DALY CITY & SERRAMONTE PODIATRY GROUP
1800 Sullivan Ave **Suite 401** Daly City, CA 94015
Tel: (650)755-3338 Fax: (866)570-2041

Office use only:
MRN: _____

PATIENT INFORMATION (Must be completed in full)

Full Name: _____Date of Birth: _____/_____/_____ Age_____

Home Address: _____City_____State_____Zip_____

Billing Address:_____City_____State_____Zip_____

Home Phone (____) _____ Cell Phone (____) _____ Opt in for apt reminders: ◯Yes ◯No

Email Address: _____ Social Security (Not Medicare) #:_____

THE GOVERNMENT REQUIRES US TO COLLECT THE FOLLOWING

Gender Identity: ____Male _____Female ____Non-Binary ____Other ____*Patient declines to specify*

Language: ___English ___Spanish ___Chinese ___Tagalog ___Arabic ___Other:_____

[We DO NOT provide translators, must bring own interpreter if needed to appointment]

Race_____ ◯ Decline to state Ethnicity_____ ◯ Decline to state

Marital Status: ◯Single ◯Married ◯Divorced ◯Widowed ◯ Other: _____

EMPLOYER INFORMATION

Occupation: _____ Place of employment: _____Phone (____) _____

EMERCENGY CONACT INFORMATION

Emergency Contact Name: _____ Relationship to patient: _____
Emergency Contact Phone (____) _____

PRIMARY CARE PHYSICAN INFOMRATION

Providers Name: _____Phone (___) _____ Fax (____) _____

Providers Address: _____Suite: _____Specialty: _____

REFERRING PHYSCIAN/GROUP INFORMATION

Referring Providers Name: _____ Specialty: _____

Providers Address: _____ Suite: _____ Fax (____) _____

PODIATRY VISIT INFORMATION

Please describe reason for visit (include date of injury if applicable:_____

_____.

PHARMACY INFORMATION

Name of pharmacy: _____Phone: (____) _____ Fax: (____) _____

Pharmacy Address: _____City_____State____Zip_____

GUARDIAN/AUTHORIZED REPRESENTATIVE (INDIVIDUAL OR ORGANIZATION) INFORMATION

Print Full Name: _____DOB: _____/_____/_____

Relation to patient: _____ / Organization Name: _____

GUARANTOR INFORMATION *Please list the information for the individual financially responsible for the patient.*

Guarantor Full Name: _____ Guarantor date of birth: _____/_____/_____

Relation to patient: _____Email: _____Phone (____) _____
Guarantor Address: _____City_____State____Zip_____

MEDICAL INSURANCE INFORMATION *Must bring ALL insurance cards including state issued **photo ID**.*

Primary Insurance Carrier:	
HMO: PPO:	**HMO/PPO Must sign insurance assignment and release located below*
Subscriber's Name:	Subscriber's Date of Birth:
Insurance ID #:	Group #:

Do you have Secondary Insurance? If so, please fill out next section

Secondary Insurance Carrier:	
HMO: PPO:	**HMO/PPO Must sign insurance assignment and release located below*
Subscriber's Name:	Subscriber's Date of Birth:
Insurance ID #:	Group #:

Medicare / Health Plan of San Mateo/ Care Advantage /HPSM-Medical Patients ONLY

I request that payment of authorized Medicare benefits, and if applicable, benefits, be made on my behalf to: **Daly City Podiatry Group/Serramonte Podiatry Group** for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and HPSM services, my HPSM insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature: _____Date: _____
**if patient is a minor (under the age of 18), form must be signed by parent or legal guardian*

INSURANCE ASSIGNMENT AND RELEASE HMO AND/OR PPO

I certify that I have insurance with_____
(Name of Insurance Company/Companies)

And assign directly to **Daly City Podiatry Group / Serramonte Podiatry Group** all insurance benefits, if any, payable for services rendered for my treatment. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below, whichever comes first. I also understand that Daly City Podiatry Group is ONLY contracted with CERTAIN MEDICAL GROUPS per HMO Plan.

Signature: _____Date: _____
**if patient is a minor (under the age of 18), form must be signed by parent or legal guardian*

FILL OUT PRIOR TO APPOINTMENT – MUST BE FILLED OUT EVERY TWO YEARS - FRONT AND BACK

CONSENT OF TREATMENT AND OFFICE POLICIES

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform treatment of my concerns upon a thorough discussion with the doctor. I hereby authorize the doctor or their assistants to initiate the diagnosis and treatment of my condition with x-ray, examination or photographs of injections as necessary.

1. **MASKS ARE *RECOMMENDED* DURING YOUR VISIT.**
2. If you need to reschedule, call within **24 HOURS** of scheduled appointment to avoid an in-office **$25 cancellation fee.** We will not set up follow up appointments until we receive payment.
3. There is a **$50 cancellation fee** for a missed procedure appointment.
4. If you are late to your appointment by **15 minutes** or more, we have the right to reschedule your appointment. Call the office ahead of time if you will be late to your appointment.
5. Patients must bring insurance card and Photo ID to every visit. **No Exceptions!**
6. All insurance CO-PAYS and applicable DEDUCTIBLES are due at the time of the visit.
7. **IT IS THE PATIENT'S RESPONSIBILITY** to update any insurance or changes in your contact information with our staff.
8. IT IS THE PATIENT'S RESPONSIBILITY to know what is covered under their insurance plan, to avoid an out of pocket expense.
9. If your insurance policy requires a referral to see a specialist, please have it at the time of the visit.
10. Should you receive payment from the insurance company for the doctor a timely reimbursement for your care is imperative.
11. If you are a diabetic, please be sure to provide your primary care physician's name and contact information.
12. It is patient's responsibility to remember their appointments. **Reminder calls are a courtesy not an obligation.**
13. **No Dogs are allowed in the office. Only seeing dogs etc.**
14. **THIS CLINIC HAS ZERO TOLERANCE FOR: SWEARING, THREATS, OR ANY ACT OF VIOLENCE WILL NOT BE TOLERATED. ANYONE GIVING VERBAL ABUSE TO STAFF WILL BE ASKED TO LEAVE THE PREMISES.**

I have acknowledged and agree to follow the policies of this office.

Signature: _____Date: _____

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PATIENT INFORMATION FORM All sections of this form are required and must be completed prior to seeing the doctor.

PLEASE INDICATE YOUR PAST OR PRESENT MEDICAL CONDITIONS – *mark any that apply*

Cardiovascular
- ◯ Heart disease
- ◯ Stroke
- ◯ High Blood pressure
- ◯ Angina
- ◯ Heart Attack
- ◯ Other: _____
- ◯ Other: _____

Respiratory
- ◯ Asthma
- ◯ Emphysema
- ◯ Tuberculosis
- ◯ Pneumonia
- ◯ Other: _____
- ◯ Other: _____

Nephrology
- ◯ Kidney Disease
- ◯ Dialysis

If yes, what days: _____

Nervous System
- ◯ Depression
- ◯ Anxiety Disorder
- ◯ Parkinson's disease
- ◯ Psychiatric treatment
- ◯ Epilepsy/Seizure
- ◯ Other: _____

Other
- ◯ Cancer

Specify type: _____

- ◯ **Diabetes**

If yes, average blood sugar: _____
- ◯ Gout
- ◯ Thyroid/Parathyroid
- ◯ Anemia
- ◯ Alcoholism
- ◯ Bleeding Disorders
- ◯ Arthritis
- ◯ Blood Clots
- ◯ HIV
- ◯ Herpes

- ◯ Rheumatic Fever
- ◯ Ear, Nose, Throat Disorder
- ◯ Stomach Disorder/Ulcer
- ◯ Prostate Disorder
- ◯ Chemical Dependency
- ◯ Other: _____
- ◯ Other: _____

◯ **Mark here if NONE APPLY**

HEALTH REVIEW

Please mark any symptoms you have had in the past 3 months. – *mark here if* ◯ **NONE**

General
- ◯ Fever
- ◯ Chills
- ◯ Fatigue
- ◯ Weight Loss
- ◯ Weight Gain

Eyes
- ◯ Light Sensitivity
- ◯ Double Vision
- ◯ Loss of vision

Ear, Nose, Throat
- ◯ Hearing problems
- ◯ Nose bleeds

Respiratory
- ◯ Asthma
- ◯ Persistent Cough
- ◯ Shortness of breath
- ◯ Wheezing

Skin
- ◯ Rash
- ◯ Itching
- ◯ Suspicious lesions
- ◯ Change in Hair/Skin texture

Neurological
- ◯ Headaches / Dizziness
- ◯ Numbness of hands/feet
- ◯ Seizures
- ◯ Tremors
- ◯ Paralysis
- ◯ Vertigo

Hematologic/Lymphatic
- ◯ Anemia
- ◯ Abnormal bleeding
- ◯ Abnormal bruising
- ◯ Blood Clots

Genitourinary
- ◯ Painful urination
- ◯ Frequent urination
- ◯ Loss of control
- ◯ Pelvic Pain

Cardiovascular
- ◯ Chest pain or angina
- ◯ Irregular heart beat
- ◯ Palpitations
- ◯ Edema/ankles swell
- ◯ Faint/ lose consciousness

Psychiatric
- ◯ Anxiety
- ◯ Depression
- ◯ Memory loss
- ◯ Difficulty sleeping

Gastrointestinal
- ◯ Abdominal Pain
- ◯ Indigestion/Heartburn
- ◯ Difficulty Swallowing
- ◯ Change in bowel habits

Musculoskeletal
- ◯ Arthritis
- ◯ Muscle Weakness
- ◯ Joint Pain
- ◯ Back Pain

Endocrine
- ◯ Excessive thirst
- ◯ Heat intolerance
- ◯ Cold intolerance
- ◯ Hot flashes
- ◯ RSV
- ◯ COVID
- ◯ Other: _____

SURGICAL HISTORY – *mark here if* ◯ NONE

Surgical procedures, serious illness/injuries etc.	DATE	PHYSICAN	HOSPITAL

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Please list current list of medications, including supplements, blood thinners and OTC meds. - *Mark here if* ◯ **NONE**

Name of medication	Dose	Name of medication	Dose

Do you have any **drug** allergies? ◯ No known drug allergies ◯ Yes, specify: _____

Any reactions: _____.

Do you have any **food** allergies? ◯ No known food allergies ◯ Yes, specify: _____

Any reactions: _____.

Do you have any **other** allergies? I.e. tapes, latex, jewelry etc. ◯ No known allergies ◯ Yes, specify:_____

_____. Any reactions? _____.

FAMILY MEDICAL HISTORY - Please specify if any relatives were diagnose with the following - mark *any that apply.*

◯ Patient has no knowledge of family history	MOTHER	FATHER	SISTER	BROTHER	OTHER
Diabetes					
Cancer					
Mental Disorder					
Arthritis					
Kidney Disease					
Emphysema					
Tuberculosis					
Heart trouble					
Stroke					
Blood Clots					
Other:					

General Information - Please specify any that apply below -

Number of caffeine drinks per day? _____

Number of alcoholic drinks per day? _____

How often do you exercise?
◯ Never ◯ _____x times per week

Height: _____Ft _____Inch Weight: _____lbs

Shoe Size: _____

Do you use a wheelchair or walker?
◯ Yes: _____ ◯ No

Are you currently ***pregnant***? ◯ Yes ◯ No

Please specify use of tobacco or other (past or present)-

Do you currently smoke *tobacco*? ◯ Yes ◯ No

How many packs per day? _____

Did smoke *tobacco* previously? ◯ Yes ◯ No

How many years? _____ Year quit: _____

Do you currently use marijuana? ◯ Yes ◯ No

◯ Narcotics/Opiate

◯ Cocaine

◯ Other: _____

TREATMENT CONSENT FORM DURING COVID PANDEMIC

COVID-19 RISK OF TRANSMISSION:

DALY CITY PODIATRY GROUP & SERRAMONTE PODIATRY GROUP operates with very strict hygienic and sanitation protocols in place to protect our patients. Despite these precautions, there is an inherent risk of human–to human transmission of the coronavirus (COVID-19). For details of our hygiene and sanitarian protocol, please speak to your Podiatrist today. We have requested any symptomatic patients to stay away from the clinic at this time. Whilst we have taken precaution to limit your risk of exposure to coronavirus, we cannot guarantee that there is no risk to you because of attending the clinic and/or receiving treatment.

HOW DOES CORONAVIRUS SPREAD?

This virus appears to be spreading easily and is thought to spread mainly from person to person through people who are in close contact with one another (within about 6 feet) or through respiratory droplets produced when an infected person coughs or sneezes. Whilst it is currently thought that people are most contagious when they are most symptomatic, it is possible some spread might be possible before people show symptoms. If you are in the 'at risk' group below, you are strongly advised not to receive care at this time, and it is very important you discuss this with your Podiatrist now. You are classified as vulnerable and at risk if you are:

- Over 60 with underlying health conditions
- Pregnant
- Have a long-term health condition like cancer, a respiratory condition, heart condition, Diabetes
- Are currently shielding after receiving a government letter or living with someone who is shielding

Consent to receive care

- I understand that there is a risk of transmission of COVID 19 because of attending the clinic and/or receiving treatment.
- I understand that DALY CITY PODIATRY AND/OR SERRAMONTE PODIATRY GROUP and associates cannot accept responsibility for transmission of COVID-19 should I become infected.
- I have had the chance to ask all the questions I wish at this time. By signing below, I consent that I have read agreed and understood the statements above and consent to receive care by Daly City Podiatry Group and/or Serramonte Podiatry Group.

JAMES W. STAVOSKY, DPM | BRUCE M. DOBBS, DPM | VARSHA IVANOVA, DPM

Patients Signature…… Date…….

Patient's name_____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Acknowledgment for HIPPA (The pages following pages)

I, _____ have been informed of this office's Notice of Privacy Practices.

Signature _____ **Date:** _____

**if patient is a minor (under the age of 18), form must be signed by parent or legal guardian*

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

___ Individual refused to sign
___ Communications barriers prohibited obtaining the acknowledgment
___ An emergency prevented us from obtaining acknowledgment
___ Other (Please Specify)

_____
_____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH AND MEDICAL INFORMATION IS IMPORTANT TO US.

OUR RESPONSIBILITIES

We at Daly City Podiatry Group understand that medical information about you and your health is personal. Applicable federal and state law requires us to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect This Notice takes effect 03/24/2017, and will remain in effect until we replace it. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose health information about you for treatment, payment, and healthcare operations. For example:

To Treat You: We can use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Billing and Payment for Services: We can use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We can use and disclose your health information in connection with our healthcare operations which include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time; your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you as described in the Patient Rights section of this Notice We may disclose your health information to a family member, friend or another person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for PCIHIPAA.com Page 1 of 3 your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency
circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, X rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing purposes without your written permission.

Required by Law: We may use or disclose your health information when we are required to do so by state or federal law, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy

law.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official's health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you: For workers' compensation claims For law enforcement purposes or with a law enforcement official With health oversight agencies for activities authorized by law For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, text messages or letters).

PATIENT RIGHTS
Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies, mailing, and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end PCIHIPAA.com Page 2 of 3 of this FRONT AND BACK Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your

health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Officer: Office Manager / Saydi Marquez
Telephone: 6507553338
E-mail: saydi_dcpg@yahoo.com
Address: 1800 Sullivan Ave. #401
Zip Code: 94015
State: California
City: Daly City
PCIHIPAA.com

Regardless if you've been vaccinated against COVID-19; MASKS ARE REQUIRED AT ALL TIME DURING EXAM AND IN THE Office