Julie M Chatigny, DPM, AACFAS
Darrel P Richards, DPM
Podiatric Physician & Surgeon

Central Coast Foot & Ankle Specialists

71 North Main Street
Templeton, CA 93465
Phone 805-209-4400
Fax 805-209-4444

PATIENT INFORMATION

Patient's Name: Last First Middle			Preferred Name	Marital status M / S / W / D
Sex	Birth Date	Home Phone	Cell Phone (Consent to text Yes/No)	Work Phone
Home address		City		State/Zip
Email		How did you hear about us?		
Social Security Number	Language	Race (optional)	Ethnicity (optional)	
Employer: Name Street City				
Preferred Pharmacy: Name Street City Phone				
Is the patient in a skilled facility or enrolled in hospice? Yes / No		Primary Care Provider	Referring Provider	

IN CASE OF EMERGENCY

Name of contact	Relationship to patient	Phone	Can CCFAAS release medical information to this person? Yes / No _____ (initials)

As a courtesy, Central Coast Foot & Ankle Specialists (CCFAAS), verifies Podiatry benefits with your insurance company and we will be happy to bill them. Please provide your insurance information to the front office staff. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan, if your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received.
It is the policy of CCFAAS that payment is due at the time of service unless other financial arrangements are made in advance. We require all patients to pay their deductible, copay and/or coinsurance payment at the beginning of each visit. Our office will explain this information to you prior to your first visit. At the conclusion of your visits with us you may be billed for any outstanding balances. If there is a credit, you will be provided a refund promptly.
Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan.
Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by another physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are 100 percent responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment.
We highly recommend you also contact your insurance carrier and check into your coverage for Podiatry services. Do not assume that you will not owe anything if you have more than one insurance policy.

I request that payment of authorized insurance or Medicare benefits be made to me or on my behalf to Central Coast Foot & Ankle Specialists. I understand that I am ultimately responsible for payments on my account. A $35. NSF charge will be applied to all accounts with a returned check. Your signature is necessary for us to submit any claim and to insure payment of services rendered on your behalf.
If you have no insurance, payment is required at the time of service.
I HAVE READ THE ABOVE AGREEMENT AND AGREE TO THE TERMS AND CONDITIONS AS SET FORTH BY CENTRAL COAST FOOT & ANKLE SPECIALISTS.
Thank you.

_____
Print Name

_____ _____
Signature of Patient/Responsible party Date

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Thank you for choosing us as your provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but you have copays or deductibles, payment in full is expected at each visit. This arrangement is part of your contract with your insurance company. 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. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

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

3. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims 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; we are not party to that contract. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

4. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

5. **Late appointments.** Our policy is to reschedule your appointment if you are more than 10 minutes late. You will be subject to a missed appointment fee ($25). Please help us to serve our patients timely by showing up to your appointment on time.

6. **Missed appointments.** Our policy is to charge for missed appointments ($25) not canceled with at least 24 hours' notice. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

7. **Surgery cancellations.** Our policy is to charge for any surgeries cancellations ($250) once appointment is made. Your request for surgery requires multiple person hours to coordinate. These charges will be your responsibility and billed directly to you.

8. **Paperwork.** Our policy is to charge for any paperwork ($25) that needs to be filled out by the physician or office staff. This fee is to be paid up front when paperwork is dropped off or called in to be filed online. The charges will be your responsibility and billed directly to you.

By signing below, you also understand that any charges not covered by your insurance for durable medical equipment (**DME**) will be your responsibility and billed directly to you.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

HIPAA Privacy Rule

In accordance with the HIPAA Privacy Rule, when Protected Health Information (PHI) is to be used or disclosed for purposes other than treatment, payment, or health care operations, the Facility will use and disclose it only pursuant to a valid, written authorization, unless such use or disclosure is otherwise permitted or required by law. Use or disclosure pursuant to an authorization will be consistent with the terms of such authorization.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of Patient / Responsible party Date

Name: _____ Appointment Date: _____

Height: ____ feet ____ inches

Reason for visit: Right Left Foot Toes Heel Ankle

Explain:

_____

Medication Allergies:	**Reaction:**
1.	Nausea / Vomiting / Rash / Respiratory Distress / Other
2.	Nausea / Vomiting / Rash / Respiratory Distress / Other

Current Medications and dosing: (or provide list)

1.	4.
2.	5.
3.	6.

Vaccinations:

Pneumonia Date:	Yes	No	Flu Date:	Yes	No
Tetanus Date:	Yes	No			

Past and Current Medical History: (please include approximate date of diagnosis)

ADHD	Yes	No	Hypertension	Yes	No
AIDS / HIV	Yes	No	Jaundice	Yes	No
Alzheimer's Dementia	Yes	No	Kidney Disease Stage: 1 2 3 4	Yes	No
Anemia	Yes	No	Lupus	Yes	No
Anxiety	Yes	No	Migraines	Yes	No
Asthma	Yes	No	Multiple Sclerosis	Yes	No
Atrial Fibrillation	Yes	No	Numbness	Yes	No
Bipolar Disorder	Yes	No	Osteoarthritis	Yes	No
Cancer Type: Date:	Yes	No	Osteopenia	Yes	No
Cirrhosis of Liver	Yes	No	Pacemaker Date:	Yes	No
Congestive Heart Failure	Yes	No	Parkinson's Disease	Yes	No
COPD	Yes	No	Poor Balance	Yes	No
Dementia	Yes	No	Psoriasis	Yes	No
Depression	Yes	No	Psoriatic Arthritis	Yes	No
Diabetes Type: Date:	Yes	No	Rheumatoid Arthritis	Yes	No
Dry Skin	Yes	No	Schizophrenia	Yes	No
DVT / Pulmonary Embolism	Yes	No	Scleroderma	Yes	No
Gout	Yes	No	Sjogren's Syndrome	Yes	No
Heart Attack Date:	Yes	No	Stroke Date:	Yes	No
Heart Murmur	Yes	No	Seizures Last Episode:	Yes	No
Hepatitis Type: Active:	Yes	No	Thyroid Disorder	Yes	No

Family History:			**Who:**
Cancer Type:	Yes	No	Father / Mother / Brother / Sister
Diabetes	Yes	No	Father / Mother / Brother / Sister
Hypertension	Yes	No	Father / Mother / Brother / Sister
Stroke	Yes	No	Father / Mother / Brother / Sister

Social History: (please circle and include details indicated)

Smoking: Current / Former	PPD: Years of use: Stop Date:
Alcohol: Occasional / Moderate / Heavy	Drinks per week: Years of use:
Illicit Drugs: Former / Current	Type(s): Last used:
Employer:	Occupation:

Surgeries: (please include dates)

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Patient Opioid Agreement Contract

This is an agreement between _____ (the patient) and Dr. Julie Chatigny, DPM / Dr. Darrel Richards, DPM (Central Coast Foot & Ankle Specialists) concerning the use of opioid analgesics (narcotic pain-killers) for the treatment of my post-operative course. I understand and voluntarily agree that (initial each statement after reviewing):

___ I understand that opioid analgesics are strong medications for pain relief and I have been informed of the risks and side effects involved with taking them.

___ In particular, I understand that opioid analgesics could cause physical dependence. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (flu-like syndrome such as nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24/48 hours of the last dose. I understand that opioid withdrawal is quite uncomfortable, but not a life-threatening condition.

___ I understand that if I am pregnant or become pregnant while taking these opioid medications, my child would be physically dependent on the opioids and withdrawal can be life-threatening for a baby.

___ Overdose on this medication may cause death by stopping my breathing; this can be reversed by emergency medical personnel if they know I have taken narcotic pain-killers.

___ Opioid analgesics cause drowsiness, sedation, or dizziness.

___ I understand that I *must not* drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy.

___ I understand it is my responsibility to inform the doctor of any and all side effects I have from this medication.

___ I agree to take this medication as prescribed and not to change the amount or frequency of the medication without discussing it with the prescribing doctor. Running out early, needing early refills, escalating doses without permission, and losing prescriptions may be signs of misuse of the medication and may be reasons for the doctor to discontinue prescribing to me.

___ I agree to keep my medication in a safe and secure place. Lost, stolen, or damaged medication will not be replaced.

___ I agree not to drink alcohol or take other mood-altering drugs while I am taking opioid analgesic medication.

___ I agree not to sell, lend, or in any way give my medication to any other person.

___ I will treat the staff at the office respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients, my treatment will be stopped.

___ I understand that there is a small risk that opioid addiction could occur. This means that I might become psychologically dependent on the medication, using it to change my mood or get high, or be unable to control my use of it. People with past history of alcohol or drug abuse problems are more susceptible to addiction. If this occurs, the medication will be discontinued and I will be referred to a drug treatment program for help with this problem.

___ I agree that I will attend all required follow-up visits with the doctor to monitor my recovery/condition and I understand that failure to do so will result in discontinuation of this treatment. I also agree to participate in other chronic pain treatment modalities recommended by my doctor.

___ I understand the common side effects of opioid therapy include nausea, constipation, sweating, itching, dry mouth, and rash.

___ I agree that the opioids will be prescribed by only *one* doctor and I agree to fill my prescriptions at only *one* pharmacy. I agree not to take any pain medication or mind-altering medication prescribed by any other physician without first discussing it with the above-named doctor. I give permission for the doctor to verify that I am not seeing other doctors for opioid medication or going to other pharmacies.

Pharmacy

Name: _____

Location: _____

Number: _____

Drowsiness may occur when starting opioid therapy when increasing the dosage. I agree to refrain from driving a motor vehicle or operating dangerous machinery until such drowsiness disappears.

I understand that the use of any mood-modifying substance, such as tranquilizers, sleeping pills, alcohol or illicit drugs (such as cannabis, cocaine, heroin, or hallucinogens) can cause adverse effects or interfere with opioid therapy. Therefore, I agree to refrain from the use of all these substances without first discussing it with my physicians.

I also understand that I may be discharged from care if I use any of these substances. If I use medicinal marijuana then I will not drive under the influence of cannabis. I agree not to provide my prescribed medication to any other person at the result in being discharged as a patient. I also understand that lost or stolen medications will not be refilled until the proper due date. If I break this agreement, my physician reserves the right to stop prescribing opioid medications for me and may discharge me from care. I hereby agree that my physician has the authority to disclose the prescribing information in my patient file to other health care professionals when it is deemed medically necessary in the physician's judgment.

_____ _____

Patient Signature / Responsible Party Date