refunded to me when my bill is paid in full. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MY INSURANCE COMPANY(IES) AND THIS AUTHORIZATION.

### **INFORMED CONSENT FOR OFFICE PROCEDURES**

I hereby authorize the staff and physicians of Foot & Ankle Institute of the West to perform those diagnostic and/or therapeutic office procedures deemed necessary to evaluate and/or treat my current medical condition(s). I make this authorization with the knowledge that the above named company will verbally describe the nature of said procedures in lay terminology, including possible complications, alternatives, and side effects and obtain verbal consent prior to procedures. I retain the right to verbally refuse any procedure, either diagnostic or therapeutic, after being informed of its nature, complications, and side effects.

### **PATIENT ACKNOWLEDGMENT OF PHYSICIAN DISCLOSURE OF OWNERSHIP INTEREST**

This is to advise you that the doctors have ownership interests in treatment or surgery centers to which you may be referred. This is to further advise you that you may choose any facility available for the purpose of obtaining the particular procedure or test being performed and to let the physician know if you wish to choose a certain facility or center other than the one which you have been referred. The facilities or centers whereby the physicians have ownership interest may include, but are not limited to: STUDIO CITY SURGICAL CENTER and AMBULATORY SURGICAL CENTERS.

*Please let us know if you have any questions or concerns.*

**I HAVE READ AND UNDERSTAND THIS POLICY AND THE ABOVE PARAGRAPHS**

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PATIENT'S (OR GUARDIAN'S) SIGNATURE

---

DATE

**NOTICE  
OF  
PRIVACY PRACTICES**

**(Patient Copy)**

**Foot & Ankle Institute of the West**

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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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by contacting us and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

**1. Uses and Disclosures of Protected Health Information**

**Uses and Disclosures of Protected Health Information Based Upon Your Written Consent**

You will be asked to sign a consent form. Once you have consented to use and disclosure of your protected health information for treatment, payment and health care operations by signing the consent form, we will use or disclose your protected health information as described in this Section 1. Your protected health information may be used and disclosed by your physician, our staff and others outside of our practice that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the practice.

The following are examples of the types of uses and disclosures of your protected health care information that we are permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but rather describe the types of uses and disclosures that may be made by us once you have provided consent.

**Treatment.** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. 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 when we have the necessary permission from you to disclose your protected health information. 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.

**Payment.** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits; reviewing services provided to you for medical necessity; and undertaking utilization review activities.

**Healthcare Operations.** We may use or disclose, as-needed, your protected health information in order to support the business activities of the practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of health care providers, licensing, marketing and fundraising activities, and conducting or arranging for other business activities.

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

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) 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. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

### **Uses and Disclosures of Protected Health Information Based upon Your Written Authorization**

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization at any time, in writing, except to the extent that your physician or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**Others Involved in Your Healthcare:** 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 with 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, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

**Emergencies.** We may use or disclose your protected health information in an emergency treatment situation. If this happens, you physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

**Communication Barriers:** We may use and disclose your protected health information if your physician or another physician attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

### **Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object**

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

**Required By Law.** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures and if permitted, allowed an opportunity to object to the disclosure.

**Public Health.** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

**Communicable Diseases.** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

**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.

**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, or track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance.

**Legal Proceedings.** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and, in certain conditions, in response to a subpoena, discovery request or other lawful process.

**Law Enforcement.** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) issues pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not at the practice) and it is likely that a crime has occurred.

**Coroners, Funeral Directors, and Organ Donation.** We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out his/her duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

**Research.** We may disclose your Protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

**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.

**Military Activity and National Security.** When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities, (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

**Workers' Compensation.** Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

**Required Uses and Disclosures:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of applicable federal health care laws and regulations.

## 2. Your Rights

The following describes your rights with respect to your protected health information and how you may exercise these rights.

**You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to any law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes, as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by submitting a written request to our Privacy Contact.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

**You may have the right to have us or your physician amend your protected health information.** This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

**You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice electronically.

### 3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Contact of your complaint or with the Office of Civil Rights, U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint.

For more information about HIPAA, our privacy practices, the complaint process or to file a complaint, please contact Adam Wegner.

This notice was published and becomes effective on April 14, 2003.

Adam Wegner  
19000 MacArthur Blvd.  
Suite 450  
Irvine, CA 92602  
(949) 705-5100  
awegner@sxcenters.com

Office of Civil Rights  
U.S. Department of Health and Human Services  
50 United Nations Plaza – Room 322  
San Francisco, CA 94102

**ACKNOWLEDGEMENT  
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PRIVACY PRACTICES**

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My signature confirms that I have been informed of my rights to privacy regarding my protected health information under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities
- Comply with legitimate requests from various governing agencies such as: The Medical Board of California, The Board of Podiatric Medicine and the Department of Consumer Affairs

I have been informed of Foot & Ankle Institute of the West's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that the practice has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient\*: \_\_\_\_\_

\*If patient is a minor

**(CHART COPY)**