High Desert Foot & Ankle Clinic *15366 11th Street Ste. A Victorville CA 92395 * Phone (760)951-1234 – Fax (760) 951-1611

Patient Registration

Name: _____ **S.S. :** _____

D.O.B: _____ **Sex:** F[] M [] **Marital status:** Married[ ] Single [ ] Divorced [ ] Widowed [ ]

Mailing Address:

Address: _____
City: _____ State: _____ Zipcode: _____

Physical Address:

Address: _____
City: _____ State: _____ Zipcode: _____

Home phone: _____ Cell Phone: _____

Email Adddress: _____

Employment:

Employer: _____ Occupation _____
Work Phone: _____

May we send you text message, leave you messages on your phone, answering machine or voicemail? **Yes [ ] No [ ]**

How did you hear about our practice? _____

What Pharmacy do you use? : _____

Who is your primary doctor? _____ Phone: _____

Emergency/Alternate Contact: This persons Phone Number MUST be different that your own.

Name: _____ Relationship: _____
Phone: _____ Cell: _____

Primary insurance holder information if different from the patient.

Name: _____ S.S: _____
Relationship: _____ D.O.B: _____
Address: _____ City: _____ State: _____ Zip code: _____
Phone: _____ Cell: _____

Secondary insurance information:

Insurance name: _____ Member ID #: _____
Group #: _____ City: _____ State: _____ Zip : _____
Phone: _____

Must Sign and Date

The undersigned certify that I (or my dependent) have insurance coverage with the insurance provided & assigned directly to High Desert Foot & Ankle Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I hereby authorize the Doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submission: The Undersigned consent to the treatment which may be performed on an outpatient basis, including emergency treatment or service, and which may include, but are not limited to, laboratory procedures, x-ray examination, medical or surgical treatment or procedure, rendered to the patient under the general and special instructions of the patient's physician or Surgeon. I Acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or head the opportunity to read if I so Choose) & understand the Notice.

Insured/Responsible Party Signature: _____ Date: _____

MEDICAL QUESTIONNAIRE (High Desert Foot & Ankle Clinic)

NAME: _____ **DOB:** _____ **AGE:** _____

ILLNESSES: (Circle What Applies)

Arthritis	Yes	No	
Gout	Yes	No	
Diabetes	Yes	No	
High Blood Pressure	Yes	No	
High Cholesterol	Yes	No	
Cancer	Yes	No	(Type)_____
Stroke	Yes	No	(What Year?)
Blood Clots	Yes	No	
Hepatitis	Yes	No	
H.I.V	Yes	No	

Other:_____

SOCIAL HISTORY

Smoking now? Yes No
When did you Start?:_____
Packs per day?_____
Past Smoker? Yes No When did you Stop?:____

Alcohol? Yes No How Much/Often?:____

PAST SURGERIES **(Include ANY surgery, including Foot/Ankle Surgeries)**

	Name	Date
1		
2		
3		
4		
5		

ALLERGIES **(Medication or substance Describe reaction or symptom)**

	Name	Reaction
1		
2		
3		

CURRENT MEDICATIONS

	Name	Dosage (How Much)	Frequency (How Often)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

FAMILY HISTORY

	Yes	No
Arthritis		
Diabetes		
Heart Diseases		
High Blood Presure		
Cancer (Type)		

High Desert Foot and Ankle Clinic
15366 11th Street Suite A.
Victorville, CA 92395
Ph760-951-1234-Fax760-9511611

ENLISH: Health Review:If you do not understand a question or you do not feel comfortable in answering a question, leave it blank and go on to the next question. Some questions may not apply to you.

Name:_____

General:				**Lungs:**		
Weight change? Greater than 10lbs	Y	N		Cough?	Y	N
Persistent Fatigue:	Y	N		Shortness of breath?	Y	N
Skin:				**Heart:**		
Any new skin rashes, lumps or bumps?	Y	N		Chest pain?	Y	N
Hot Flashes?	Y	N		Ever been told you had a heart murmur?	Y	N
EYES:				Abnormal EKG?	Y	N
Recent vision change?	Y	N		**Gastrointestinal:**		
Mouth:				Nausea or vomiting?	Y	N
Sore throat?	Y	N		Constipation?	Y	N
Sore mouth?	Y	N		Change in appetite?	Y	N
NECK:				Any liver or colon problems?	Y	N
New lumps?	Y	N		**Genitourinary:**		
Thyroid Problems	Y	N		Problems with urination?	Y	N
Blood:				**Joints/Extremities:**	Y	N
Any history of anemia or blood disorder?	Y	N		Bone or Joint pain/Stiffness?		
Neurologic:				Swelling/Lymphedema?		
Have you ever had a seizure?	Y	N		Ever had a blood clot?		
Weakness of: arm, leg, or other part of your body?	Y	N		**Psychological:**		
				Been treated for depression or anxiety?	Y	N

ESPAñOL: Revisión de la Salud:Si usted no entiende una pregunta o usted no se siente cómodo en responder a alguna pregunta, déjela en blanco y siga a la siguiente pregunta. Algunas preguntas podrian no applicarle a usted. **Nombre:**_____

General:				**Pulmones:**		
A tenido cambio de peso por mas de 10lbs	Si	N		Tos?	Si	N
Cansancio Persistente?	Si	N		Siente que le falta el aire?	Si	N
Piel:				**Corazón:**		
Tiene nueva erupciones en la piel, bultos o protuberancias?Sofocos?	Si	N		Dolor en el pecho?	Si	N
	Si	N		Murmuro o soplo en el Corazon?	Si	N
Hot Flashes?	Si	N		ECG [EKG] abnormal?	Si	N
OJOS:				**Gastrointestinal:**		
A tenido cambios en su vision?	Si	N		Náusea o vómito?	Si	N
Boca:				Estreñimiento?	Si	N
Dolor de garganta?	Si	N		Cambio de apetito?	Si	N
Dolor de boca?	Si	N		Preblemas del hígado o de colon? ?	Si	N
Cuello:				**Genitourinario:**	Si	N
bultos?	Si	N		Problemas cuando orina?		
Problemas de la tiroides?	Si	N		**Articulaciones / Extremidades:**		
Sangre:				Hueso o dolor articular / Rigidez?	Si	N
Historial de anemia o algun otro desorden de la sangre?	Si	N		Hinchazón / linfedema?	Si	N
Neurologico:				Ha tenido un coágulo de sangre?	Si	N
¿Alguna vez ha tenido una convulsión?	Si	N		**Psicólogico:**	Si	
¿Debilidad de: brazo, pierna u otra parte del cuerpo?	Si	N		Ha sido tratado por depresión o ansiedad?	Si	N

TELEHEALTH ACKNOWLEDGEMENT FORM

Patient's Name:_____ Birthdate: _____

1. I understand that my health care provider, Dr. W. Bollmann, Dr. S. Choi and Dr. B. Katz have recommended to me that I engage in a telehealth appointment in case I am not unable to report to the High Desert Foot & Ankle Clinic due to any circumstances including Shelter In Place order for pandemic infection such as COVID-19.

2. My health care provider has explained to me how the telehealth technology will be used to connect me with a provider. Telehealth appointments may be conducted by videoconferencing, video images, still images, or by telephone conference. I understand that this appointment will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telehealth appointment if it is felt that the videoconferencing connections are not adequate for the situation. I understand that I can discontinue the telehealth appointment at any time

4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the appointment other than my healthcare provider and other specialty health care provider in order to operate the equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence during the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telehealth examination room; and/or (3) terminate the telehealth appointment at any time.

5. I have had the alternatives to a telehealth appointment explained to me, and in choosing to participate in a telehealth appointment, I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the specialty health care provider or the primary care provider.

6. In an emergency situation, I understand that the responsibility of the telehealth specialist or provider may be to direct me to emergency medical services, such as emergency room. Or the telehealth provider may discuss with and advise my local provider. The telehealth specialist's or provider's responsibility will end upon the termination of the telehealth connection.

7. I understand that billing for the telehealth consultation may occur from 1) telehealth provider and 2) as a facility fee from the site from which I am presented. Billing is at the discretion of the provider. Billing procedures will be explained to me.

8. I have read this document carefully, and understand the risks and benefits of the telehealth appointment and have had my questions regarding the procedure explained and I hereby consent to participate in a telehealth appointment visit under the terms described herein.

Patient Name: _____ Date signed: _____

Witness: _____ Date signed: _____

High Desert Foot & Ankle Clinic
WonSik Bollmann D.P.M-Sean Choi D.P.M-Robin Lie D.P.M
15366 11th Street Ste. A Victorville CA 92395
Phone (760)951-1234 – Fax (760) 951-1611

English

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, signification other, parents, children, Care Takers, Nurse or Friends to request the results of tests, procedures and financial information. Under the requirements for HIPPA we are not allowed to give this information to anyone without the patients consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on you prior consent.

I Authorize the High Desert Foot and Ankle Clinic to release my records and any information to the following individuals.

	Name:		
1.	_____	**Relation to Patient**	_____
2.	_____	**Relation to Patient**	_____
3.	_____	**Relation to Patient**	_____
4.	_____	**Relation to Patient**	_____
5.	_____	**Relation to Patient**	_____

Would you like to give Additional Authorization besides the ones mentioned above?
(ex. *Allow Care taker to change my appointments.*)

_____
_____
_____
_____
_____

I the Patient or Legal Guardian Allow the Release of information to the above listed Family Members:

_____ _____ _____
Signature **Print** **Date**

High Desert Foot & Ankle Clinic
WonSik Bollmann D.P.M-Sean Choi D.P.M-Robin Lie D.P.M.-Bryan Katz D.P.M.
15366 11th Street Ste. A Victorville CA 92395 Phone (760)951-1234 Ext. 301– Fax (760) 951-1611

Office Policies

Our Clinics policies are as follows, we ask that you please read our policies thoroughly and initial and sign indicating that you have read and understand our policies. Note: Fees may change, Policies may be updated.

Initial ALL

_____*1* ***Initial*** Inform us of any of the following:
- Changes in your insurance [it is imperative that you always inform us of any changes]
- Address and/or telephone number
- Or changes in name

_____*2* ***Initial*** Our facility provides a courtesy appointment reminder call; however it is the patient's responsibility to keep and remember his/her appointment. We ask for our patients not to solely rely on a reminder call, since this courtesy might not be able to be fulfilled 100% of the time.

_____*3* ***Initial*** Copays are due at the time services are rendered.
- We take:Cash, Check, Money Order, Credit/debit cards with the Visa, MasterCard or Discover logos.
- Make Checks payable to **Dr. Wonsik Bollmann** or we can stamp his name on your check.

Bounced checks [*Example. Returned check due to no funds available****] there will be an additional $25 charge.***

_____*4* ***Initial*** If a patient is more than 15 minutes late to a scheduled appointment without prior notice, he/she will have to reschedule the appointment to a later date.

_____*5* ***Initial*** For appointment Cancelation or Rescheduling, we require a 24 hour notice. There will be a $50 fee for last minute rescheduling [We will take Emergencies into account]. If a patient is a 'no show' at his/her appointment without prior notice the Patient will be charged and billed $50. If same appointment is rescheduled or cancelled last minute or are a 'no show' more than 3 times, you will have to see your PCP and be redirected to another provider. At least 1 month notice is required to reschedule an already scheduled Out Patient Surgery. If an Out Pt Surgery is cancelled there will be a $200 fee charged and billed to Patient. This fee must be paid before you can reschedule an Out Pt Surgery. [This $200 fee will only be waived in emergency situations with documentations to prove]. Patients MUST CALL 760-951-1234 ext 301 to Cancel or Reschedule, DO NOT try to cancel or reschedule via Text message or email.

_____*6* ***Initial*** **There will be a $25 charge for any paperwork that our Doctors fill out**. For example, the paperwork can range from "Disability" forms to any form generated by the patient, a relative of the patient, patient's work or any other external form relating to the patient other than forms generated by our office. Note, the Doctors make every attempt to fill out your paperwork in a timely fashion, however the doctors will give precedence to the performance of their medical duties at the High Desert Foot and Ankle clinic and patient health. For a copy of Medical Records the Patient/Guardian/Parent must sign a "Medical Release form" in office, there will be a $25 processing fee.

_____7 **Initial** **'Cash Patient'**, [Office Visit in which I will be paying for all my services in cash and forgo the use of my Health Insurance]. If I ever come to this clinic as a 'Cash Patient' I agree to be personally and fully responsible for payment. I was fully explained that there will be **no reimbursements** of my cash payments for services rendered once I begin using my Health Insurance to cover services. Retro Authorizations will not be procured by this office and if I decide to procure a Retro Authorization myself The High Desert Foot and Ankle Clinic has explained to me that there will be no reimbursements of services even if a Retro Authorization has been approved.

Signature of Patient / Parent / Legal Guardian _____ _____

Name in (Print): _____ **Date:** ___/___/_____
Patient/Parent/Legal Guardian

High Desert Foot & Ankle Clinic
WonSik Bollmann D.P.M-Sean Choi D.P.M
15366 11th Street Ste. A Victorville CA 92395
Phone (760)951-1234 – Fax (760) 951-1611

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please Review it carefully, the privacy of your medical information is important to us.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties and your right concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003 and will remain effective until we replace it.
We reserve the right to change our privacy practices and the terms of this notice at any time provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain including medical information we created or received before we made the changes. You may request a copy of our notice for any subsequent revised notice at any time. For more information about our privacy practices or for additional copies of this notice, please contact us using information listed at the end of this notice.

Uses and Disclosures of Protected Health information

We will use and disclose your protected health information about your for treatment, payment and health care operations. Following are the examples of the types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosure that may be made by our office.'

Treatment: we will use and disclose your protected health information to provide coordinated or manage your health care and any related services. This includes the coordination or management of your health care with the third part; For example, we would disclose your protected health information as necessary to a home health agency that provides care for you. We will also disclose protected heath information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure, that the physicians has the necessary information to diagnose or treat you.
In addition, we may disclose your protected health information from time to time to another physicians or health care provided [e.g. a specialist or laboratory] who at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activates. For example, obtain approval for a hospital stay may require that you relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health care operations: We may use or disclose, an s needed, your protected health information in order to conduct certain business and operational actives. These activates include, but are not limited to quality assessment activities, employee review activities, training of students, licensing and conduction or arranging for to the business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment. We will share your protected health information with third party "business associates" that perform various activities [e.g. billing, transcript services] for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy, of your protected health information. We may use or disclose your protected health information as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities, for example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact us to request that these materials not be sent to you.

Uses and Disclosures based on your written authorization: Other uses and disclosures of your protected health information will be made only with your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice. Others involved in your health care: Unless your object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information, as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

Marketing: We may use your protected health information to contact your with information about treatment alternative that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of normal value, you may opt out of receiving further such information by telling us using the contact information listed at the end of this notice.

Research; Death/ Organ Donation: We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government or agency authorized to oversee the health care system or government programs or its contractors, and to public health authorizes for public health purposes.

Health oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigation and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal state laws.

Food and Drug Administrations: We may disclose your protected health information to a person or company required by the food and Drug Administration to report adverse events, product defects or problems, biologic product recalls, to make repairs or replacements; or to conduct post marketing surveillance, as required.

Required by law: We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

Process and proceedings: We may disclose your protected health information in response to a court or administrative order, subpoena; discover request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials. Law Enforcement: We may disclose limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, and crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Patients' Rights

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a $1 per page and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of your fee structure. Accounting of Disclosures: you have the right to receive a list of instances in which our business associates or we disclosed your protected health information for purposes other than treatment, payment health care operations and certain other activities after April 14, 2003. After April 14, 2009, the accounting will be provided for the past six (6) years. We will provide your with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information if you request this list more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Andy agreement we may make to a request for additional restrictions must be in writing and signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment form you.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities your name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Questions and Complaints

If you want more information about our privacy practices or has questions or concerns, please contact us using the information below. If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: Clinic Supervisor
15366 11th Street Suite A
Victorville, CA 92395
Phone: 760-951-1234Fax: 760-951-1611