

# 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: \_\_\_\_\_

**PHARMACY ADDRESS:** \_\_\_\_\_

### 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.

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Signature of Patient

Date

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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: \_\_\_\_\_

# Dr. Melody Chong D.P.M.

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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

Completed by (Print): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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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.

Effective September 18, 2015

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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.

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Signature of Patient / Legal Guardian

Relationship

Date

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Patient Name (print)

Date