Dr. Melody Chong D.P.M

2250 Hayes Street, Suite 206 * San Francisco, CA 94117 * Telephone (415) 386-3338

Patient Registration Form

Demographic Information

Last Name:_________________________ First Name_____________________ Middle:_________________

Home Address:____ City:______________________

State: _______ Zip: __________ **Home Phone** (___)_______________**Cell phone** (____)_________________

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:____

Insurance Company Phone (____)________________ Policy Number:________________________________

Subscriber Name:___________________________ **Date of Birth of Subscriber**: ______ / ______ / ______

Relationship to patient: ☐Self ☐Spouse ☐Child ☐Other:____________

Completed by (Print):__________________________ Signature:______________________ Date:________

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.

____

Signature of Patient   Date

____

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: ________________________

Patient Medical History

Height:___________ Weight:___________ Weight one year ago: _________How many children:________

Referring Physician/Provider: ___________________

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
☐Asthma
☐Bowel Disorder
☐Cancer / Type:______________
☐Chest Pain
☐Diabetes
☐Emphysema
☐Heart Failure
☐Heart Murmur
☐Hepatitis
☐High Blood Pressure
☐High Cholesterol
☐HIV, Covid-19
☐Kidney Disease
☐Prostate Disease
☐Thyroid Disease
☐Ulcer
☐Other:_______________

1. List the medication(s) you take (Doses & Frequency)

____

____

____

2. Are you allergic to any medication? Yes ☐ No ☐

List the medication(s) you are allergic to and the reactions

____

____

____

3. List all surgeries and dates

____

____

____

How many times per week do you exercise? ________ What type(s) _________________________________

Do you smoke now? Yes ☐ No ☐ # pack(s) per day_________ How many year(s)__________

If you quit, how many year(s) ago___________ # pack(s) per day_________ How many year(s)__________

Do you drink alcohol? Yes ☐ No ☐ How many drink(s) per day_________

Do you drink coffee/ tea? Yes ☐ No ☐ How many cup(s) per day________

Are there any disease(s) run in your family?____

Father ☐Alive ☐Deceased Age and medical issue:__________________________________

Mother ☐Alive ☐Deceased Age and medical issue:__________________________________

Sibling ☐Alive ☐Deceased Age and medical issue:__________________________________

Sibling ☐Alive ☐Deceased Age and medical issue:__________________________________

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 2 business days advanced notice will be charged a missed appointment fee of $75. This fee cannot be charged to our insurance carrier.**

All payments are expected at the time of service
Payment is required at the time services 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 your 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 difficulties. Please communicate with our billing and collection staff members so that they may assist in creating 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 assistance 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, you are responsible for all charges not covered by your medical insurance policy including, but not limited to, co-payments, deductibles, co-insurance, and non-covered services. You also agree to complete all necessary paperwork in order for your claim to be paid by your insurance company and accept full liability for all charges if payment is not made on your behalf by your insurance company.

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 who 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
You 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., your insurance carrier, or any other medical entity. A copy of this authorization will be sent to your insurance company or other entity if requested. The original authorization will be kept on file by Dr. Melody Chong D.P.M.

You understand that you are financially responsible to the organization for any charges not covered by healthcare benefits. It is your responsibility to notify Dr. Melody Chong D.P.M. of any changes in your healthcare coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. You are responsible for the entire bill or balance of the bill, as determined by Dr. Melody Chong D.P.M. and/or your 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.

You have read and understand the policies as outlined above. You understand that by signing this form you are accepting financial responsibility as explained for all payment for products and services received. You understand your financial responsibility as a patient.

____

Signature of Patient / Legal Guardian   Relationship   Date

____

Patient Name (print)