Jeffrey S. Hurless, DPM, FACFAS
Michael LeCastre, DPM
425 Haaland Drive #201
Thousand Oaks, CA 91361
805-496-2383

I. Patient Information

Name _____

Address of Financially Responsible Party_____
(No P.O. Boxes)
City_____ State_____ Zip_____

Home Phone #( )_____ Mobile Phone #( )_____

Would you like your appointment reminder via text message? Yes____No____ Please provide cell phone carrier_____

What is the best number to contact you? Home_____ Cell_____ Work_____

E-Mail address_____

Age _____ Date of Birth_____ Marital Status M___ S____ D____ W____ Sex M_____ F_____

Ethnicity: White_____Latino_____Asian_____Black/AA_____Other_____

If you prefer a language other than English, please list. _____

Social Security #_____ Drivers License #_____

Employer_____ Work Phone #( )_____

Occupation_____ Responsible for Payments_____

In Case Of Emergency Contact:_____ Phone #( )_____

Pharmacy Name_____Pharmacy #_____

II. Referred By: Dr._____ Friend or Relative_____

Google _____Yahoo _____Other _____Insurance Handbook_____

III. Primary Insurance:

Insurance Company Name_____

Deductible Amount _____Co-Pay Amount _____

Subscriber's Name_____ Subscriber's Phone #( )_____

Subscriber's Birthdate_____ Sex _____M _____F

Subscriber's Social Security #_____

Patient Relationship to Subscriber Self_____ Spouse_____ Child_____ Other_____

I give my consent to have photographs or videotaped images made of my feet. I understand and agree these images may be used by Advanced Foot & Ankle Medical Center for teaching purposes, advertisement or our website. If disagree please check here. ____

Patient Signature_____ **Date**_____
(Parent or guardian signature required if patient is a minor)

Patient Name_____ **Date**_____

Reason for today's visit: (chief complaint)_____

Weight:_____ **Height** _____**Shoe Size:**_____

Current medications:_____

Allergies to medications:_____

Surgeries you have had:_____

Current or past problems with: (Review of systems)

	Yes	**No**	**(if yes, explain)**
Diabetes	___	___	_____
Eyes	___	___	_____
Ears/Nose/Throat/Mouth	___	___	_____
High blood pressure	___	___	_____
Heart (murmur, artificial valves)	___	___	_____
Lungs	___	___	_____
Stomach/bowel	___	___	_____
Kidneys	___	___	_____
Arthritis/muscles/joints	___	___	_____
Skin	___	___	_____
Psychological disorder	___	___	_____
Blood/bleeding disorder	___	___	_____
Allergic/immunologic	___	___	_____
Cancer	___	___	_____
Circulatory problems	___	___	_____
Liver disease	___	___	_____
Phlebitis	___	___	_____
Varicose veins	___	___	_____
Stroke	___	___	_____

Females: are you pregnant ___yes ___no planning to become pregnant ___yes ___no

Family History: (Past family & social history)

No. of children:____ age(s)_____

Check the following medical conditions that have occurred in your family:

Disease	**Mother**	**Father**	**Blood Relative**
Arthritis	____	____	____
Cancer	____	____	____
Diabetes	____	____	____
Eczema	____	____	____
Heart disease	____	____	____
High blood pressure	____	____	____
Lung disease	____	____	____
Malignant Melanoma	____	____	____
Skin cancer	____	____	____

Social History:

Who is your primary care or family doctor? _____ Do you live alone? ___no ___yes

Do you smoke? no ___ yes ___ –frequency_____ Have you ever smoked? no ___ yes ___ and how long?_____

Do you drink alcohol? no ___ yes ___ -frequency_____ Do you use recreational drugs? no ___ yes ___ -frequency_____

Occupation_____ Hobbies/leisure activities _____

Reviewed:_____ Date_____ Update_____

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PATIENT FINANCIAL POLICY

Thank you for choosing Advanced Foot & Ankle Medical Center as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office any patient information changes (i.e. address, name, insurance, etc).

Co-pays: The patient is expected to present an insurance card at each visit. All co-payment and past due balances are due at time of check-in unless previous arrangements have been made. Please note, any payment made at the time of service is an estimate cost of your portion. We accept cash, check or credit cards.

Insurance Claims: Insurance is a contract between you and your insurance company. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, (we are not contracted with Podiatry Plan) you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Failed Appointments
We require 24 hour advance notice for all cancelled appointments. If you fail your appointment a $50 fee will be assessed to your account.

Statements
All statements will be sent via e-mail. Statements will be sent on the 1St of every month.

Surgery: When possible, prior to scheduling surgery, an estimated surgical cost analysis will be provided at your request. It is your responsibility to pay the deductible, coinsurance or any outstanding balances on your account at least five (5) days prior to the date of your scheduled surgery. There will be a $250 cancellation fee for all non-medical cancellations. In addition you will be given a separate bill from the surgery center, lab, and anesthesia. It is your responsibility to confirm that they are within your network.

DME Products: All splints / orthotics dispensed are non-refundable.

Returned Checks: The charge for a returned check is $25 payable by cash, credit card or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned checks.

Outstanding Balance Policy: It is our office policy that all balances be sent two statements. If payment is not made on this account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney, and possible discharge from the practice. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections cost including attorney fees and court costs

Patient Agreement: I understand that I am ultimately responsible for all services. Balances greater than 30 days from date of service will be charged $5per month. Payment is due at the time services are rendered.

I authorize Jeffrey S. Hurless, D.P.M., Nazila Eshraghi D.P.M, to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim. I have read, understand and agree to the Financial Policy.

Patient Signature (Parent or guardian for minors) _____ Date _____

Jeffrey S. Hurless DPM, FACFAS
Michael LeCastre, DPM
Podiatrist / Foot Surgeon
425 Haaland Drive # 201
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Advanced Foot and Ankle Medical Center patients may request COPIES of all medical documents and x-rays at anytime, in receipt of a written request.

Medical records (i.e.: Progress notes, and X-rays), created by a medical office are legal property of that facility. Pursuant Health and Safety Section Code 123110.

Advanced Foot and Ankle Medical Center charges a processing and clerical fee for these documents, these records will be produced upon payment.

Medical Records $30.00

X-rays $30.00 (C.D. ONLY)

Please sign below in agreement of our Medical Records policy.

Patient Signature_____

Witness_____