REDWOOD PODIATRY GROUP, INC.

PHILIP ALWAY, D.P.M.
MATTHEW BOOKWALTER, D.P.M.
TIFFANY HO, D.P.M.

3258 Timber Fall Court
Eureka, California 95503-4888
Phone: (707) 441-1112
Fax: (707) 441-1711

Date _____

Dear _____

You are scheduled for an appointment with Dr. _____

On _____ at _____ check-in time. You will be seen at the following office:

☐ **Eureka** - 3258 Timber Fall Ct., Eureka, CA 95503 (map on back of this form)

Our phone number is **(707) 441-1112**.

On the day of your appointment you will need to bring in the following items or have them filled in on the enclosed paperwork:

1) Your insurance cards (**we will need the actual cards to make a copy of**).
2) Your Social Security number.
3) Email address – **sign up for email notifications of appointments and access to our patient portal!**
4) A current list of your medications with dosage and frequency.
5) A list of anything you are allergic to including the severity and type of reaction.
6) A list of any surgeries you have had (dates are not needed)

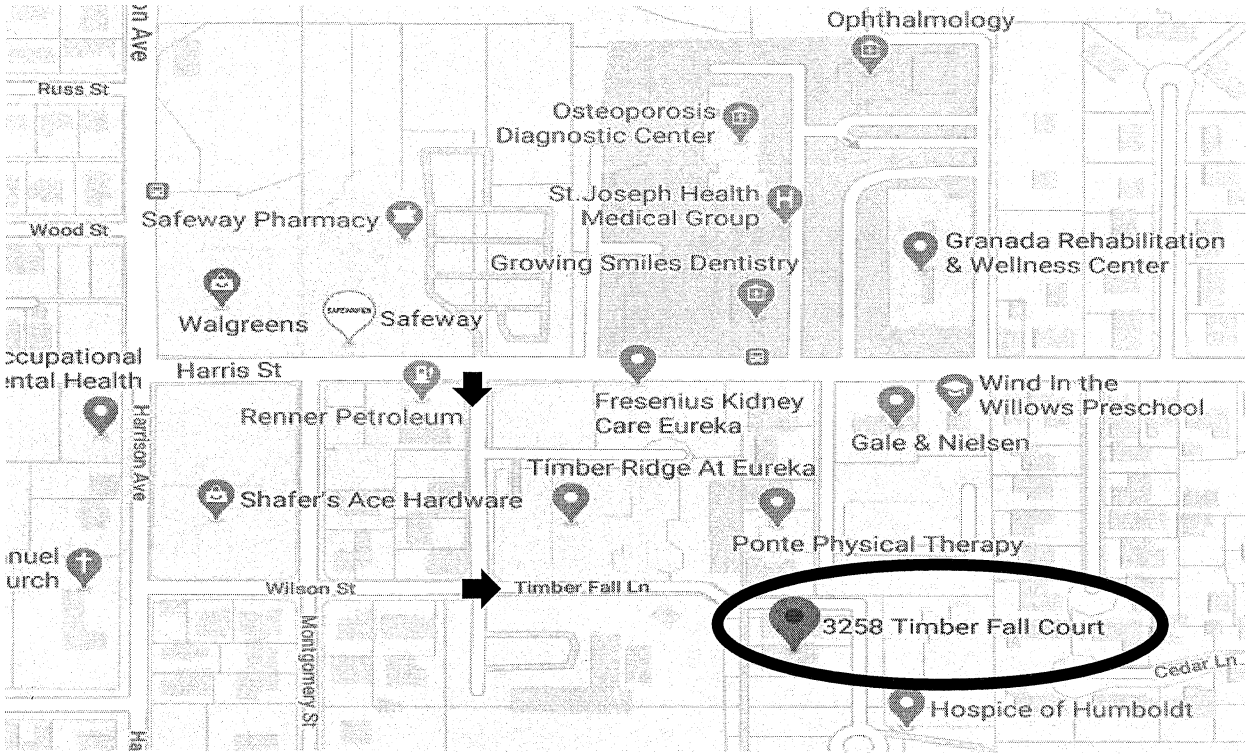
Please complete the enclosed forms and bring them with you to your appointment.

Please note that we have a **NO SHOW & LATE CANCELLATION FEE OF $45** if you miss your appointment or cancel with less than **24 hours' notice**. We look forward to seeing you!

Sincerely,

Redwood Podiatry Group

Eureka Office



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Welcome To Our Office

Patient Information

Last Name:_____First Name:_____ MI:_____

Mailing Address:_____

City:_____ State:_____ Zip:_____-_____

Home Phone: ( ) _____ Work: ( ) _____ Cell: ( ) _____

Date of Birth: _____ Age: _____ Female Male

Social Security #: _____-_____-_____ Single Married Divorced Widowed

Emergency Contact ( ) _____Name: _____ Relation:_____

Email Address:_____

How did you hear about our office? _____

Employer Information

Name of Employer: _____ Occupation:_____

_____

Insurance Information

Primary Insurance:_____ ID#:_____
Secondary Insurance: _____ ID#: _____

_____

Primary Care Doctor:_____

Pharmacy of Choice: _____

_____

Lifestyle

Do you drink alcohol? Yes No How much? _____

Do you currently use tobacco? Yes No How much do you smoke? _____
What year did you begin?_____ When did you quit?_____

Do you do any recreational drug use? Yes No Type:_____ 215 Card: Yes No

_____

Family History (list any medical conditions pertinent to the following relatives)

Mother:_____

Father:_____

Siblings: _____

Grandparents: _____

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Pregnancy Are you pregnant Yes No Are you breastfeeding? Yes No

Medications (Please include a separate list if not enough room)

Name of Medication	Strength (mg's, etc.)	Dose (i.e., twice/day)	Reason for taking med

Allergies (Please include a separate list if not enough room)

Allergy	Reaction	Severity

Medical History (list any ongoing medical problems you are being treated for)

Hospitalizations / Surgeries

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Authorization For Treatment

I hereby give my permission to Philip Alway, DPM and/or Matthew Bookwalter DPM and/or Tiffany Ho Alway, DPM, to evaluate and administer treatment and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of the feet and ankles. I understand that I am financially responsible for all charges whether paid by my insurance provider or not. I authorize the release of all the information necessary to secure the payment of benefits. I understand that fees for service are payable at the time of service, unless other arrangements are made in advance. It is my responsibility to pay any deductible amount or co-insurance. My signature on page 2 is acceptance/acknowledgement of this policy.

Missed Appointment Policy

Missed appointments prevent other patients from receiving care in a timely manner. There will be a $45 charge for appointments missed or cancelled without 24 hours notice. This fee must be paid prior to being rescheduled, and is not billable to your insurance company. My signature on page 2 is acceptance/acknowledgement of this policy.

Medicare Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to any listed provider above for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me to release to the below Medigap insurer any information needed to determine benefits payable for services from this provider.

I understand my signature on page 2 requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on the other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

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Authorization for Release of Information
(Optional)

I authorize any provider or pharmacy that has treated me to disclose my records to Redwood Podiatry Group, including, but not limited to, medication lists and chart notes. **I understand that this authorization is voluntary**. This authorization will remain in effect until revoked by the patient, at which time a new consent will need to be signed

☐ Check here if authorizing release of records as stated above and sign below.

_____ _____
Signature of Patient or Patient's Representative Date

Authorization for Text Notification
(Optional)

I would like to opt in to receive appointment notifications from Redwood Podiatry Group, Inc. via text. I understand that I will be able to discontinue receiving notifications at any time.

☐ Check here if authorizing appointment notification via text and sign below.

_____ (_____)_____ _____
Signature of Patient or Patient's Representative Cell phone number Date

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

Please sign below to indicate you have read and agree to everything on this 2-page form, with exception to the optional Release of Information sections above.

_____ _____
Signature of patient or authorized representative Date

_____ _____/_____/_____
Printed name of patient Date of Birth

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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.

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 privacy practices, our legal duties, and your rights concerning your protected health information.

We must follow the privacy practices that are described in this notice and 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. You may request a copy of our notice (or subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the 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 you for treatment, payment, and health care operations. Following are examples of the types of uses and disclosures of your protected health information that may occur:

- **Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. We will also disclose protected health information to other physicians who may be treating you.

- **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.

- **Health Care Operations:** We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. We will share your protected health information with third party "business associates" that perform various activities for the business. When an arrangement such as this takes place, 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 services.

- **Uses and Disclosures Based On Your Written Authorizations:** Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law. You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time.

- **Other Uses and Disclosures of Your Protected Health Information:** We may use and disclose your protected health information for purposes such as, Public Health and Safety, Research, Health Oversight, Abuse or Neglect, Food and Drug Administration, Criminal Activity, Court or Administrative Proceedings, providing to Others Involved in Your Health Care, or as Required by Law.

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Patient Rights

Access: You have the right to look at or get copies of your protected health information. You must make a request in writing to the contact person listed herein to obtain access to your protected health information.

Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities. We will provide you 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.

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).

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 and we must accommodate your request if it is reasonable.

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, and we would do so by providing you with a written explanation. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities that you name, of the amendment.

Questions and Complaints

If you want more information about our privacy practices or have 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, you may complain to us using the contact information below. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with that address to file your complaint upon request.

We support your right to protect the privacy of your protected health information.

Contact: Redwood Podiatry Group
Attn: Privacy Coordinator
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PARENTAL CONSENT FOR TREATMENT

I hereby authorize Philip Alway, D.P.M., Matthew Bookwalter, Tiffany Ho, D.P.M., and/or such assistants as may be selected by him/her to treat:

_____who is a minor under the age of 18.

I am also aware that a parent or authorized legal guardian (with properly documented parental consent) will need to be present at all appointments until the patient reaches the legal age of 18.

_____ _____
Parent or Legal Guardian Date

_____
Printed name of Parent or Legal Guardian

_____ _____
Witness Date

_____ _____
Patient Name DOB

****

In the event that a parent or legal guardian is not available to bring the patient in, I consent to allow the following person to bring the patient in and authorize services.

_____ _____
Name of alternate adult relation

_____ _____
Signature of Parent or Legal Guardian date