Required information and forms to be completed for house call or facility care visits

*These forms are also available for download on our website: moultonpodiatry.com

1. Completed patient registration information sheet and medical questionnaire
2. Initialed and signed consent to treat form
3. Signed Notice of Privacy Practices form
4. Attach a copy of insurance card/s

This information may be sent to us via:

Email moulton.pod@cox.net

Fax: (949) 495-3715

Mail: Moulton Podiatry Group
30001 Town center drive E2
Laguna Niguel, Ca. 92677

We can be reached at (949) 495-2506 for additional information

Thank You,

Moulton Podiatry Group

HOME VISIT PATIENT INFORMATION

PATIENT INFORMATION

Date__________________ Social Security #___________________ Birthdate______________

Name____

Last Name First Name Initial

PLEASE CIRCLE: Sex: M F Single Married Long Term Partner Divorced Widowed Separated

PHYSICAL ADDRESS OF PATIENT OR FACILITY

Address_____________________________________Phone____________________________

City____ State_____________Zip_____________

Contact In Case of Emergency__________________________ Phone______________________

RESPONSIBLE PARTY (FOR CORRESPONDENCE AND BILLING STATEMENTS)

Person Managing Account____

Last Name First Name Initial

Relationship to Patient____________________________ Contact Phone__________________

Address___________________________City__________________State______ Zip_________

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to the treating physician for all insurance benefits otherwise payable for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on physicians behalf.

I authorize the physician to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party_________________________________ Date__________________

PRIMARY INSURANCE

Insurance Company____

Insurance Address____

Subscriber I.D.#_________________________________ Group #_________________________

SECONDARY INSURANCE (IF APPLICABLE)

Insurance Company____

WELCOME TO THE OFFICE

Please take a few minutes to complete the following medical questionnaire. It will help the doctor familiarize himself with your foot problem as well as you general health status. *"Yes, your feet are connected to the rest of your body"*

NAME ______________________________

PLEASE DESCRIBE YOU FOOT PROBLEM/S: ______________________________

____

IF YOU HAVE PAIN PLEASE DESCRIBE IT ______________________________

HOW LONG HAS THIS BEEN A PROBLEM? ______________________________

WHAT MAKES THE PROBLEM WORSE? ______________________________

WHAT MAKES THE PROBLEM BETTER? ______________________________

IF YOUR PROBLEM RELATED TO AN INJURY, ACCIDENT OR WORK, PLEASE EXPLAIN:

____

PREVIOUS EVALUATION OR TREATMENT ______________________________

GENERAL MEDICAL HISTORY

PRIMARY PHYSICIAN: ______________________________ **LAST VISIT:** ______________

DO YOU HAVE ANY ALLERGIES?: [ ] NO LIST IF ANY : ______________________________

WHAT MEDICATIONS DO YOU TAKE?: [ ] NONE
PLEASE LIST ANY

____

____

DO YOU NEED TO TAKE ANTIBIOTICS BEFORE DENTAL VISITS? [ ] YES [ ] NO

FAMILY HISTORY: [ ] FOOT PROBLEMS [ ] DIABETES [ ] HEART DISEASE [ ] GOUT [ ] ARTHRITIS [ ] CANCER

TOBACCO USE: [ ] NEVER [ ] QUIT - WHEN __________ [ ] YES - AMOUNT ______________

ALCOHOL USE: [ ] NONE [ ] SOCIAL [ ] MODERATE [ ] HEAVY [ ] ALCOHOLISM [ ] FORMER ALCOHOLIC

DRUG ABUSE OR ADDICTION [ ] NO [ ] YES ______________________________

ACTIVITY LEVEL: [ ] SEDENTARY [ ] MODERATE [ ] HEAVY [ ] SPORT / EXERCISE ______________

HEIGHT ______________ **WEIGHT** ______________ **SHOE SIZE** ______________

ARE YOU PREGNANT? YES NO

PLEASE MARK IF YOU HAVE A HISTORY OF ANY OF THE FOLLOWING?

___ **Anemia**
___ **Asthma**
___ **Blood clots / phlebitis**
___ **Dementia**
___ **HIV / AIDS**
___ **Hypertension**
___ **Pneumonia**
___ **Ulcers (stomach)**
___ **Anticoagulant therapy**
___ **Auto immune disease**
___ **Cancer**
___ **Diabetes**
___ **Heart disease**
___ **Kidney disease**
___ **Poor leg circulation**
___ **Ulcers (foot)**
___ **Arthritis**
___ **Back problems /sciatica**
___ **Chronic pain**
___ **Emphysema**
___ **Heart murmur**
___ **Liver disease**
___ **Stroke**
___ **Artificial joints/implants**
___ **Bleeding problems**
___ **Cortisone/steroid therapy**
___ **Gout**
___ **Heart attack**
___ **Neuropathy / numbness**
___ **Thyroid disease**

DESCRIBE ANY OTHER SIGNIFICANT MEDICAL PROBLEMS, INJURIES OR SURGERIES:

____

______________________________ ______________
signed date

Jill Berlin DPM

Moulton Podiatry Group (949) 495-2506

Please initial each item:

______1. I understand that Dr. Berlin/Moulton Podiatry Group accepts regular (PPO) Medicare, secondary insurance, Monarch based HMO insurance, PPO insurance, and will bill on behalf of of the patient.

______2. I understand that Kaiser, VA, non-Monarch HMO are not accepted, and patients are charged the following fees: $50/visit when seen at the same time as other patients in the facility, and $65/visit as a private visit.

______3. I understand that cancelling an appointment/refusing treatment once Dr. Berlin has arrived at my residence may result in a $35 cancellation fee.

______4. I understand that if Dr. Berlin is unable to see a patient due to combativeness/agitation, patient positioning, or any other reason, the patient may incur a $35 cancellation fee.

______5. I understand that all paperwork must be filled out, signed and returned to Dr. Berlin/Moulton Podiatry Group, eligibility confirmed, and referral/authorization (if needed) in place before any appointment is made.

By signing this form, I agree to Dr. Berlin/Moulton Podiatry Group's policies, and agree to be financially responsible for the account of the patient listed below. I further consent to treatment by Dr. Jill Berlin DPM for the patient listed below.

Date____________________

Printed name of patient____

Signature of patient/responsible party____

Printed name of responsible party (if applicable)____

(please specify your relationship to the patient)____

Patient/Responsible party information:

Address____

____

Phone________________________________

Email________________________________

This form may be sent to us via:

Email moulton.pod@cox.net Fax: 949 495-3715 or mail: Moulton Podiatry group
30001 Town Center E2
Laguna Niguel Ca. 92677

Moulton Podiatry Group, Inc.
George J. Maraczi, D.P.M.
Matthew J. Cox, D.P.M.
30001 Town Center Dr., E-2
Laguna Niguel, CA 92677
949-495-2506

NOTICE OF PRIVACY PRACTICES

1. **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.**

2. **How we may use and disclose your health information.** We use health information about you for treatment, for administrative purposes, and to evaluate the quality of care that you receive. For example, your health information may be shared with other providers to whom you are referred. Information may be shared by paper, mail, electronic mail, fax or other methods. We may use or disclose your health information without your authorization for several reasons. But beyond those situations, we will ask for your written authorization before using or disclosing your health information. If you sign an authorization to disclose information you can late revoke it to stop any future uses and disclosures.

3. **Your rights.** In most cases, you have the right to look at or get a copy of your health information that we may use to make decisions about you. If you request copies, we may charge you a cost-based fee.. You also have a right to request a list of certain types of disclosures of your information that we have made. If you believe your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information.

4. **Our legal duty.** We are required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practices that are described in this notice, and seek your acknowledgment of receipt of this notice. We may change our privacy policies at any time. Before we make any significant changes in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at anytime.

5. **Privacy complaints.** If you are concerned that we have violated your privacy rights, our privacy policies or you disagree with a decision we have made about access to your health information, you may contact management.

Moulton Podiatry Group, Inc.
George J. Maraczi, D.P.M.
Matthew J. Cox, D.P.M.
30001 Town Center Dr., E-2
Laguna Niguel, CA 92677
949-495-2506

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

1. I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read, if I so choose) and understand the Notice.

_______________________________ Print Patient Name

_______________________________ Date

_______________________________ Authorized Representative (if applicable)

X_______________________________ Signature of Patient or Representative

2. I agree to pay for any services provided to me or requested by me or on my behalf, which are not paid by my insurance company or other party responsible for paying for my care. I also understand that I am responsible for interest and penalties, any collection costs, court costs, and reasonable attorney's fees incurred in the enforcement of this agreement.

X_______________________________ Signature of patient

if minor _______________________________ Signature of authorized person

AUTHORIZATION TO DISCLOSE PRIVATE MEDICAL INFORMATION

1.. I authorize my physician and his associated staff to disclose my personal and private medical information to the following person(s) when deemed appropriate and necessary in the interest of providing quality healthcare to me.

_______________________________ Name (please print)

_______________________________ Relationship

X_______________________________ Signature of Patient

_______________________________ Date

2. Furthermore, I hereby authorize the doctors and staff to leave voice messages on my home voice mail and/or answering machine informing me of laboratory results, appointment reminder calls and information regarding the status of my insurance authorizations for referrals to specialists and/or diagnostic procedures.

_______________________________ Name (please print)

X_______________________________ Signature of Patient

_______________________________ Date

3. If you would like to receive medical information via email, please provide email address.

____