NORTHERN CALIFORNIA FOOT AND ANKLE CENTER SANTA ROSA
"Committed to Excellence in Care of the Lower Extremity Since 1980"

WALTER F. D'COSTA, DPM, FAPWCA
KEVIN R. GRIERSON, DPM

Reconstructive Surgery of the Foot and Ankle
Pediatric and Geriatric Foot Care
Gait Related Disorders of Hip and Knee

Fellow of the American Professional Woundcare Assn.
Diabetic Wound Care and Limb Salvage
Sports Medicine

PATIENT INFORMATION				
Patient's Name: First:	Middle:	Last:		☐ Mr. ☐ Miss ☐ Ms. ☐ Mrs.
Sex: ☐ M ☐ F	Age:	Birthdate:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	
Street Address:	City:	State:	Zip Code:	
Home Phone:	Email:	Social Security #:		
Occupation:	Employer:	Employer Phone:		
Race/Ethnicity: ☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic ☐ Pacific Islander ☐ Other: _____	Preferred Language: ☐ English ☐ Spanish ☐ Other: _____	Interpreter Needed? ☐ Yes ☐ No		

INSURANCE INFORMATION (Please give your insurance card and ID to receptionist)			
Name of primary insurance:	Subscriber name:	ID/Policy #:	Group #:
Patients relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other			
Name of secondary insurance:	Subscriber name:	ID/Policy #:	Group #:
Patients relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other			

EMERGENCY CONTACT INFORMATION			
Name of emergency contact:	Relationship to patient:	Home phone:	Work phone:
Alternate contact:	Relationship to patient	Home phone:	Work phone:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Walter D'Costa, Dr. Kevin Grierson, or my insurance company to release any information required to process my claim(s).

Patient/Guardian Signature: _____ Date: _____

2281 Cleveland Ave Santa Rosa, CA 95403 ● (707)-544-3337 ● Fax: (707)-544-0608 ● norcalpodiatry.com

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Medical History

Name: _____

Describe the nature of your foot or ankle complaint: _____
_____

Is this an injury? ☐ Yes ☐ No Have you had any x-rays or other imaging? ☐ Yes ☐ No

Are you in good health? ☐ Yes ☐ No

Are you currently taking any medications or supplements? ☐ Yes (fill out below) ☐ No

Name	Dose	Reason

Do you have Diabetes? ☐ Yes ☐No If yes, how is it managed?: ☐ Insulin ☐ Pills ☐ Other:_____

Do you have, or been treated for any of the following?:

☐ Diabetes ☐ Broken bones ☐ Cancer ☐ Tuberculosis
☐ Heart problems ☐ Liver disease ☐ Ulcers ☐ Rheumatic fever
☐ High blood pressure ☐ Anemia ☐ Seizures ☐ Stomach problems
☐ Gout ☐ Asthma ☐ Blood clots ☐ Other: _____
☐ Arthritis ☐ Bleeding problems ☐ Kidney disease

Do you have any allergies? ☐ None ☐ Penicillin ☐ Codeine ☐ Iodine ☐ Latex
☐ Adhesive Tape ☐ Sulfa ☐ Other:_____

Name of your family doctor: _____ Last visit: _____

Who referred you to us?: _____

I hereby give my permission to the doctors at the Northern California Foot and Ankle Center Santa Rosa to administer treatment as deemed necessary in the diagnosis and treatment of the patient named above.

Signature _____ Date _____

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Patient: _____ Insurance: _____

I request that my payment of authorized Medicare/ Insurance benefits be made on behalf or Dr. Walter F. D'Costa or Dr. Kevin Grierson for any services furnished to me by the listed providers. I authorize the holder of medical information about me to release any information needed to determine these benefits payable to related services.

I understand my signature below requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated on item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider and supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-pay, and non-covered services.

I UNDERSTAND THAT IS IT MY RESPONSIBILITY TO TELL THE OFFICE ALL THE DETAILS OF MY COVERAGE, IMMEDIATELY INFORM THEM OF ANY CHANGES TO MY INSURANCE/COVERAGE, AND BE FULLY AWARE THAT ANY SERVICE NOT COVERED IS MY SOLE FINANCIAL RESPONSIBILITY. INITIAL: _____

I hereby instruct and direct my insurance company to pay by check mailed directly to Walter F. D'Costa, DPM 2281 Cleveland Ave, Santa Rosa, CA 95403. If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make out the check to me and mail is as follows: c/o Walter F. D'Costa DPM 2281 Cleveland Ave, Santa Rosa, CA 95403. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above the insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.

Signature of policy holder: _____ Date: _____

Signature of claimant, if other than policy holder: _____

PRACTICE REQUIREMENTS:

a) Is required by federal law to maintain the privacy of your protected health information (PHI) and provide you with this privacy notice detailing our legal duties and privacy practices with respect to your PHI
b) Under the privacy rule, may be required by state law to grant greater access or maintain greater restrictions on the use or release of your PHI than which is provided under federal law
c) Is required to abide by the terms of this privacy notice
d) Reserves the right to change the terms of this privacy notice and make the new privacy notice provisions effective for your entire PHI
e) Will distribute any revised privacy notice to you prior to implementation
f) Will not retaliate against you for filing a complaint

This notice is in effect as of 4/15/2003

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

Patient/Guardian Signature: _____ Date: _____

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Notice for updated office policies: Effective May 1, 2013

All patients:

There will be a required 24 hour cancellation policy for all appointments. It will be $20 for all cancelled and missed appointments due before you can be seen for another visit.

Patients are also required to update all information including, but not limited to, name, address, contact number, and insurance information. If payment for services is delayed or denied due to any of these factors the patient will be held responsible for all charges incurred at that visit.

Also, all balances over 90 days late for payment will be put on hold and the patient cannot be seen until the balance has been cleared off the account or a payment plan has been set up in writing with our office manager.

Private pay wound patients:

Due to the increased cost of supplies and shipment as of May 1, 2013, there will be an increase to the office visit payments based on your wound size and grade. Inquire about fee schedule changes at the front desk.

Please sign below to acknowledge you have read and understand the above policies and agree to the terms. A patient cannot be seen without a signature of acknowledgement.

Patient signature: _____ Date: _____

Patient name (printed): _____

Relationship to patient if anyone other than the patient signs: _____

Office staff witness: _____ Initials: _____ Date: _____

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