

NORTHERN CALIFORNIA FOOT AND ANKLE CENTER
ROBERT S. SALK, DPM | KIRK A. GROGAN, DPM | MARK S. CO, DPM | JAVERIA HUSSAINI, DPM
Davies Campus - 45 Castro St, Suite 315 San Francisco, CA 94114
Pacific Campus – 2100 Webster St, Suite 209 San Francisco, CA 94115

Last Name: _____ First Name: _____ MI: _____ Pref. 1st Name: _____

Birth Date ____/____/____ Shoe Size: _____ Sex: _____ E-Mail _____ @ _____

Home Address _____ Apt #: _____

City: _____ State _____ Zip _____

Primary Contact Phone Number: (____) _____ - _____ Cell: (____) _____ - _____

Marital Status: __Married | __Single | __Domestic Partnership | __Widowed | Other: _____

Occupation: ____ Full-Time Student ____ Part-Time Student | Employment Status: ____ F-Time ____ P-Time
____ Self-Employed Other: _____ Employer Name _____

Emergency Contact Name & Relationship to Pt _____ Day Phone (____) _____ - _____

Primary Care Dr. _____ Phone (____) _____ - _____

Physician Address _____

Under 18 Years- Complete Responsible Party Information

Parent / Responsible Party Name _____ Relationship to Patient _____

Address if Different from Home _____ Day Phone (____) _____ - _____

How did you choose NCFAC for your Podiatric needs? __Physician Referral __ Insurance Website __Other Medical Referral
__Yelp Review__ Family Member/ Friend/Colleague Other: _____

Insurance ID(s) and Mandatory Completion Required From Computer Billing Service (415) 683-3223

Primary Insurance Company _____ PPO | HMO

Are you the Subscriber or Primary Policy Holder on this Insurance? ____ Yes | ____ No

Name of Subscriber (Policy Holder) _____ **Subscriber Birth Date** ____/____/____

Patient's Relationship to Subscriber _____ Subscriber's Employer _____

Secondary Insurance Co _____

Name of Subscriber 2nd Insurance _____ Subscriber Birth Date ____/____/____

Patient's Relationship to Subscriber _____ Subscriber's Employer _____

Is visit related to accident or injury? __Yes __No | If Yes, Date of Injury _____ Type of Injury: __Work __Auto __Other
Place of Injury _____ How were you injured? _____

Assignment of Benefits: I hereby assign payment directly to Northern California Foot & Ankle Center, the insurance benefits otherwise payable to me. I understand that I am financially responsible for the charges not covered by this authorization. I also authorize a photocopy of this assignment as if it were an original copy. If it becomes necessary for the account to be referred to an attorney for collection or suit, the undersigned shall pay the reasonable attorney's fee and collection expenses. Further, I understand that coinsurance, unsatisfied deductible amounts, etc. are requested at the time of services unless other financial arrangements are made in advance. I understand that if I don't keep my scheduled appointment or if I don't cancel my appointment at least 24 hours in advance, I will be charged a \$85.00 missed appointment fee.

Signature: _____

Date: _____

MEDICAL HISTORY

Name: _____

Today's Date: ____/____/____

Complaint: _____

If you're a Sutter West Bay Network patient and you recently saw a Sutter Affiliated Primary Care Doctor, write your initials here _____ to mark that system is updated and sign the bottom part of the page. Otherwise, please fill out the form.

Please check all applicable medical conditions that apply to you:

- | | | |
|---|--|---|
| ☐ Arteriosclerosis | ☐ Bronchitis | ☐ HIV/AIDS |
| ☐ Glaucoma | ☐ Hepatitis | ☐ Thyroid Problems |
| ☐ Liver Disease | ☐ Rheumatic Fever | ☐ Emphysema |
| ☐ Arthritis | ☐ Cancer | ☐ Joint Pain/Stiffness |
| ☐ Gout | ☐ High Blood Pressure | ☐ Tuberculosis |
| ☐ Muscle Spasms | ☐ Sinus Trouble | ☐ Fainting |
| ☐ Asthma | ☐ Chronic Cough | ☐ Kidney Problems |
| ☐ Heart Disease | ☐ High Cholesterol | ☐ Ulcers |
| ☐ Anemia | ☐ Stroke/Seizures | ☐ Vascular Disease |
| ☐ Hemophilia | ☐ Diabetes Type 1 | ☐ Other: _____ |
| ☐ Pneumonia | ☐ Diabetes Type 2 | |

Social History:

Do you smoke? __Yes __No __Quit

Do you use e-Cigarette/ Vaping? __Yes __No __Quit

Do you drink Alcoholic Beverage? __Yes __No If Yes, How Much per day? _____

Surgical History:

- | | | | |
|----------|-------------|----------|-------------|
| 1. _____ | Year: _____ | 2. _____ | Year: _____ |
| 3. _____ | Year: _____ | 4. _____ | Year: _____ |
| 5. _____ | Year: _____ | 6. _____ | Year: _____ |

Medications:

- | | | |
|----------|-----------|-----------|
| 1. _____ | 6. _____ | 11. _____ |
| 2. _____ | 7. _____ | 12. _____ |
| 3. _____ | 8. _____ | 13. _____ |
| 4. _____ | 9. _____ | 14. _____ |
| 5. _____ | 10. _____ | 15. _____ |

Known Allergies to Medication(s):

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

Preferred Pharmacy and Address (if known) : _____

Signature: _____

Date: _____



Northern California FOOT & ANKLE CENTER

Reconstructive Surgery of the Foot and Ankle
Sports Medicine and Arthroscopy
Pediatric and Geriatric Foot Care
Diabetic Foot Care

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Cancellation Policy/ No Show Policy

Dear Patients:

We understand that there are times when you must miss an appointment due to emergencies or obligations to work or family. However, when you do not call to cancel a scheduled appointment, you may be preventing another patient from getting much needed treatment at the same time slot.

If an appointment is not cancelled at least 24 hours in advance, you will be charged a fee of \$85.00; this is not covered by your insurance.

Our phones are open from 8:00AM -12:00 PM and 1:00PM TO-5:00PM, and staff are ready to assist you Monday thru Friday. If you reach us during non-office hours please leave a voicemail.

Thank you for your consideration to the doctors and our office.

Signature: _____

Date: _____

CALIFORNIA PACIFIC MEDICAL CENTER

Pacific Campus

2100 Webster Street, Suite 209
San Francisco, CA 94115
Phone: (415) 431-FOOT (3668)
Fax: (415) 703-6248

Davies Campus

45 Castro Street, Suite 315
San Francisco, CA 94114
Phone: 415-565-0200
Fax: 415-565-0296



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Privacy Notice

This page serves to inform you of the privacy practices of Northern California Foot & Ankle center and its representatives. The privacy of your medical information is important to us. We intend to honor your privacy in every way possible. By signing below, you will allow us to disclose your personal health information:

- For treatment of your medical condition
- For help in attaining the maximum benefits allowed by your insurance company
- To any 3rd party representatives also working in the treatment of your medical diagnosis.
- By Superior or Federal Court Subpoena.

We respect your rights in maintaining the utmost in privacy in regards to your individual health information. We will not release any of your health information to non-medical entities without your prior written permission. Northern California Foot & Ankle Center maintains physical and electronic safeguards that restrict unauthorized access to your health information. Such safeguards include secured office facilities, locked file cabinets and controlled computer network systems and password accounts. We will only disclose your medical information to your health plan or other health care professionals or facilities for purposes of diagnosis or treatment of your medical condition. If you prefer that we do not disclose any or all of your medical condition(s), please inform us so that we may take any necessary precautions.

NOTICE TO CONSUMERS

Doctors of Podiatric Medicine are licensed and regulated by the Medical Board of California.
(800) 633-2322 | bpm.ca.gov

Signature: _____

Date: _____

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Virtual Appointments

In order to better serve our patients' medical needs, we are offering options available through a two-way, live telehealth interaction often times referred to as a "virtual appointment."

These visits use audio, video and other e-communication to allow interaction with a physician for the purpose of diagnosis, treatment, patient education and follow-up.

Prior to your virtual appointment, new patients are responsible for submitting all required forms online, and provide insurance information.

Our staff will provide instructions on how to access our TeleMed platform, Doxy.me., and other details relevant to your scheduled virtual appointment.

Virtual appointments are professional services for which the patient, or his or her guardian, must accept full financial responsibility in accordance with the regular rates and terms of Northern California Foot and Ankle Center. This includes financial responsibility for all copays, deductibles, and co-payments that may be required by your health plan. You are encouraged to confirm coverage of virtual visits with your health plan.

Please contact our billing service at CBS (Computer Billing Service), 1-415-683-3223, if you have additional questions/concerns regarding your billing statement.

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