Dr. Melody Chong D.P.M.

3838 California Street, Suite #514 • San Francisco, CA 94118
Tel. (415) 386-3338 (FEET)

Patient Registration Form

Demographic Information

Last Name:_____ First Name_____ Middle:_____
Home Address:_____ City:_____
State: _____ Zip: _____ Home Phone (_____)_____ Cell (_____)_____
Social Security #: _____- _____- _____ Date of Birth: _____ / _____ / _____ Age:_____
Email:_____

Employer:_____ Occupation:_____
Address:_____ City:_____
State: _____ Zip: _____ Work Phone (_____)_____ Extension:_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widow
Name of Spouse / Partner:_____

Who is your Primary Care Physician?

Name (First & Last): _____ Phone (_____)_____
Address:_____ City: _____State: _____ Zip:_____

Emergency Contact

Name (First & Last): _____ Phone (_____)_____
Address:_____ City:_____State: _____ Zip:_____
Relationship:_____

Insurance Information

Name of Primary Insurance Company:_____
Insurance Company Phone (____)_____ Policy Number:_____
Subscriber Name:_____ Date of Birth of Subscriber: _____ / _____ / _____
Relationship to patient: ☐Self ☐Spouse ☐Child ☐Other:_____

Name of Secondary Insurance Company:_____
Insurance Company Phone (____)_____ Policy Number:_____
Subscriber Name:_____ Date of Birth of Subscriber: _____ / _____ / _____
Relationship to patient: ☐Self ☐Spouse ☐Child ☐Other:_____

Name of Tertiary Insurance Company:_____
Insurance Company Phone (____)_____ Policy Number:_____
Subscriber Name: _____ Date of Birth of Subscriber: _____ / _____ / _____
Relationship to patient: ☐Self ☐Spouse ☐Child ☐Other:_____

Completed by (Print):_____ Signature:_____ Date:_____

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Patient Consent Form

By signing this Consent Form, I give Dr. Melody Chong D.P.M. permission to use and disclose protected health information about me for treatment, payment, and healthcare operations (TPO) except for any restrictions specified in the Form to Request Restrictions. Protected health information is individually identifiable information we create or receive, including demographic information relating to my physical or mental health to provision of healthcare services to me and to the collection of payment for providing healthcare services to me

With this consent, Dr. Melody Chong D.P.M. may call my home or other alternative location and leave a message on voicemail or in person in reference to any item that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Dr. Melody Chong D.P.M. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as patient statements as long as they are marked as Personal or Confidential. In addition, I give Dr. Melody Chong D.P.M. permission to speak with the following family members, spouse, roommate, etc. regarding billing issues, lab results, or any other information pertaining to my treatment and care.

Name: _____ Relationship:_____ Phone: (_____)_____

Name: _____ Relationship:_____ Phone: (_____)_____

Name: _____ Relationship:_____ Phone: (_____)_____

If I do not sign this Consent Form, I understand Dr. Melody Chong D.P.M. has the right to refuse me treatment unless she is required by law to treat me. I have the right to revoke this consent in writing except where Dr. Melody Chong D.P.M. has already made disclosures in reliance to my prior consent. I may request to use our Authorization for Release of Information Form for purposes of requesting my revocation, or I may simply send Dr. Melody Chong D.P.M. a letter in writing.

I have read and understand the policy as outlined above. I understand my financial responsibility as a patient.

_____

Signature of Patient Date

_____

Patient Name (print)

FOR MINORS ONLY

For patients **under the age of 18 years old**, the undersigned Parent/Guardian authorizes treatment and agrees that the policy holder will be named as the account guarantor unless noted otherwise in writing.

Print Name:_____ Signature:_____
Relationship:_____ Today's Date: _____

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Patient Medical History

Last Name:_____ First Name_____ Middle:_____

Date of Birth: _____ / _____ /_____ Age:_____ Sex: ☐Female ☐Male Marital Status:_____
Height:_____ Weight:_____ Weight one year ago:_____ Children:_____

I am: ☐Left Handed ☐Right Handed Primary Care Physician: _____
Occupation:_____

Have you ever been treated by a podiatrist before? ☐Yes ☐No
If Yes, what was your foot problem? _____
What is your specific foot problem for this visit? _____

Are we seeing you in relation to an injury/accident? ☐Yes ☐No If Yes: Date of Injury_____

☐Automobile Accident ☐Work-Related Injury ☐Other:_____

Are you on Disability? ☐Yes ☐No If Yes: Last Date of Work:_____

Current Medical Problems:

☐Arthritis	☐Emphysema	☐HIV
☐Asthma	☐Heart Failure	☐Kidney Disease
☐Bowel Disorder	☐Heart Murmur	☐Prostate Disease
☐Cancer / Type:_____	☐Hepatitis	☐Thyroid Disease
☐Chest Pain	☐High Blood Pressure	☐Ulcer
☐Diabetes	☐High Cholesterol	☐Other:_____

1. What medications do you take routinely? (Include dosage and frequency)_____
   _____
   _____
2. Are you allergic to any medication? ☐Yes ☐No
   If Yes, what are you allergic to?_____
   If Yes, please indicate the reaction you have?_____
3. Past Surgeries (Include type and dates) :_____
   _____

How many times per week do you exercise?_____ What type?_____

Do you smoke now? ☐Yes ☐No # of packs per day? _____ How many years? _____
If you quit, how long ago did you quit? _____ # of packs per day? _____ How many years? _____

Do you drink alcohol? ☐Yes ☐No How many ounces per day? _____
(One 12 oz. beer or one glass of wine = 1 oz. of hard liquor)

Are there any diseases that run in your family?_____

Father: ☐Alive ☐Deceased Age and cause of death:_____

Mother: ☐Alive ☐Deceased Age and cause of death:_____

Sibling: ☐Alive ☐Deceased Age and cause of death:_____

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Review of Systems

Last Name: _____ First Name:_____ Middle:_____

Please check any illness, symptoms, or problems that you have had in the last month:

Constitutional
☐Blood pressure
☐Respiration
☐Fever/sweats
☐Fatigue
☐Loss of appetite/weight change

Eyes
☐Eye Disease or injury
☐Eye glasses/contact lenses
☐Blurred/ double vision
☐Glaucoma

Ears/Nose/Mouth/Throat
☐Hearing loss
☐Hearing noises in ear
☐Earaches and drainage
☐Nosebleeds
☐Trouble swallowing
☐Bleeding gums
☐Sore throat
☐Snoring
☐Voice changes
☐Problems with thyroid

Other Symptoms
☐Memory loss/confusion
☐Nervousness/anxiety
☐Depression
☐Insomnia

Musculoskeletal
☐Joint pain/stiffness
☐muscle pain/cramps/weakness
☐back pain

Skin
☐Rashes
☐Lesions
☐Ulcers

Cardiovascular
☐Chest pain/angina
☐Palpitations
☐Shortness of breath
☐Swelling of feet, ankles or hands
☐Murmur

Respiratory
☐Cough
☐Spitting up blood
☐Shortness of breath
☐Wheezing

Gastrointestinal
☐problems with bowel movements
☐nausea/vomiting
☐rectal bleeding/blood in stool
☐Abdominal pain/heartburn

Genitourinary
☐Flank pain
☐Problems with urination
☐Blood in urine
☐Kidney Stone

Neurological
☐Headaches
☐Numbness/tingling sensation
☐Tremors
☐Head injury

Hematologic/ Lymphatic
☐Slow to heal after cuts
☐Tendency to bleed/bruise
☐Blood clots
☐Past blood transfusion

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Office Policies & Procedures

Dr. Melody Chong D.P.M. does everything possible to minimize the cost of medical care. You can help a great deal by eliminating the need for us to bill you. In order to make our relationship work more effectively, the following is a summary of our payment policy.

Missed Appointments
We will make every effort to accommodate your scheduling needs. In return we ask that you help us by keeping your scheduled appointments, and by notifying us in advance if you are unable to do so. All patients who fail to arrive for their scheduled appointments or who cancel with less than 24 hours advanced notice will be charged a missed appointment fee of $50. This fee cannot be charged to our insurance carrier.

All payments is expected at the time of service
Payment is required at the time of service are rendered unless other arrangements have been made in advance. This includes applicable co-insurance and co-payments for participating insurance companies. If our office must bill you for a co-payment, you will be charged a $15 administrative fee. This fee cannot be charged to you insurance carrier. Dr. Melody Chong D.P.M. accepts, cash, personal checks, Visa and MasterCard. A $35.00 fee will apply to any returned check.

Outstanding Balance
Patients with an outstanding balance must make arrangements for payment prior to scheduling appointments. We realize that people may have financial difficulty. Please communicate with our billing and collection staff so that they may assist to create a financial plan with you.

Copies of Records
For copies of medical records an advance payment of $25.00 is required. This fee *cannot* be charged to your insurance carrier.

Disability Forms
For completion of all insurance and disability forms other than California State Disability and Worker's Compensation forms, an advance payment of $20.00 is required. This fee cannot be charged to your insurance carrier.

Billing Questions/ Refunds
If you need any assistant or have any questions, please call our biller. Overpayments will be refunded upon written request within 30 days of our office confirmation.

Medication Refills
For all medication refills, please call your pharmacy directly. We are unable to access patient records on evenings and weekends. Accordingly, narcotic refills cannot be honored during these times.

Insurance
Dr. Melody Chong D.P.M. will bill participating insurance companies as a courtesy; however, I understand that I am responsible for all charges not covered by my medical insurance policy including, but not limited to, co-payments, deductibles, co-insurance, and non-covered services. I also agree to complete all necessary paperwork in order for my claim to be paid by my insurance company and accept full liability for all charges if payment is not made in my behalf by my insurance company.

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Surgery Cancellation Policy
All patients who fail to arrive for their scheduled surgery or who cancel with less than 48 hours advanced notice will be charged a non-refundable administration fee up to $500. This fee cannot be charged to your insurance carrier. If your primary care physician has not cleared you for surgery prior to this time, please let us know as soon as possible.

In addition, all patients that cancel and re-schedule a procedure two (2) or more times will be charged a non-refundable deposit of $500 for each occurrence. This fee cannot be charged to your insurance carrier.

Assignment of Benefits & Treatment Authorization
I authorize the release of any medical or other information necessary to determine benefits or the benefits payable for related equipment or services to Dr. Melody Chong D.P.M., my insurance carrier or other medical entity. A copy of this authorization will be sent to my insurance company or other entity if requested. The original authorization will be kept on file by Dr. Melody Chong D.P.M.

I understand that I am financially responsible to the organization for any charges not covered by healthcare benefits. It is my responsibility to notify Dr. Melody Chong D.P.M. of any changes in my healthcare coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Dr. Melody Chong D.P.M. and/or my healthcare insurer if the submitted claims or any part of them are denied for payment.

Notice of Privacy Practices
The misuse of Personal Health Information has been identified as a national problem. We want you to know that our employees, managers, and physicians continually undergo training so that they understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act of 1996 (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of Personal Health Information in accordance with the government rules, laws, and regulations. As part of this plan, we have implemented a Compliance Program that oversees the prevention of any inappropriate use of Personal Health Information.

I have read and understand the policies as outlined above. I understand that by signing this form I am accepting financial responsibility as explained for all payment for products received. I understand my financial responsibility as a patient.

_____

Signature of Patient / Legal Guardian Relationship Date

_____

Patient Name (print) Date