VIPMD FOOT & ANKLE SPECIALISTS
3545 SAN DIMAS ST.
BAKERSFIELD, CA 93301
PHONE: 661-323-1947|FAX: 661-323-1904

Today's Date_____ ☐ Male ☐ Female

Last Name_____ First Name_____

Mailing Address_____

City_____ State_____ Zip _____

Primary Phone #_____Secondary Phone #_____

Email Address_____ SSN Last 4_____ Birthdate_____

Age_____ Height _____ Weight _____ Shoe Size _____

Emergency Contact _____ Contact #_____

Pharmacy Name_____ Pharmacy Phone #_____

Pharmacy Address_____

INSURANCE INFORMATION (PLEASE PRESENT INSURANCE CARD (S) TO THE RECEPTIONIST)

Primary Insurance_____ Relationship to Patient_____

Name of Policy Holder_____ Policy Holder's Date of Birth_____

Secondary Insurance_____ Relationship to Patient_____

Name of Policy Holder_____ Policy Holder's Date of Birth_____

REFERRAL INFORMATION HOW DID YOU FIND OUT ABOUT US?

☐ Insurance Company ☐ Doctor _____

☐ Website ☐Family Member/ Friend _____

GENERAL

Family Physician_____ Phone Number_____

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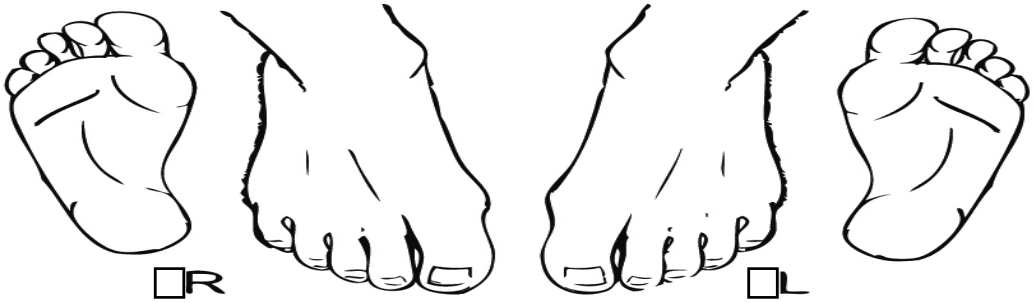
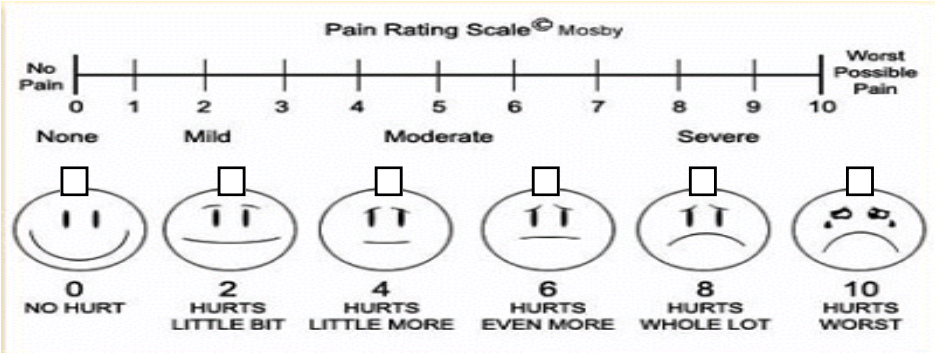
HISTORY OF PRESENT COMPLAINT (INSURANCE REQUIRES ALL PARTS TO BE FILLED OUT)

Please explain foot/ankle problems and use the below images and pain scale to describe these problems:

_____

_____





☐Left ☐Right ☐Both

Quality
☐No Pain ☐Acute Pain ☐Chronic ☐Constant ☐Dull Ache
☐Feels Heavy ☐Improving ☐Intermittent ☐Numbing ☐Sharp
☐Stabbing ☐Stable ☐Throbbing ☐Tingling ☐Worsening

Severity
☐Mild ☐Moderate ☐Severe
☐1-Mild ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10-Severe

Duration _____X Days _____ X Weeks _____ X Months _____ X Years

Timing ☐Continuous ☐Day time ☐In the morning ☐Night time ☐Intermittent

Context Occurs ☐At Rest ☐At Work ☐When Standing ☐When Stressed
☐While Walking ☐With Activity ☐With Exercise ☐Other _____

Modifying Factors

Relieved ☐Stopping Activity ☐When Cold Applied ☐When Heat Applied ☐With Activity
☐With Anti-Inflammatories ☐With Lying Down ☐With Pain Medication ☐With Rest
☐Other_____

Exacerbated ☐With Activity ☐With Eating ☐When Exercise ☐With Standing ☐While Walking
☐Other _____

Associated Signs and Symptoms ☐Fever ☐Itching ☐Redness ☐Swelling ☐Weakness ☐Pain
☐Other _____

Previous Treatment_____

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SURGICAL HISTORY PLEASE LIST ALL SURGERIES AND YEAR

☐ Denies having prior surgeries performed

_____
_____
_____
_____
_____
_____
_____
_____
_____

MEDICAL HISTORY SELECT ALL THAT APPLY

☐ No major illnesses or other prior medical conditions

☐ Alcohol Dependency
☐ Alzheimer's
☐ Anemia
☐ Arthritis_____
☐ Artificial Joints_____
☐ Asthma
☐ Bleeding Disorders/ Blood Clots
☐ Cancer_____
☐ Cataracts/ Lens Replacement
☐ Chemical Dependency
☐ Chemo/ Radiation Treatment
☐ Current Pregnancy
☐ C-Section
☐ Diabetes Type 1
☐ Diabetes Type 2
☐ Dialysis
☐ Disk Herniation
☐ Drop Foot
☐ Endocrine/ Hypothyroidism
☐ Eye, Glaucoma
☐ GI- reflux GERD
☐ Gout
☐ Heart Arrhythmias (irregular heartbeat)
☐ Heart Attack
☐ Heart Disease
☐ Hearing Loss
☐ High Blood Pressure
☐ Implants _____
☐ Inflammatory
☐ Kidney Failure
☐ Kidney Stones
☐ Kyphosis (abnormal spine)
☐ Liver Disease/ Hepatitis
☐ Menopause
☐ Mental Illness
☐ Migraine Headaches
☐ Neurological
☐ Neuropathy, numbness
☐ Osteopenia (low bone mass)
☐ Osteoporosis (decreased bone mass)
☐ Paralysis
☐ Prostate
☐ Rheumatoid Arthritis
☐ Seasonal Allergies
☐ Sciatica
☐ Scoliosis (spine curved side to side)
☐ Short Limb
☐ Sinusitis
☐ Spinal Cord Injures
☐ Spinal Disk Disease
☐ Stroke/ TIA/ CVA
☐ Tremors
☐ Ulcer- stomach/ esophagitis
☐ Urinary Incontinence
☐ Other_____
☐ Other_____
☐ Other _____

Hospitalization ☐ Yes ☐ No

FAMILY HISTORY SELECT ALL THAT APPLY AND RELATIONSHIP (MOTHER,FATHER, ECT..)

☐ Unknown family history
☐ Not Known-Adopted
☐ Alive and Well
☐ Arthritis
☐ Cataracts
☐ Diabetes 2
☐ Hypertension
☐ Stroke
☐ Heart Attack
☐ Gout
☐ Anemia
☐ Alcoholism
☐ Anxiety
☐ Cancer
☐ Diabetes 1
☐ Hyperlipidemia
☐ Kidney Disease
☐ Neuropathy
☐ Scoliosis
☐ DVT (blood clot in leg)/ PE (blood clot in lungs)

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ALLERGIES (MEDICATIONS/ TOPICAL ALLERGIES) PLEASE EXPLAIN ALLERGY REACTION BELOW

☐No Known Allergies

	Rate Severity 1,2,3,4 (Check Box)	Explain- (Check Box)
☐_____	1 2 3 4	Hives, Rash, Trouble Breathing, Fever
_____	1 2 3 4	Hives, Rash, Trouble Breathing, Fever
_____	1 2 3 4	Hives, Rash, Trouble Breathing, Fever
_____	1 2 3 4	Hives, Rash, Trouble Breathing, Fever
_____	1 2 3 4	Hives, Rash, Trouble Breathing, Fever
_____	1 2 3 4	Hives, Rash, Trouble Breathing, Fever

MEDICATIONS YOU ARE TAKING please list all medications along with dose and reason why you are taking

Medication/ Dose	Reason
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY

Occupation_____

Smoking Status ☐Current Every Day Smoker ☐Current Some Day Smoker ☐Former Smoker ☐Never Smoker ☐Smokeless/Vape ☐Medical Marijuana

Alcohol Use ☐None ☐Former Drinker ☐Occasional ☐Alcoholic

Marital Status ☐Single ☐Married ☐Divorced ☐Widowed

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REVIEW OF SYSTEMS

☐ **Cardiovascular:** Do you have any history of chest pain/ angina, high blood pressure, heart murmurs?
☐ Yes ☐No
145456
Musculoskeletal: Do you have any history of back, neck or joint pain or injury?
☐ Yes ☐No

Integumentary: Do you have any skin rashes, persistent itching or other skin problems?
☐ Yes ☐No

Neurological: Do you have any history of tremors, dizzy spells, numbness or tingling?
☐ Yes ☐No

Psychological: Do you have any history of depression, anxiety attacks, or suicidal thoughts?
☐ Yes ☐No

Endocrine: Do you have any history of excessive thirst, weight loss/ gain or too hot/ too cold?
☐ Yes ☐No

How far can you walk?

Any crampinig at night?
YES or NO
What do you do to make it better?

I request that payments of authorized benefits be made on my behalf for any services furnished me by Vipmd Foot and Ankle Specialist. I authorize any holder of information about me to release any information needed to determine these benefits or the benefits payable to related services to the insurance agent. I recognize my financial obligation of any co-insurance, co-pays or deductibles and non-covered services that may be required. I give permission to Vipmd Foot and Ankle Specialist, to examine, photograph, administer and perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle problems.

Patient Signature_____Date_____

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HIPAA AUTHORIZATION

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) states that the Practice cannot share your protected health information (PHI) without your permission, except in certain situations. For example, your PHI can be shared without your permission if it is used to facilitate your healthcare treatment, payment, or for healthcare operations. By signing this form, you are giving us permission to share your PHI as you indicate below.

I understand that my healthcare and the payment for my healthcare will not be affected by my signing this form. I understand that treatment, payment, enrollment or eligibility for benefits will not depend in any way on whether I sign this authorization or not. I further understand that I may inspect and copy any information disclosed pursuant to this authorization, and that I will receive a copy of this form upon signing it if I request it.

I understand that if the organization authorized to receive the information is not a health plan or healthcare provider or other entity considered a covered entity under HIPAA, the released information may no longer be protected by federal privacy regulations. I further understand that information disclosed pursuant to this authorization may be re-disclosed by the parties listed below and no longer protected.

I understand that this authorization is voluntary and may be revoked at any time. The request to revoke this authorization must be received by the Practice in writing. I further understand that any such revocation does not apply to the extent that persons authorized to use and/or disclose my health information have already acted upon my previous authorization(s).

Patient Name (Please Print): _____

☐ I authorize the release of selected medical information, as outlined below:

List the name of the individual to receive information: _____

Relationship to Patient: ☐ Spouse ☐ Child ☐ Other:_____

Information to be disclosed (Please check all that apply):
☐ Medical Records ☐ Imaging ☐ Finanical ☐ Billing/Insurance

Purpose for Disclosure: **At the request of the individual**

☐ I do not authorize information to be released to anyone.

Patient Signature: _____ Date: _____

This authorization will remain in effect until terminated by the patient in writing.

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FINANCIAL POLICY WE ACCEPT VISA, MASTERCARD, AMERICAN EXPRESS & DISCOVER

Thank you for choosing us as your podiatric physicians. We are committed to your treatment being successful, as you, the patient, are our first and foremost concern. As part of our service, we try to contain the cost of health care. In an effort to do this, we have implemented a Financial Policy.

The following is a statement of our FINANCIAL POLICY which we request you read and sign prior to any treatment. To avoid any misunderstandings, please contact us should you have any questions about our policies.

INSURANCE: If your doctor is a participating provider with your insurance plan, the claim is submitted to your insurance company. To do this we must have complete and accurate insurance information and a copy of your identification card or claim form. Your insurance policy is a contract between you and your insurance company; therefore, you are responsible for payment whether or not your insurance company pays. It is your responsibility to contact your insurance company regarding pre-authorizations, obtaining required referrals, second opinions, etc. Failure to do so may reduce the amount of benefits paid by your insurance, and the balance will then become your responsibility to pay. All co-payments must be paid at the time of service.

NO INSURANCE: If you do not have insurance or the doctor is not a participating provider with your insurance plan, please be prepared to fully cover the fees for each visit at the time of treatment.

PAYMENT: Payments for the balance due, co-payments, deductibles, etc., are due at the time of service and may be made by cash, check or credit card (Visa, MasterCard, American Express, Discover. There will be a $25.00 charge for returned checks. Delinquent accounts will be referred for collection at the discretion of the office manager.

MANAGED CARE PATIENTS/PRIVATE INSURANCE: If you are in a managed care plan (HMO, PPO, IPA with whom we participate, we abide by our contract with them. In either managed care plans or private plans, we will bill your insurance company; however, you are responsible for paying any co-pays, coinsurance and deductibles required by your plan at the time of treatment.

MEDICARE PATIENTS: We accept assignment for Medicare; that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any co-payments, which are usually 20% of the allowed amount for an item or service.

MINOR PATIENTS: The adult or the parent (custodial guardian accompanying a minor is responsible for payment of services. For unaccompanied minors, non-emergency treatment will be denied unless prior authorization from the parent or guardian has been made for the charges and treatment. Young adults (age 18 & over are legally responsible for their accounts unless a parent accompanies them to the initial appointment and signs this financial agreement, regardless of insurance coverage.

MISSED APPOINTMENTS: Please help us serve you better by keeping scheduled appointments. If it is necessary to cancel, please call our office 24 hours in advance. This allows us to accommodate our other patients. We reserve the right to charge for missed appointments.

Please complete the following items:
What is your co-payment per visit: $_____
What is your insurance annual deductible: $ _____ How much of the deductible is current (not yet paid: $_____ (if you are not sure what your current (not yet paid deductible is, please call your insurance company prior to your visit.Please be prepared to pay your co-payment and any charges within your current deductible at the time of your visit.

I have read and agree to the terms set forth in the above financial policy. I am financially responsible for any balance due.

Patient Signature _____Date_____

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OFFICE PROTOCOL

Welcome to the office Dr. Marshall Shieh, we and the staff are very pleased to have you as a patient. We understand that your foot or ankle issue may be significant enough to interfere with your lifestyle and we will be very cognizant of your time. We recognize that you may be in pain and very frustrated with your situation and we hope to make this process as easy and pleasant as possible. We would like to cover a few items before we started.

Financial surprise or misunderstandings are the most common reasons for frustration. Please let us know as soon as an issues develop so that we can be very clear, open, and transparent to help avoid misunderstandings.

Definition of covered: When the staff uses the word "covered" it means that this item, whether a procedure or a piece of medical equipment, is normally paid by your insurance company. However, even with insurance coverage, remaining fees after co-insurance and deductibles will apply to the patient. Therefore, even though the item is covered, you may still have a bill.

Deductible: The deductible is an amount of money that is to be paid by the patient before any insurance benefits will be reimbursed. This means that the office will collect any charges to the patient at the time of service until this amount is reached. Please understand your deductible and how much has been met currently.

Co-Insurance: This is a percentage that some insurances do not pay and will require the insured patient to reimburse the physician or facility. A common co-insurance is between 10% and 30%, though this varies significantly between specific procedures or medical equipment that is provided.

Co-pay: This is the amount your insurance requires you pay at each office visit and is due at check-in. You cannot be seen unless this fee is paid.

Late for appointment: We try to stay on time, but many times is not possible. This is made worse by patients being late for their appointment time. If you are greater than 15 minutes late, we may be able to work you into the schedule later in the day or we may ask you to reschedule. The new patient intake forms take about 15 minutes. If you are a new patient and have not filled out the intake forms by your appointment time, we may also ask you to reschedule.

Missed Appointments: Please help us serve you better by keeping scheduled appointments. If it is necessary to cancel, please call our office 24 hours in advance. This allows us to accommodate our other patients. We reserve the right to charge for missed appointMents.

Orthotics: Prescription arch supports are designed to help manage the mechanical movement and motion of your foot. We use these regularly for treatment of many maladies. They are commonly not paid for by insurance companies and generally cost $400.

Cell phone: Please be courteous and turn your cell phone ring tone off. Innumerable times during office appointments, cell phone calls interrupt the evaluation and treatment process. If you are speaking on the phone during an appointment the doctors will bypass your appointment until you are finished with your phone call.

Medical records: The office owns the medical record. It is not the property of a patient. The original copy must always stay in possession of the office. As a patient you may have access to your medical records and purchase copies per the fee schedule set by the state of California. We require a signed waiver and request 2 weeks' notice.

Routine foot care: This is callus trimming and nail care. We do not perform routine nail trimming in our office. Callus care is not normally covered by insurance companies, especially Medicare. There is a $45 fee for callus, payable at the time of service.

Common courtesy: This is a professional office and we expect patients and their family members to behave accordingly. Please use professional behavior at all times.

Many common foot ailments do not improve one single treatment and may require several weeks or months for improvement. Several different modalities may be needed depending upon the severity and the condition. Be prepared that multiple visits may be needed for diagnostic testing and possibly more than 1 treatment.

Medication refills: We try to refill PRN and daily use medication over the phone and we will ask you to be seen by physician relatively routinely. If you have not been seen within one year, your prescription will not be refilled. We ask gout patients to return every 6 months for labs and refills.

Lab testing, MRIs, and pathology reports: These imaging and testing results take time to be performed and then reported to our office. These will be interpreted by our staff and we will call you as soon as possible, and therefore we ask for your patience. Please allow 1 week for follow up on non-urgent results and test scheduling. Obviously we will be in contact with you immediately for more serious results.

Patient Signature _____Date_____