Beverly Hills Foot and Ankle, P.A.

Specializing in Wound Care, Trauma and Reconstructive Surgery of the Foot, Ankle and Leg

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PERSONAL INFORMATION

First Name_____ Middle Initial_____ Last Name_____

DOB_____/_____/_____ Sex: Male___ or Female___ Race_____ Language_____

SSN_____ Marital Status_____ Pregnant? **Yes** or **No**

Address _____

City_____ State_____ Zip_____

Home Phone_____ Work Phone_____

Cell Phone_____ Email _____

EMPLOYER INFORMATION

Name_____ Phone_____

Address _____

City_____ State_____ Zip_____

EMERGENCY INFORMATION

Name_____ Phone_____

Address_____

City_____ State_____ Zip _____

Relationship to Patient _____

INSURANCE INFORMATION

Primary Insurance _____

ID#_____ Group#_____

Secondary Insurance _____

ID#_____ Group#_____

PRIMARY CARE PHYSICIAN

Name of Physician: _____ **Last Seen:** _____

Address_____

Phone _____ Fax _____

Preferred Pharmacy: _____ Phone _____
Pharmacy Location: _____
Do You Smoke Cigarettes or Vape: Yes or No **Former Smoker:** Yes or No **Drink Alcohol:** Yes or No
Influenza Vaccine: Yes or No **Circle Date:** Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec 20_____
Pneumonia Vaccine: Yes or No **Circle Date:** Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec 20_____
Height: _____'_____ **Weight:** _____ **Last eye exam:** _____/_____/____

HEALTH HISTORY **(Check all that apply)**

- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Arthritis, rheumatoid
- ☐ Arthritis, wear and tear
- ☐ BPH
- ☐ Back Problems
- ☐ Blood Pressure, high
- ☐ Cancer _____
- ☐ Coronary Artery Disease
- ☐ CHF
- ☐ COPD
- ☐ Cholesterol, high
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Dialysis
- ☐ Fibromyalgia
- ☐ Fungus
- ☐ Glaucoma
- ☐ Gout
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Heart Attack
- ☐ Heart Burn
- ☐ Heart Problems _____
- ☐ Joint Implants _____
- ☐ Kidney Problems _____
- ☐ Leukemia
- ☐ Liver Problems
- ☐ Lung Disease _____
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Psoriasis
- ☐ Ulcers, Stomach
- ☐ Ulcers, Foot
- ☐ Urinary Tract Infection
- ☐ Seizures
- ☐ Sickle Cell Disorder
- ☐ Stents
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tuberculosis **(TB)**
- ☐ Varicose Veins
- ☐ Alcohol Abuse
- ☐ Drug Abuse

Other Medical Problems: _____

Have you been treated by a Podiatrist in the past? Yes or No **(If Yes, please explain)**

_____

Allergies: **(Please Include Symptoms)**

_____

Current Medications Taken: **(Please Include Dosage and Frequency of Use)**

_____

_____

_____

Past Surgeries: **(Please Include Surgeon Name, Surgery Type, Surgery Date & The Facility)**

_____

_____

Are you diabetic: **Yes** or **No** **Blood Sugar:** ____ Hemoglobin **A1c:** ____ Last **checked:** ___/___/___

Do you have any of these problems with your diabetes? Kidney ___ Eye___ Nerve___ Skin___

What specific problem(s) bring you to the office today and when did the problem(s) begin?

_____

_____

How would you describe your pain? (Circle) Burning Stinging Aching Throbbing Dull Stabbing Radiating Itching Sharp Numb No Pain

If you have pain, what would you rate your pain on a scale of 1 to 10? (0 = no pain, 10 = worst pain)
0 1 2 3 4 5 6 7 8 9 10

Where is your pain located? (Circle) Right Lower leg Ankle Foot Heel Toe
Left Lower leg Ankle Foot Heel Toe

FAMILY HISTORY **(PLEASE BE SPECIFIC AS POSSIBLE ABOUT FAMILY HISTORY)**

Family	Arthritis	Cancer	Diabetes	Heart Problems	Stroke	High BP	Skin Disease	Foot Problems	Other
Mother									
Father									
Siblings									
Children									
Spouse									
Grandparents									

REVIEW OF SYSTEMS **(Check all that apply)**

Constitutional	**Respiratory**	**Cardiovascular**	**Gastrointestinal**
☐ Chills	☐ Cough	☐ Chest pain	☐ Hepatitis
☐ Fever	☐ Sputum	☐ Palpitations	☐ Jaundice
☐ Fatigue	☐ Asthma	☐ Heart Attack	☐ Diarrhea
☐ Nausea	☐ Wheezing	☐ Varicose Veins	☐ Heartburn
☐ Vomiting	☐ Bronchitis	☐ Swelling of Legs	☐ Constipation
☐ Weakness	☐ Tuberculosis	☐ Extremity **(Cool)**	☐ Excess Thirst
	☐ Shortness of Breath	☐ Hair Loss on Legs	☐ Excess Hunger
		☐ Leg Pain **(Walking)**	☐ Liver Problems
		☐ High Blood Pressure	☐ Abdominal Pain
Musculoskeletal	**Psychiatric**	**Skin**	**Neurological**
☐ Gout	☐ Anxiety	☐ Eczema	☐ Burning
☐ Arthritis	☐ Depression	☐ Rashes	☐ Fainting
☐ Paralysis	☐ Disorientation	☐ Dryness	☐ Strokes
☐ Joint Pain	☐ Hallucinations	☐ Itching	☐ Tremors
☐ Weakness	☐ Excess Stress	☐ Hives	☐ Tingling
☐ Deformities	☐ Memory Loss	☐ Lumps	☐ Dizziness
☐ Gait Problems	☐ Nervousness	☐ Moles	☐ Black Outs
☐ Joint Stiffness	☐ Mood Changes	☐ Skin Ulcers	☐ Numbness
☐ Muscle Cramps	☐ Disturbing Thoughts	☐ Nail Problems	☐ Headaches
☐ Muscle Stiffness		☐ Skin Discoloration	☐ Unsteady gait

REVIEW OF SYSTEMS **(Check all that apply)**

Endocrine	Hematologic	Allergic - Immunologic	Urinary
☐ Sweats	☐ Anemia	☐ Hives	☐ Burning
☐ Diabetes	☐ Blood Clots	☐ Coughing	☐ Infections
☐ Weakness	☐ Bleed Easily	☐ Sneezing	☐ Urine Odor
☐ Weight Gain	☐ Bruising Easily	☐ Wheezing	☐ Incontinence
☐ Weight Loss	☐ Swollen Glands	☐ Itchy Eyes	☐ Blood in Urine
☐ Thyroid Trouble	☐ Blood transfusion	☐ Itchy Nose	☐ Kidney Stones
☐ Increased Thirst		☐ Runny Nose	☐ Pain on Urination
☐ Cold Intolerance			☐ Urine Discoloration
☐ Excess urination			

BEVERLY HILLS FOOT & ANKLE, P.A.- FINANCIAL POLICIES

- **A $25.00 fee will be charged to all patients who does not call to cancel their appointment within 48 – hours or is a no show on the day of their scheduled appointment. This fee is not paid by your insurance carrier and it is the patient's responsibility to be paid in the form of cash or credit card only & must be paid before a future appointment can be scheduled.**
- **There is a service fee of $30.00 for all returned checks. Your insurance carrier does not cover this.**
- **All Copays, Deductibles, Coinsurance, 20% and Self-Pay patients, all forms of payment for office services rendered are due at the time of service. No payment arrangements will be authorized.**
- **As our patient, you are responsible for all Referrals and any 10-Digit Authorization Numbers with an allotted number of visits needed to seek treatment in our practice prior to your appointment date.**
- **Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim on your behalf if the benefits are assigned to the doctor. You agree to have your insurance company pay the doctor directly. If your insurance company does not pay the doctor within a reasonable period of time, you will be responsible for prompt payment.**
- **We have contracts with certain insurance carriers to accept an assignment of benefits. We will bill those plans with which we have a contract and will require you to pay the Copay, Deductible, Coinsurance, and 20% at the time of service.**
- **In the event your insurance carrier sends the doctor's payment directly to you, please sign the check over to Beverly Hills Foot and Ankle, PA and bring it into the office immediately.**
- **All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "Not Covered" you will be responsible for these charges to any services rendered. Patients are encouraged to contact their insurance carrier for clarification of benefits prior to your office visit.**
- **By signing this form, you agree that if your insurance carrier is Out-of-Network, you will incur and pay any and all costs associated with your office visit that your insurance carrier does not pick up or cover at time of service.**
- **You must inform the office of all insurance changes. In the event the office is not informed, you will be responsible for any charges that are denied.**
- **For most services provided in the hospital, we will bill your insurance carrier. Any balance due is your responsibility.**
- **There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure requires pre-payment, payment will be due one week prior.**
- **Past due accounts will be placed with Gulf Coast Collection Agency. All costs incurred, including but not limited to; collection fees, attorney fees, court fees, and the office balance will be your responsibility.**

Signature: _____ **Date:** _____

BEVERLY HILLS FOOT & ANKLE, P.A.- HIPAA PRIVACY POLICIES

It is the policy of our practice that all doctors and staff preserve the Integrity and Confidentiality of the Protected Health Information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice, its doctors, and staff have the necessary PHI to provide the highest quality care possible while protecting the confidentiality of the PHI of all our patients.

OUR PRACTICE, ITS DOCTORS AND STAFF WILL:

- **Adhere to the standards set forth in the Notice of Privacy Practices.**
- **Collect, use and disclose PHI only in conformance with state and federal laws, current patient covenants and/or authorizations. Our practice, its doctors and staff will not use or disclose PHI for uses outside of practice's TPO (Treatment, Payment and Health Care Operations), such as marketing, employment, life insurance applications, etc. without written authorization from the patient.**
- **Use and disclose PHI to remind patients of their appointments unless they instruct us otherwise.**
- **PHI collected about patients must be accurate, timely, complete and available when needed.**
- **Implement reasonable measures to protect the integrity of all PHI maintained and stored.**
- **We recognize that the patients have a right to privacy. Our practice, its doctors and staff respect the patient's individual dignity. Our practice, its doctors and staff will respect the patient's privacy to the extent consistent with providing the highest quality medical care possible with the efficient administration of the practice.**
- **The practice treats all PHI data as sensitive and confidential. Treat all PHI data as confidential in accordance with professional ethics, accreditation standards and legal requirements.**
- **PHI will not be disclosed unless the patient (or authorized representative) has properly authorized in writing that the release of such data.**
- **Although our practice "owns" the medical records, the patient has the right to inspect and obtain a copy of his/her information. Patients will be provided the opportunity to request the correction of inaccurate or incomplete PHI.**
- **Patients will be given access to their medical records 10 business days after a written request is filled out and approved by the Practice Manager. If the request is denied, we will inform the patient that they may request a review of our denial.**

All doctors and staff of our practice will maintain a list of certain disclosures of PHI for purposes other than TPO (Treatment, Payment and Health Care Operations) for each patient and those made pursuant to an authorization as required by HIPAA (Health Insurance Portability and Accountability Act). We will provide this list to patients upon request.

All doctors and staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy which will bring grounds for disciplinary action, up to but not limited to; termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.

BEVERLY HILLS FOOT & ANKLE, P.A. - PRIVACY PROCEDURES

- **When a patient request to copy their Medical Records and it is approved, the Front Office Coordinator will copy his/her records within 10 business days at a charge of $1.00 per page.**
- **The Privacy Officer will provide the Front Office Coordinator with an original form for patients to complete when the patient desires to inspect or request a copy of their PHI.**
- **The Front Office Coordinator will photocopy and provide the patient with the form to inspect the PHI.**
- **The Front Office Coordinator will respond to the patients' request and questions concerning the inspection.**
- **Once the patient completes the form, the Front Office Coordinator will forward the form to the Privacy Officer for review.**
- **Once the patient has submitted their request in writing, using the practice's form, the Front Office Coordinator must verify the patient's signature matches his/her signature on file.**
- **The Privacy Officer must review the patient's request and respond to the patient within 30 days from the date of request. The Privacy Officer can request an additional 30-day extension as long as the request is made to the patient in writing explaining the reason for the delay.**
- **The Privacy Officer should agree to all reasonable requests. If access is denied, the Privacy Officer must provide the patient with an explanation for the denial as well as a description of the patient's review appeal.**
- **When the patient has requested to inspect their PHI and the request has been accepted, the Privacy Officer or the Authorized Practice Representative should accompany the patient to a private area to review his/her records and remain with the patient during the inspection. After the patient inspects the records, The Privacy Officer will note in the record the date and time of the inspection, and whether the patient made any requests for amendments or change to the record.**
- **When the patient signs this form, Beverly Hills Foot and Ankle, PA will request your past prescription history through the electronic medical records (EMR). All records will remain confidential and within the electronic medical records system (EMR).**
- **Alternatively, the patient can request access to their Next Gen (EMR) personal patient portal so that they may view their medical records electronically. The patient must submit this request in person to the Privacy Officer so that the login and password information is created and given to the correct individual. The Privacy Officer and support staff reserve the right to ask for proof of identification and verification of demographic information to process this request.**
- **Please note that while the email is HIPAA COMPLIANT, texting is not. If you decide to initiate text regarding your patient information, please understand that you are accountable for the information that is disseminated.**
- **By signing this form, you agree to photographic documentation of your feet, ankles and your legs below the knee, taken for evaluation of treatment purposes only.**

Signature: _____ Date: _____

HOW DID YOU HEAR ABOUT DR. KRISHNAN AND BEVERLY HILLS FOOT & ANKLE, P.A.?

__ Company Website __ Internet Search __ Doctor Referral __ Magazine Ad __ Family Member
__ Friend __ Other _____

BEVERLY HILLS FOOT & ANKLE, P.A.- CONSENT TO COMMUNICATE AUTHORIZATION OF PROTECTED HEALTH INFORMATION

The Health Insurance Portability Accountability Act (HIPAA), federal privacy law requires that the patient designate and authorize which individuals such as; spouse, siblings, significant other or any relatives that can speak on your behalf regarding your medical treatment, financial obligations or any healthcare questions or concerns.

- **I understand by my signature, signing this Consent to Communicate Authorization Form, I hereby authorize Beverly Hills Foot and Ankle, PA to share/communicate PHI with myself or my designated representative (s) that I have hereby authorized.**
- **I understand that Beverly Hills Foot and Ankle, PA may communicate information such as; future appointments, medication refills, medical treatment rendered by the physician, future treatment recommended by the physician or any financial statements and information.**
- **I hereby release Beverly Hills Foot and Ankle, PA and its employees from any and all liability that may arise from the release of my Protected Health Information.**
- **I understand that I have the right to revise and revoke any and all designated representatives at any time.**
- **I understand that if I choose to revise or revoke any and all designated representatives that I must do so in writing to Beverly Hills Foot and Ankle, PA. The revocation will not apply to any information that has been already released.**
- **I understand that I do not have to designate anyone or sign the Consent to Communicate Authorization of Protected Health Information Form.**

❖ **I do not authorize anyone on my behalf to obtain any of my Protected Health Information**

Patient Signature: _____ Date: _____

I authorize Beverly Hills Foot and Ankle, PA to verbally share my Protected Health Information with the following individual (s):

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Patient First Name (Print): _____ Middle Initial: ____ Last Name (Print): _____

Date of Birth: _____

Patient Signature: _____ Date: _____

Signature By: Patient____ Legal Guardian____ Legal Representative ____ Proxy____