



Appt Date: \_\_\_\_\_

# Advance Foot & Ankle Associates Dr. Gunasayan / Dr. Abernathy

**Templeton:** 1310 Las Tablas Rd, Ste.#205, Templeton, CA 93465 Phone 805.226.4060  
**San Luis Obispo:** 862 Meinecke Ave., Ste.#204, S.L.O., CA 93405 Phone 805.540.5770

Patient Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

How would you like the staff to address you?(nickname) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ ZipCode \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Employed \_\_\_ Retired \_\_\_ Student \_\_\_

Message Choice(s): Voice \_\_\_ Text \_\_\_ Email \_\_\_ Social Sec.# \_\_\_\_\_

Marital Status: S \_\_\_ M \_\_\_ D \_\_\_ W \_\_\_ Email: \_\_\_\_\_

Spouse/Parent Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Social Sec.# \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone# \_\_\_\_\_

Name of Insured (if other than self) \_\_\_\_\_ Insured's DOB \_\_\_\_\_

Patient is: Spouse \_\_\_ Child/Dependent \_\_\_

*Notice: We need a copy of your photo ID and current insurance card(s) on file in order to bill your insurance for you. If we do not have this information, you will be billed directly and are solely responsible for all charges. Payment is due at the time of service.*

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Notice: Release of Benefits- I authorize my insurance benefits to be paid directly to Advance Foot & Ankle Associates. I understand that the provider's office will bill my insurance as a courtesy and that I am responsible for all co-payments, deductible, and non-covered services. I authorize the release of information required to process my claims. (If not signed, payment for each visit is due at the time of service.)

**ALL CO-PAYS AND PREVIOUS BALANCES ARE DUE ON THE DAY OF SERVICE.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to the patient if not self: \_\_\_\_\_

**Patient Medical History**

Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Shoe Size: \_\_\_\_\_

What condition are you being seen for today? \_\_\_\_\_

How long have you had it? \_\_\_\_\_

What started it or makes it worse? \_\_\_\_\_

What treatment have you had for it? \_\_\_\_\_

Is this work related? \_\_\_\_\_

**ALLERGIES (check all that apply & list reaction):**

\_\_\_ Aspirin \_\_\_\_\_

\_\_\_ Codeine \_\_\_\_\_

\_\_\_ Iodine \_\_\_\_\_

\_\_\_ Metal \_\_\_\_\_

\_\_\_ Other -Antibiotics \_\_\_\_\_

\_\_\_ Penicillin \_\_\_\_\_

\_\_\_ Tape/Band Aids \_\_\_\_\_

\_\_\_ Sulfa \_\_\_\_\_

\_\_\_ Other: (Food, fabric, etc.) \_\_\_\_\_

\_\_\_ Anesthesia \_\_\_\_\_

**Do you have a history of the following?  
(check all that apply) or None \_\_\_\_\_**

- \_\_\_ Arthritis
- \_\_\_ Rheumatoid \_\_\_\_\_
- \_\_\_ Osteoarthritis Location \_\_\_\_\_

- \_\_\_ Asthma
- \_\_\_ Cancer Location: \_\_\_\_\_

- \_\_\_ Circulatory
- \_\_\_ Diabetes - Type 1 \_\_\_\_\_ Type2 \_\_\_\_\_
- \_\_\_ Eye Condition
- \_\_\_ Fractures: Location \_\_\_\_\_

- \_\_\_ Glaucoma
- \_\_\_ Gout
- \_\_\_ Heart Problems \_\_\_\_\_
- \_\_\_ Hepatitis
- \_\_\_ High Blood Pressure
- \_\_\_ HIV/AIDS
- \_\_\_ Injuries: \_\_\_\_\_
- \_\_\_ Paralysis
- \_\_\_ Psychiatric History
- \_\_\_ Rheumatic Fever
- \_\_\_ Stomach or Bowel Problems
- \_\_\_ Stroke
- \_\_\_ Thyroid Disorder
- \_\_\_ Tuberculosis
- \_\_\_ Seizures
- \_\_\_ Varicose Veins
- \_\_\_ Other: \_\_\_\_\_

**Current Conditions: (check all  
that apply) or None: \_\_\_\_\_**

- \_\_\_ Anemia
- \_\_\_ Anxiety
- \_\_\_ Back Pain
- \_\_\_ Bleeding Problems
- \_\_\_ Chest Pain
- \_\_\_ Cough
- \_\_\_ Currently Pregnant
- \_\_\_ Depression
- \_\_\_ Digestive Problems
- \_\_\_ Fatigue
- \_\_\_ Frequent Sore Throats
- \_\_\_ Frequent thirst
- \_\_\_ Frequent urination
- \_\_\_ Headaches
- \_\_\_ Hearing Problems
- \_\_\_ Immune Problems
- \_\_\_ Joint pain/stiffness
- \_\_\_ Large weight changes
- \_\_\_ Leg cramps
- \_\_\_ Muscle weakness
- \_\_\_ Neurological Problems
- \_\_\_ Numbness
- \_\_\_ Poor Healing
- \_\_\_ Rash
- \_\_\_ Shortness of Breath
- \_\_\_ Sinus

# Patient Medical History

**Surgeries:** List all previous surgeries and approximate dates:

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**Other problems or conditions not previously listed**

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## **SOCIAL HISTORY:**

Exercise, Sports or recreational activities \_\_\_\_\_ How Often Each Week \_\_\_\_\_  
Alcohol Use: Never \_\_\_\_ Social \_\_\_\_ Mild \_\_\_\_ Moderate \_\_\_\_ Heavy \_\_\_\_ Daily \_\_\_\_ Quit \_\_\_\_  
Tobacco Use: Every day \_\_\_\_\_ Sometimes \_\_\_\_\_ Never \_\_\_\_\_ Former \_\_\_\_\_  
Recreational/Street Drug Use: Never \_\_\_\_\_ Rare \_\_\_\_\_ Daily \_\_\_\_\_

## **Family History:**

Please list any diseases common to your family including heart disease, diabetes type 1 or type 2, rheumatoid arthritis, etc..

Father: \_\_\_\_\_

Mother: \_\_\_\_\_

Brothers: \_\_\_\_\_

Sisters: \_\_\_\_\_

No history (adopted) \_\_\_\_\_

Last Flu Vaccine \_\_\_\_\_ Last vaccine for Pneumonia \_\_\_\_\_

**Medications:** Please list ALL. (check if list was provided to office \_\_\_)

Name	Dosage	How often taken	Why?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**PATEINT ACKNOWLEDGEMENT OF USE/DISCLOSURE OR PROTECTED  
HEALTH INFORMATION**

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Primary Phone Number \_\_\_\_\_ Email: \_\_\_\_\_

I understand that my health information is private and confidential. I understand that the practice of Advance Foot & Ankle Associates and staff work hard to protect my privacy and preserve the confidentiality of my health information. I give permission to retrieve my medication and health history from various sources.

The practice of Advance Foot & Ankle Associates has a detailed document called the "Notice of Privacy Practices." It contains more detailed information about how they may use and disclose patient health care information. I understand I have the legal right to read the "notice of Privacy Practices" before I sign this consent. The "practice" may update this "Notice of Privacy Practices." If I ask, I will be given a copy of the current "Notice of Privacy Practices."

I may cancel this consent in writing at any time by doing the following:

1. Signing and dating a form the "practice" staff will give me called "Revocation of Consent for Use and Disclosure of Healthcare Information.

**OR**

2. Writing, signing, and dating a letter to Advance Foot & Ankle Associates. It must state, "I want to revoke my consent to authorize the use and disclosure of my health information for treatment, payment, and healthcare operations".

If I revoke this consent, Dr. Gunasayan / Dr. Abernathy does not have to provide any further health care services to me.

My signature below indicates that I have been given the chance to review a current copy of the "practice's" "Notice of Privacy Practices." My signature means that I agree and consent to allow Advance Foot & Ankle Associates to use and disclose my protected health information to carry out treatment, payment, insurance claims, and healthcare operations including to my primary care/referring physician.

Communicating with you is a necessary part of our continued care of your medical health. We may need to communicate with you for various reasons including but not limited to lab results, appointment reminders, billing questions, etc.

Please indicate any person that you give us permission to leave your health information with. If you would like to provide us with permission to give your health information to additional individuals please ask for our "Medical Information Release" form.

Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
Name: \_\_\_\_\_ Relation: \_\_\_\_\_

**NOTE: We cannot guarantee that cell phone calls and e-mails are confidential due to the nature of these lines of communication. If you choose to list your cell phone number/email, you do so knowing we cannot protect your confidentiality.**

\_\_\_\_\_  
**Patient or Legally Authorized individual Signature** **Date**

\_\_\_\_\_  
Relationship to patient if signed by anyone other than the patient.

## Financial Policy of Advance Foot & Ankle Associates

Thank you for choosing Dr. Gunasayan / Dr. Abernathy. We are committed to the highest standards and excellence in your treatment. The financial aspects of providing Health Care are complex and difficult both for patients and physicians. Therefore, we have instituted the following financial agreement in order to continue to meet our patient's expectations of the highest standards. Please review this binding document carefully and acknowledge agreement with your signature.

**Please initial by each line item acknowledging you have read and understand our policies.**

### **PATIENTS ARE RESPONSIBLE FOR SERVICES RENDERED**

1. We accept cash, personal checks, Visa, MasterCard, and Discover.
2. **As a courtesy** we will file a claim to your primary insurance carrier: Current insurance cards and information are required by our office. **There is a \$15.00 fee per date of service for rebilling your insurance if incorrect information is given.**

**Our billing company will gladly file a claim with your PRIMARY INSURANCE CARRIER.**

3. Your insurance is a contract between you and your health plan. It is your responsibility to know your health plan and its benefits. We will not become involved in disputes between you and your insurance company, other than to supply factual information when necessary.
4. We will allow 60 days from the date of service for your health plan to pay.  
**After that time the unpaid balance is your responsibility.**

### **CO-PAYS, CO-INSURANCE AND DEDUCTIBLES**

1. Co-payments are a predetermined amount and will be collected on the date of service.
2. Co-insurance and deductibles may be calculated and payable on the date of service. Please contact your insurance carrier if you have any questions regarding your coverage.
3. If you are not prepared to pay the appropriate fees at the time of service your appointment may be rescheduled.
4. Due to the current high deductibles plans many insurances offer, our office will collect the estimated share of cost from the current fee schedule at the time of service.

### **HMO**

1. Your insurance carrier requires that you obtain a referral from your Primary Care Physician (PCP) before receiving services.
2. Any services you receive without a referral or prior authorization will be your responsibility.

### **ORTHOTICS/DIABETIC SHOES**

1. **Full payment is required prior to ordering custom items such as orthotics and diabetic shoes.**

### **SUPPLIES**

1. For the convenience of our patients we carry foot care items. These are self-pay items. They will not be billed to your insurance.

### **SURGERY PATIENTS**

1. We will verify coverage on surgery procedures for the patient's convenience. Please keep in mind surgical authorizations are for professional service of the doctor ONLY.
2. After verification, deductibles, co-pays and/or deposits will be collected when a patient consents to surgery.
3. **Due to the many changes within the insurance industry, we will collect the estimated charges prior to surgery. Payment may be made at the time of the Pre-Op appointment.**

**MINOR PATIENTS**

- 1. We require a minor patient to be accompanied by a parent or legal guardian.
- 2. The adult accompanying the minor patient is required to pay in accordance with our policies.
- 3. We **DO NOT** acknowledge or enforce the terms of a divorce decree or other civil settlements.

**CANCELED / MISSED APPOINTMENT**

- 1. Patients who fail to keep their scheduled appointments **without giving 24 hours notice will be charged \$25.00 for a missed visit.** REMINDER CALLS ARE A COURTESY, NOT A GUARANTEE. **You are responsible for your appointment.**

**DELIQUENT ACCOUNTS**

- 1. Accounts past due are placed on a cash-only status. All balances must be paid in full at each visit.
- 2. A fee of \$5.00 will be charged for each additional statement if your account is overdue.
- 3. Accounts are past due if not paid in full within 30 days of the statement date. Payment plans may be arranged in advance. Full payment is expected.
- 4. Patients with delinquent accounts that necessitate involvement of an outside collection agency may be discharged from the practice.
- 5. **I understand my credit card on file will be charged if my account is 30 days past due. I understand that a receipt will be emailed or mailed to me.**

**X-Rays**

- 1. We are able to make **one (1) CD** copy of your x-ray. There will be a \$5.00 for additional copies.

**NON-COVERED BENEFITS**

- 1. Occasionally patients request certain professional services that are not covered by health plans.
- 2. These services are billed at our current cash rate.

**They include but are not limited to the following:**

- a. Completion of prior authorization forms for non-HMO plans \$25.00 per auth
- b. Disability forms (DMV, FMLA, EDD, or other employer requested forms) \$25.00 per auth
- c. Authorizations requiring doctor phone conversation \$25.00 per request

\*\*\*\* As a courtesy our office will mail or fax applications or forms. We will not take responsibility for your forms after they leave our office. It is your responsibility to check with recipient to insure receipt of forms. \*\*\*\*\*

+ I HAVE READ AND UNDERSTAND THIS BINDING FINANCIAL DOCUMENT AND AGREE TO ABIDE TO ITS TERMS,  
+ I UNDERSTAND THAT CHARGES NOT COVERED BY MY HEALTH CARE PLAN, AS WELL AS ANY APPLICABLE FEES, CO-PAYS, AND DEDUCTIBLES ARE MY RESPONSIBILITY. THIS BINDING DOCUMENT PRESIDED OVER ANY PAST OR CURRENT AGREEMENT BETWEEN ME AND MY HEALTH PLAN.

+ I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO Advance Foot & Ankle Associates, WHENEVER NECESSARY. I AUTHORIZE Advance Foot & Ankle Associates, TO RELEASE PERTINENT MEDICAL INFORMATION TO MY INSURANCE COMPANY WHEN REQUESTED TO FACILITATE PAYMENT OF A CLAIM.

+ ALL QUESTIONS ABOUT THIS POLICY HAVE BEEN ANSWERED TO MY SATISFACTION.

**PATIENT NAME (PLEASE PRINT)** \_\_\_\_\_

**SIGNATURE (PATIENT OR RESPONSIBLE PARTY)** \_\_\_\_\_

**DATE** \_\_\_\_\_