PAK PODIATRY CORP
DR JAMES S PAK, DPM

5475 E La Palma Ave Ste: 208
Anaheim Hills CA 92807

Please Note: So that we may maintain the most up to date and accurate information on our patients, in addition to the face sheet presented to you at every visit, we will request that you review and update this form at least once a year.

DATE:_____

PATIENT INFORMATION

Patient Name: Last_____ First_____ MI_____
SS#_____

DOB:_____ Sex: □ M □ F Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated □ Life Partner

Parent / Legal Guardian Name if patient is a minor Name_____ DOB_____

Race: □ White □ Black/African American □ Asian □ American Indian/Alaska Native □ Native Hawaiian/Pacific Islander □ Declined
Ethnicity: □ Not Hispanic/Latino □ Hispanic/Latino □ Declined

Preferred Language: English_____ Spanish_____ Vietnamese _____ Other_____

Do you have any communication difficulties/ special needs? Hearing Loss Interpreter Required Reading Difficulty Sight Impaired Other? Yes No

If yes, please list: _____

Address: _____Apt # _____ City_____St_____Zip _____

Phone: Home_____Cell_____ Work_____

E-Mail_____

Best Contact Method: □ Home □ Cell □ Work □ E-Mail □ Mail

Employment Status: □ Full-Time □ Part-Time □ Unemployed □ Student □ Disabled □ Retired Employer/School:_____

FINANCIALLY RESPONSIBLE PARTY

☐ **Same as Patient Information** *(If different, please complete section below)*

Name: First_____MI_____ Last_____

Relationship: Spouse Parent Guardian Other (Please Specify): _____

Address: _____Apt #_____ City_____St_____Zip _____

Phone: Home_____ Cell_____ Work_____

Email Address _____

Employer: _____

EMERGENCY NOTIFICATION

Name: _____ Relationship to Patient: _____

Phone: Home_____ Cell_____ Work_____

Name: _____ Relationship to Patient: _____

Phone: Home_____ Cell_____ Work_____

REFERRAL SOURCE

□ Friend/Family Member □ Insurance Company □ Walk-in □ Web Search □ Practice Website □ Event

□ Physician/Provider _____ Number:_____

FOR OFFICE USE ONLY: *Patient Name*_____
*MRN*_____

OPTIONAL AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO OTHERS

☐ **Do Not Release Information**

I authorize **Pak Podiatry Corp** and its representatives to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, billing information and/or medical care. This authorization will remain in effect until I provide written notification to **Pak Podiatry Corp** changes or update. I authorize **Pak Podiatry Corp** to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, insurance, billing information, test results and/or medical care with the following:

Name _____ Relationship_____ Phone_____

You may release the following information to the person named above: □ Appointments □ Billing Information □ Medical Care □ Leave Message

Name _____ Relationship_____ Phone _____

You may release the following information to the person named above: □ Appointments □ Billing Information □ Medical Care □ Leave Message

Please provide a copy of all Insurance Cards and a Driver's License / Photo ID

You will be asked to present your insurance card(s) at each visit so that we can confirm that all information in our files remains current.

INSURANCE INFORMATION - If insurance card not presented

Medicare ID# _____

Do You Have Insurance Primary to Medicare? Yes No If Yes, Please List: _____

Medicare Supplement _____ ID# _____

Medicare Advantage Plan _____ ID#_____

Medicaid ID# _____

Or

Commercial Insurance

Primary Insurance_____ ID _____ Gp: _____

Policy Holder Name:_____ Relationship (Circle One) Self Spouse Parent Other _____

SS#_____ Policy Holder's DOB_____ Employer_____

Secondary Insurance_____ ID: _____ Gp _____

Policy Holder Name:_____ Relationship (Circle One) Self Spouse Parent Other _____

SS#_____ Policy Holder's DOB_____ Employer_____

MEDICATION REFILL

Please contact your pharmacy for medication refills. Your Pharmacy will fax us a medication refill request which the physician will review. Refill authorizations may require 48-72 hours. Please allow sufficient time for us to process your refill request. **Initials** _____

Pharmacy Name_____ Phone Number_____

Authorization to Treat a Minor
(for patients ages 0-18 yrs of age)

******* Not Applicable- if patient is an adult ******

If there are circumstances when I am unable to bring my child to the office for his/her evaluation and treatment, I give my permission and authorization for the following persons (over the age of 18) to obtain medical care for my child. I also authorize the providers of Pak Podiatry Corp to discuss or disclose information regarding any matters relating to my child's appointment, insurance, test results or medical care to those listed below. This authorization will remain in effect until I provide written notification to Pak Podiatry of changes or update. I authorize Pak Podiatry Corp to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, insurance, billing information, test results and/or medical care.

Name _____ Relationship_____ Phone_____

Name _____ Relationship_____ Phone_____

CONSENT FOR TREATMENT, RELEASE OF INFORMATION, AUTHORIZATION & ASSIGNMENT OF BENEFITS

I consent to treatment necessary to the care which has been discussed and directed by the provider.

I authorize the release of all medical records to specialists and/or consulting physicians if applicable to my care and condition.

I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration, its intermediaries, its carriers, or any other insurance carrier any information needed for this or any other related claim to be processed. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to me or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any party who may be responsible for paying for my treatment.

I further authorize and request that insurance payments be directed to Pak Podiatry Corp.

I have read, fully understand and agree to the above **medication refill guidelines, Financial responsibility statement, payment guidelines, consent for treatment** and **release of medical information & insurance authorization**.
I also certify that all of the information, provided is complete and accurate.

SIGN HERE X _____ **DATE** _____

PATIENT SIGNATURE

Cancellation Policy/No Show Policy for Doctor Appointment

1. Cancellation/No Show Policy for Doctor Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligation for work or family. However, when you do not call to cancel or reschedule an appointment you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not canceled at least 24 hours in advance you will be charged a ten dollar ($10) fee; this will not be coved by your insurance company.

2. Scheduled Appointments

We understand that delays can happen however we must try to keep the other patients and doctors on time.

If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

3. Account Balances

We will require that patients with self pay balances do pay their account balances to zero (0) prior to receiving further services by our practice.
Patients who have questions about their bills or who would like to discuss a payment plan option may call our billing department with whom they can review their account and concerns.
Patients with balances over $100 must make payment arrangements prior to suture appointments being made.

_____	_____	___/___/___
Print Patient Name	**Signature Patient/Guardian**	**Date**

Telehealth Consent Form Policy

1. I hereby authorize Health Care Services to use the telehealth practice platform for telecommunication for evaluating, testing and diagnosing my medical condition.

2. I understand that technical difficulties may occur before or during the telehealth sessions and my appointment cannot be started or ended as intended.

3. I understand that my current insurance will be billed as a telehealth visit, and all copayment and co-insurance will be applied. My insurance may not cover the additional fees of the telehealth practices and I may be responsible for any fee that my insurance company does not cover.

_____	_____	___/___/___
Print Patient Name	**Signature Patient/Guardian**	**Date**

ARBITRATION

Article 1) **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or we improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2) **ALL Claims Must Be Arbitrated**. It is the intention of the parties that this agreement binds all parties whose claims may arise out of or relate to treatment or services provided by the physician including and spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mothers expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employee, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patients shall not waive the right to compel arbitration or any malpractice claim.

Article 3) **Procedures and Applicable Law**: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (Neutral arbitrator) shall be selected an arbitrator appointed by the parties within thirty days of a demand for a neutral arbitrator by rather party. Each party to the arbitration shall pays such party's prorated share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, of expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer form civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issue of liability and damages upon written request to the neutral arbitrator.

The parties consent to the in intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The party's agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Section 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; However, Deposition may be taken without prior approval of the neutral arbitrator.

Article 4) **General Provisions**: All claims based upon the same incident, transaction or circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claims, if asserted in a civil action, would be barred by the applicable California statute of limitations or (2) the claimant falls to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrations shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5) **Revocation**: This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6) **Retroactive Effect**: If patients intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patients should initial below.

Effective as of the date of first medical services. _____

Patients' or Representative's Initial's

If any provision of this arbitration agreement is held invalid or unenforceable the remaining provisions shall remain in full force and shall not be affected by the invalidity of any provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ By: _____ Date _____

Physician's Signature

Patient's or Representative's Signature

By: James Pak D.P.M By: _____

Print Physician's Signature Print Patients name