CHICO
PODIATRY
GROUP

Daniel D. Caviness, DPM, ABPM, FACPM
Michael L. Wilson, DPM, Inc.

2103 Forest Avenue
Chico, California 95928
(530) 895-3668
(530) 895-1248 fax

WELCOME

We are glad you have chosen us to assist in your medical care. Our goal is to provide you with the highest quality of health care available.

The specialty of Podiatric Medicine and Surgery is dedicated to the care and treatment of the bones and joints of the foot and ankle as well as related skin, nerves, tendons, ligaments and muscles.

Our office hours are:

Monday:	8:00 am to 5:00pm
Tuesday:	8:00 am to 5:00 pm
Wednesday:	8:00 am to 5:00 pm
Thursday:	8:00 am to 5:00 pm
Friday:	8:00 am to 12:00 pm

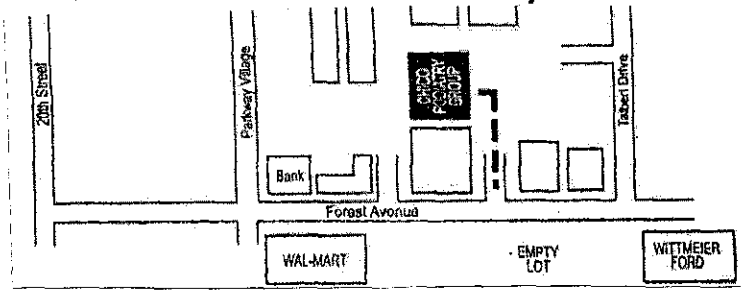
All patients are seen by appointment. We make every effort to see each patient at their appointed time. If you are unable to keep your scheduled appointment, please provide our office with 24 hours' notice.

PLEASE COMPLETE EACH OF THE ENCLOSED FORMS AND BRING THEM IN WITH YOU ALONG WITH YOUR INSURANCE CARD(S) AND A LIST OF YOUR CURRENT MEDICATIONS WITH DOSEAGE.

IF YOU HAVE A HIGH-DEDUCTIBLE >$250.00 INSURANCE PLAN WE WILL COLLECT $100.00 MINIMUM PAYMENT TOWARDS THE DEDUCTIBLE

Location: We are located at 2103 Forest Ave, Chico. Our office is across the street from the empty lot between Walmart and Wittmeier Ford. Our driveway is between the Fountain Square sign and the Chico Vison Care sign.

We have chosen our personnel, office procedures and medical equipment with much thought and care to provide quality medical service in a pleasant, efficient and friendly atmosphere. If you have any ideas, suggestions or concerns, please feel free to share them with us. Our desire is to do all we can to make your visit and care as pleasant as possible.



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REGISTRATION AND PATIENT INFORMATION

❑ Male
❑ Female

Patient's Name _____ (First / Middle / Last)

Address _____ Birthdate _____ Age _____

City & Zip _____ Home # ( ) _____

Email Address: _____ Cell # ( ) _____

Marital Status: S M W D (Circle one) Social Security # _____

Race / Ethnicity _____ Language _____

O.K. to leave personal /medical information on answering machine? Yes / No (Circle one)

Employed by _____ Occupation _____

Business Phone _____

Spouse Name _____ Spouse Birthdate _____

Spouse Social Security # _____

Spouse Employer (if primary insurance holder) _____ Occupation _____

Primary Care Doctor _____ Referred by _____

In case of an emergency, nearest contact:

Name _____ How Related _____ Phone _____

Primary Insurance _____ **Subscriber's Name:** _____

Birthdate: _____ Relation to patient _____

Secondary Insurance _____ **Subscriber's Name:** _____

Birthdate _____ Relation to patient _____

Name of person responsible for bill _____

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES INCURRED BY ME REGARDLESS OF INSURANCE COVERAGE.

Signed _____ Date _____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was offered a copy of the Notice of Privacy Practices, and that I have read or had the opportunity to read if I so chose, and understand the Notice posted at the front check-in counter.

_____ _____

Patient's Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

INSURANCE AUTHORIZATION

I authorize the release of any medical or other information necessary to process claims. I also request the payment of insurance benefits either to myself or to the party who accepts assignment.

_____ _____

Patient's Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

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PATIENT FINANCIAL POLICY

In an effort to help you understand, and to meet your financial obligations to our practice, we have put together the following policies. We understand that sometimes it may be difficult to meet your financial obligations. If this should occur, we encourage you to discuss your account, and any payment arrangements with our Office Manager.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account. I authorize Chico Podiatry Group to furnish my insurance company with all necessary information regarding my present condition. I also authorize payment of medical benefits to Chico Podiatry Group.

By signing below, I acknowledge that I have read, understand and agree to the following:

Insurance: Contact your insurance carrier and/or representative prior to your appointment regarding your plan coverage. Patients are responsible for knowing their individual plan, benefits and if we are a participating provider with your insurance plan. As a courtesy to you, this office will file claims for all visits and procedures. This is not a guarantee of coverage. **You are responsible for payment of all non-covered services, deductibles, co-pays and co-insurance.**

No Insurance: Patients who do not have insurance are expected to pay for all services rendered at the time of service. We also require payments for outpatient procedures in advance of having the procedure performed.

Returned Check Charge: Your account will be charged a $35.00 fee for each returned check. In addition, you will be asked to bring cash to our office to cover returned check and fee.

Past Due Accounts: All services are due and payable within 30 days. Patients who fail to make payment arrangements or have not expressed interest in meeting their financial obligations, will be turned over to our collection agency. Collection fee charges will be added to your account. *You are ineligible to be seen in our office until you satisfy your financial obligations. Future services must be paid in advance before you are seen by our doctors.*

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

Non-Covered Services: Your health insurance company may determine that your visit with our doctors is not "medically necessary," and will deny payment for our services. If this happens, it is your responsibility to pay for these services.

Surgeries: When a surgical procedure is scheduled, we will give you an estimate of the amount you will be responsible to pay. This amount is collected before the procedure is performed.

Medical Records: We will gladly send your medical records to other physicians (at no charge) with a signed medical release form signed by you. *Your cost to obtain your records will be $25.00. Records on CD will be $6.50 and X-Ray cost $5.00.*

I have been informed of the Chico Podiatry Group Patient Financial Policy as stipulated above. By signing below I acknowledge that I have read and understand that I am responsible for all charges incurred by me regardless of insurance coverage.

Patient's Name (print)	Patient's Signature	Date
Parent / Legal Guardian signature	Relationship to patient	Date

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PODIATRIC HISTORY

PATIENT NAME:_____ **DATE TAKEN:**_____

Are you in general good health? [ ] Yes [ ] No If no, explain:_____

Family Doctor_____ Last Visit_____ Regular [ ] Yes [ ] No

Chief Complaint (Please describe in your own words why you are here):

Nature of Pain: [ ] Sharp [ ] Burning [ ] Dull ache [ ] Throbbing [ ] Bruised [ ] Pins & Needles
On a scale of 1-10 (10 being the worst) how bad is your pain at its worst? _____
Location of Pain (or Lesion):
Onset: [ ] Sudden [ ] Gradual Duration_____ Frequency: [ ] Constant [ ] Intermittent
Timing: [ ] Weight Bearing [ ] Non-Weight Bearing [ ] Shoes Aggravate [ ] During Work
[ ] A.M. [ ] P.M. Other_____

Prior Treatment:

PAST MEDICAL HISTORY - Have you ever been told by a Physician that you have or have had:

O ANXIETY DISORDER	O CORONARY ARTERIOSCLEROSIS	O H / O HYPERTENSION
O ANEMIA	O DEPRESSIVE DISORDER	O HEARING LOSS
O ARTHRITIS	O DIABETES MELLITUS	O HEPATITIS
O ASTHMA	O ELEVATED BLOOD PRESSURE	O HUMAN IMMUNODEFICIENCY VIRUS INFECTION
O ATRIAL FIBRILLATION	O END-STAGE RENAL DISEASE	O HYPERCHOLESTEROLEMIA
O BENIGN PROSTATIC HYPERPLASIA	O EPILEPSY	O HYPERTHYROIDISM
O BLEEDING PROBLEM	O FOOT / LEG ULCERS	O HYPOTHYROIDISM
O CEREBROVASCULAR ACCIDENT	O GOUT	O INFLAMMATORY DISEASE OF LIVER
O CHRONIC OBSTRUCTIVE LUNG DISEASE	O GASTROESOPHAGEAL REFLUX DISEASE	O OTHER_____

Have you had any prior surgery(ies), please describe:_____

PRESCRIPTION MEDICATIONS (Please include herbs & vitamins):_____

Pharmacy Name & Location:_____

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PATIENT NAME:_____ **DATE:**_____

ALLERGIES -

[ ] Penicillin	[ ] Iodine	[ ] Sulfa
[ ] Novacaine	[ ] Adhesive Tape	[ ] Aspirin
[ ] Codeine		[ ] Latex
[ ] Other antibiotics_____		[ ] Other medications_____

SOCIAL HISTORY -

Do you Smoke	[ ] No	[ ] Yes	Per day_____ How many years:_____
Do you drink: Alcohol	[ ] No	[ ] Yes	Per day_____
Coffee	[ ] No	[ ] Yes	Per day_____
Tea	[ ] No	[ ] Yes	Per day_____
Recreational Drugs	[ ] No	[ ] Yes	Per day_____

Your occupation:_____ How many hrs. on your feet per day:_____

Do you have an Advance Care Directive? [ ] Yes [ ] No

Do you have a family history of:
MOTHER'S SIDE: Diabetes_____ Arthritis_____ Cancer_____ Heart Disease_____
FATHER'S SIDE: Diabetes_____ Arthritis_____ Cancer_____ Heart Disease_____

Are you subject to:

○ FAINTING	○ CHRONIC INFECTIONS	○ HEART BURN
○ SWELLING OF THE LEGS	○ FOOT / LEG CRAMPS: NIGHT WALKING	○ BURNING PAIN
○ FOOT PAIN AT REST	○ PROLONGED BLEEDING	
○ NERVOUSNESS	○ BACK PAIN	

Female: Last menstrual period_____

FOR DOCTORS USE:

Sex: [ ] Male [ ] Female Ht_____ Wt_____ Age:_____ B.P._____ P_____ T_____

LOWER EXTREMITIES:

Dermatology: Temperature_____ Texture_____ Hair_____ Nails_____ Pigment_____

Musculo-skeletal: Spasticity_____ Paralysis_____ Strength_____

Range of Motion: Rt Dorsiflexion_____ Inversion_____ Eversion_____ RF/FF_____ Hip Motion_____

Lt Dorsiflexion_____ Inversion_____ Eversion_____ RF/FF_____ Hip Motion_____

Neurological: Patella R_____ L_____ Achilles R_____ L_____ Plantar Response R_____ L_____

Positional R_____ L_____ Tactile R_____ L_____

Circulatory: D.P._____ P.T._____ C.F.T._____ Edema_____ Varicosities_____

IMPRESSION:

TREATMENT: