***DOUGLAS M. TAYLOR, D.P.M.***
PODIATRIC PHYSICIAN AND SURGEON
**1855 San Miguel Dr. #30 Walnut Creek, CA 94596** Phone (925) 945-7796
**13847 E. 14th St., Ste. 110A San Leandro, CA 94578** Phone (510) 351-4331

PLEASE BE SURE TO HAVE AUTHORIZATIONS AND REFERRALS IF NEEDED

**PATIENT INFORMATION SHEET**

Welcome to our office. Please take a moment to fill out our information sheet. After doing this, we will talk with you about your problem, take a history of your medical background and examine your feet. We will discuss our findings with you in depth. If you have any questions at all during your visit with us, please don't hesitate to ask.

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**Patient's Name_____ Gender M____ F____**
**Birth date _____Social Security # _____ Age_____**
**Preferred Language_____Ethnicity** Hispanic/Latino or Non Hispanic/Latino
**Race** Decline, American Indian/Alaska Native,Asian, Black/African American,Native Hawiian or Other Pacific Islander, White
**Address_____City_____Zip_____**
**Home Phone_____ Cell Phone_____**
**Email Address:_____**
**Occupation _____ Employer _____Phone_____**
**Emergency Contact (name, phone & relationship)**
**_____**
**Spouse/Partner's name_____ SS# _____Occupation_____**

**Name(s) of Medical Insurance Company and numbers of your Policy/Identification#**
**_____Group_____ Cov. Code_____**
**_____ I.D. #_____**
**Primary Subscriber_____Relationship_____**
**Gender M____F___ DOB_____ Employer_____**

**Whom may we thank for referring you to our office?_____**
**Have you ever been treated by a Podiatrist before? _____ Name_____**
**Name of your Family Physician_____ City_____**
**Preferred Pharmacy_____Phone_____**

**I hereby give my permission to Dr. Douglas M. Taylor, DPM to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition. I understand that any Durable Medical Equipment dispensed by Dr. Taylor's office may not be covered by my insurance or is excluded from contractual obligation and is my responsibility to pay for such fees. I also am aware of the advanced 24 hour notice cancellation policy. Any missed appointments that don't follow office policy will be billed to the patient. A service charge of 1 ½ % per month will be added on past due accounts (18% annually).**

**Date_____ Signature_____**
**Relationship_____**

**Over →**

**HEALTH QUESTIONNAIRE**

**Shoe Size_____ Height_____ Weight_____**

**Reason for your visit today _____**

**History of present Podiatry issue _____**

**When was your last physical examination?_____ Did you have an EKG Yes/No**

**Did you have a chest x-ray? Yes/No Were the findings normal? Yes/No**

**Date of your last Flu Vaccine: _____ Date of your last Pneumonia Vaccine:_____**

**Has your doctor ever told you that you have had any of the following (circle all that apply):**

Breathing problems (asthma, emphysema, Tuberculosis, shortness of breath) ….Yes / No

**Problems with Blood Circulation/Blood Clots/Varicose Veins (circle all) …Yes / No**

Heart trouble/Recent chest pain….Yes / No Stomach or Intestinal Ulcers……Yes / No

**Hepatitis or HIV..…Yes / No** **Kidney or Liver Disease…… Yes / No**

Diabetes……Yes / No Thyroid Condition…….. Yes / No

**High Blood Pressure…Yes / No** **High Cholesterol ……...… Yes / No**

Excessive Bleeding/Bruising….. Yes / No Arthritis or Gout……..… Yes / No

**Rheumatic Fever or Scarlet Fever…. Yes / No** **Skin Conditions (psoriasis/rash)..Yes / No**

Neurological Problems… Yes / No (Describe) _____

**Cancer yes / no (If so what type)_____**

**Surgical History:_____**

**Do you have any major medical conditions_____**

**Have you ever had any serious infections? Yes/ No (Please describe) _____**

**Have you had any traumatic injuries or broken bones? Yes/No (Please list date & reason)**

**List all medications you are taking including frequency/dosage and OTC: _____**

**Are you allergic to any medications or food? (Pain medication, antibiotics, sulfa, iodine, anesthetics, adhesive, latex etc.) _____**

**Smoking Status: Never Smoked, Current Every Day (How much_____) Current Some Day (How often _____) Former (When did you quit _____)**

**Do you Drink Alcohol? Yes / No If so how much?_____**

**Are your Parents living? Yes / No**

**Current diseases: Mother_____ Father _____**

**Have you had any complications from childhood diseases? (Describe) _____**

**Are there any other conditions the doctor should know about? (Describe) _____**

**Do you have an Advanced Directive… Yes / No**

Please use the back of this page if you need to provide more information.

# OFFICE POLICIES

The purpose of our policy is to allow us to best serve you and to properly schedule our time and that of your fellow patients.

**THINGS YOU SHOULD DO:**

- Give the front office staff a copy of your most current insurance card and update of any address or phone number changes.
- Understand that your insurance is an agreement between you and your insurance company. You are financially responsible for all services rendered to you in this office.
- 24 Hours notice is required for all cancellations or changes to your appointments. If such notice is not received, you may be charged $25.00. We will not bill your insurance companies for missed visits- you are personally responsible.

**OTHER FEES:**

| | |
|---|---|
| -Returned checks | $25.00 |
| -Unpaid co –pays at the time of visit | $10.00 |
| -Copying of medical records | $ To be determined |
| -Physicians telephone advice (>15min.) | $ To be determined |
| -Letters and form completion | $ To be determined |

- Failure to provide 24hr notice for cancellations of office visit $25.00

**DURABLE MEDICAL EQUIPMENT and MISCELLANEOUS:**

Durable medical equipment (DME) is any shoes, pads, braces, boots, creams, lotions, orthotics, adjustments to orthotics, modifications to shoes, miscellaneous supplies, etc. Generally these products are not covered by your insurance companies and are the patient's financial responsibility. All sales of DME are final, non-refundable and non-returnable. If you accept these products (or agree to the fabrication of these items) and leave the office they are yours to keep and will be your responsibility to pay for the full cost of the billed DME.

**MEDICARE PATIENTS:**

Our office does not accept assignment for Medicare patients. This means that the patient pays for the visit and services at the time that services are rendered. We then will submit all claims to Medicare and you will be reimbursed. We only submit to Medicare it is your responsibility to submit to any other insurance you carry.

**I ACKNOWLEDGE RECEIPT OF THIS POLICY AND ITS GUIDELINES.**

_____ _____

**SIGNATURE** **DATE**

**DOUGLAS M. TAYLOR, DPM**
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**Phone (510) 351-4331 Fax (510) 351-1797**

# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
# "HIPAA"

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), effective 4/14/2003. I have certain rights to privacy regarding my protected health information. I understand that information can and will be used to:

-Conduct, plan a direct treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
-Obtain payment from third-party payers.
-Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received (or been offered a copy), read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this office has the right to change its Notice of Privacy Practices from time to time and that I may contact this office at any time at the address above to obtain a current copy of Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature _____Date_____

Print Patient's Name _____

Relationship to Patient _____

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**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date _____ Initials _____

Reason _____

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## NOTICE OF PATIENT PORTAL ACCESS

I understand that, I now have access to my PHR (Personal Health Records). This will be done through direct e-mail. I have certain rights to privacy regarding my protected health information. I understand that any e-mail transmission between provider and me/the patient will become part of my health record. I understand that information can and will be used to:

-Exchange secure messages with you instantly.
-Instantly share lab results, medications, diagnoses, care plans, history, patient education, and more.
-Receive a patient engagement summary of office visits.
-You will play a more active role in your health care with our new free patient portal.

I have received (or been offered a copy), read and understand your Notice of Patient Portal Access containing a more complete description of the uses and disclosures of my health information. I understand that I have received (or been offered) the detailed report of Microsoft HealthVault's PHR data practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. You have the right to revoke this Authorization at any time.

"[When patients] participate more actively in the process of medical care, we can create a new healthcare system with higher quality services, better outcomes, lower costs, fewer medical mistakes and happier, healthier patients."
-Christopher G. Chute, MD, DrPHD, President of the American Medical Informatics Association

Please recognize that our e-mail communication will be through Microsoft HealthVault and that you shall open your (first) e-mail that you receive from us.

_____

Authorize e-mail communication:

____ Authorize ____ Does Not Authorize ____ Change e-mail address

____ Discontinue e-mail use ___ Doesn't have e-mail

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Notification of Secure Patient Portal

E-mail Address _____

Signature _____Date_____

**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement on this Notice of Secure Patient Portal Notification, but was unable to do so as documented below:

Date _____ Initials _____

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