Carol C. Frey, M.D. 1200 Rosecrans Ave, Suite 208, Manhattan Beach, CA 90266 310-416-9700

Patient Information

Patient Name________________________________

Address________________________________
Street City State Zip

Home Phone ____________ Date of Birth ____/____/____ Age______

Employer________________________________

Employer Address________________________________
Street City State Zip

Cell Phone________________ Email________________

Work Phone________________ Occupation________________

Social Security # ________________ Driver's License #________________

Emergency

Emergency Contact________________________________

Emergency Contact Employer________________________________

Address________________________________
Street City State Zip

Work Phone ________________ Relationship to Patient____________

Social Security # ________________ Driver's License #________________

Insurance Info.

Primary Ins.____________ Member #____________ Group#____________

Address________________________________
Street City State Zip

Insured's Name________________ Insured's D.O.B.____________

Circle patient's relationship to insured: Self Child Spouse Other ________

Secondary Ins: ____________ Member #____________ Group#____________

Address________________________________
Street City State Zip

Insured's Name________________ Insured's D.O.B.____________

Circle patient's relationship to insured: Self Child Spouse Other________

Accident Info.

Injury Related to: □Work □Accident Date of Injury____/____/____ Date of Last Work ____/____/____

Send Bills To: □Insurance □Attorney

Attorney Name________________ Phone #________________

Address________________________________
Street City State Zip

Employer________________ File#________________

Claims Adjuster________________ Phone # ________________

Authorization: I hereby authorize the physician to furnish to insurance carriers concerning this illness/accident, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. A copy of this authorization shall be considered as valid as the original.

X________________________________ ________________
Signature Date

WEST COAST CENTER FOR ORTHOPEDIC SURGERY AND SPORTS MEDICINE

FINANCIAL POLICY

We appreciate the opportunity of participating in your medical care. Your health is our concern. Our financial policy as set forth below is designed to allow us to offer the best medical care to all of our patients. With this in mind, we thank you in advance for adhering to the following terms.

The usual charge for an initial comprehensive examination is $750.00. Thereafter, a copayment and/or a percentage payable, as stated by your insurance policy, will be expected at the time of each visit. If you have not met your deductible however, then payment in full will be expected until your deductible is met. Thereafter your copayment/percentage will apply. If your insurance company refuses to divulge your deductible status, we will assume your deductible is not met unless you provide us with written proof that it is met, such as a copy of an explanation of benefits.

As a courtesy to you, we will bill your insurance company at no charge. However, we do ask that you provide complete and accurate insurance information as requested on the Patient Information sheet, which you complete at your first visit. It is your responsibility to update us regarding any change in that information and we may periodically ask you to complete a new form.

Once payment is received from your insurance company, we will bill you for any remaining balance due. If the insurance payment results in a credit balance and you are still receiving treatment, it will be applied to your account. If you have completed treatment, a refund check will be mailed to you.

If we experience undue delay in payment by your insurance company (beyond 45 days from the date of submission) we may ask you for full or partial payment and/or ask that you promptly follow-up with your insurance company to obtain expedited payment. If you have secondary insurance coverage, we will also bill them for you for the balance due after your primary insurance has paid.

If you are involved in an automobile accident and have “med pay” coverage, we will bill them directly until benefits have been exhausted. We can then bill your private health insurance for any dates not exceeding one year from time of submission or you can continue on a cash basis.

Please understand that your insurance coverage involves a contract between you/your employer and the insurance company and we are not a party to that agreement. West Coast renders service directly to you. Therefore, regardless of any insurance coverage (except Workers Compensation & Training to Win), you are personally responsible for all charges.

For your convenience we accept payment by cash, check or credit card.

If you are unable to meet these terms, or if you have any questions, please contact me at (310) 416-9700 to make other arrangements or have your questions answered. You will be asked to sign a financial agreement reflecting any special terms we agree upon.

Please sign and date below to indicate that you understand and agree to the foregoing terms.

Sincerely,

WEST COAST CENTER/KEITH S. FEDER, MD INC.

____________________________________ ____________________

SIGNATURE **DATE**

West Coast Center for Orthopedic Surgery & Sports Medicine
Release-Authorization-Assignment of Benefits

Consent to Treatment

I, the undersigned patient, agent for the patient, or legal guardian, consent to the procedures which may be performed on me during my visits to this office. I authorize **West Coast Center for Orthopedic Surgery and Sports Medicine** and its physicians, fellows, visiting residents, and/or technicians to perform on me any and all required and all required treatments and/or procedures, including but not limited to emergency treatment and services, laboratory procedures, minor surgeries, physical examinations, x-rays, injections, ultrasound guided injections, EMG/NCV studies, Ultrasound studies, or physical therapy sessions. I agree that if I discontinue medical care at this office contrary to the opinion or decision of this physician, I will hereby relieve this office, physicians, and associates of all responsibilities for my health.

Release of information

I, the undersigned patient, agent for the patient, or legal guardian, agree that the **West Coast Center for Orthopedic Surgery and Sports Medicine** and associates may disclose and/or release a portion or all of the patients record including his/her medical record, to any person or entity which is or may be responsible for all or any portion of the office and/or physician's charges.

In considering the amount of medical expenses to be incurred, I, the undersigned patient, agent for the patient, or legal guardian, have insurance, health insurance, and/or employee health care benefits coverage with the above captioned and/or has healthcare benefits/insurance/health insurance per the information provided, and hereby assign and convey directly to The West Coast Center for Orthopedic Surgery/Keith S. Feder MD Inc., Carol Frey, MD, Inc., associates, and healthcare provider(s), **as my designated Authorized Representatives,** ALL medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand and agree that I am legally responsible for any and all actual total charges expressly authorized by me regardless of any applicable insurance or benefit payments. **I hereby authorize the above-named provider(s) to release all medical information necessary to process my claims under HIPAA.**

I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named provider(s), to the full extent permissible under the law including but not limited to, ERISA §502(a)(l)(B) and §502(a)(3), under any applicable employee group health plan(s), insurance policies or public policies, any benefit claim, liability or tort claim, chose in action, appropriate equitable relief, surcharge remedy or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s), with respect to any and all medical expenses legally incurred as a result of the·medical services I received from the named provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies including, but not limited to, (]) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my providers/in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived.

APPENDUM TO PATIENT FINANCIAL RESPONIBILITY

I acknowledge the possibility that a check and or checks may be sent directly to me instead of you, my provider. I understand this money is not mine even though the check may be written to me. I understand you are billing my insurance company as a courtesy to me, but the money paid by the insurance company belongs entirely to you. I therefore, agree to immediately, but certainly no later than 48 hours upon receipt of any such monies, forward this money directly to you. I will make no attempt to negotiate what portion I send to you. In any event, I acknowledge and

agree that I am legally responsible for any charges for service rendered to me and I will pay all fees including any co-pays or deductibles, if applicable.

NOTE: Please read the above agreements carefully and make sure that you understand all the items and conditions before signing below. If you do not understand, please review contents with the staff prior to signing. Your signature confirms that you have read and fully understand all the agreements, terms, and conditions above.

Authorization for the Release of Medical Records

I, the undersigned patient, agent for the patient, or legal guardian, hereby grant permissions to and authorize any physicians, medical practitioner, hospital, pharmacy, clinic, or other medical or medically-related facility or provider of medical or dental services or supplies, any employer, insurance or reinsurance companies, benefits plan administrator, educational institutions, or any federal, state or local government agencies, including social security administration, veteran administration, and/or entities release my complete medical records in their possession to **West Coast Center for Orthopedic Surgery and Sports Medicine** and/or its physicians. A photocopy or facsimile of this authorization shall be valid and effective as the original.

Medicare Patients Release of Information

I certify that the information given by me in applying for payment under the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made directly to this physician and/or medical group and I understand that I am responsible for the remaining balance not covered by other insurance.

Notice of Privacy Practice- HIPAA Compliance

This facility is HIPAA compliant. The patient's privacy is protected including medical and personal information. As required by law, we will use and disclose our patient's health information in a limited way according to the requirements by all applicable laws, I, the undersigned patient, agent for the patient, or legal guardian, have been informed of my privacy rights.

Patient's Name_________________________________ **Signature**________________________________

Relationship to patient________________________________ **Date**____________________________

West Coast Center for Orthopedic Surgery and Sports Medicine

Carol Frey, M.D.
1200 Rosecrans Ave #208, Manhattan Beach, CA. 90266
310-416-9700 www.westcoastorthopedics.com

RE: Cancellation of PPO/EPO Contracts

Dear Patient:

Effective immediately our office does **not** participate with the Insurance plans listed below. This became necessary due to the unreasonably low contract payments forced upon us by these plans.

- **Aetna**
- **Cigna**
- **Healthnet**
- **Oscar**
- **United Healthcare**

We will bill your insurance companies as an out-of-network provider on your behalf.

Any questions regarding your insurance company should be directed to our billing staff at time of service.

Thank you for your cooperation and understanding.

Sincerely,

Dr. Carol Frey

I have read and understand the above information.

____

Signature Date

____

Print Patient Name

Keith S. Feder, M.D.
West Coast Center for Orthopedic Surgery and Sports Medicine

Carol Frey, M.D.
Orthopedic Foot & Ankle Center

POLICY FOR SUPPLIES

Because there is no guarantee that your insurance company will pay for the supplies that the doctor has ordered for you, we have made the following two options available to you, our patient.

1) The doctor requests that all supplies are paid for at the time the patient receives the item. You have the option of paying for the supplies at the time of your visit. **(or)**
2) You can wait until we submit a claim to your insurance carrier to request payment for the supplies needed. This may take up to 60 days or more to get a response from your insurance company. If you decide on this option, you will not receive any supplies until your insurance company pays us in full for the supplies, unless the doctor has made prior arrangements with you, the patient.

With either option, you will be responsible for any remaining balance that your insurance company does not pay. If your insurance company pays 100% then your deposit will be applied to any unpaid balance due on your account. If you do not have any unpaid balance on your account, your account will be credited, the balance will be used toward any further services rendered. If you do not have any unpaid balances a refund check will be issued, if requested by the patient.

PLEASE NOTE:

1) You will be responsible for any attempts or inquiries to your insurance company, regarding processing of this claim for payment. Professional services are rendered to you, our patient, not to your insurance company. Which means the insurance company is responsible to you directly.
2) All supplies are non-returnable once they leave our office for health and safety reasons.

Thank you for your understanding and cooperation.

PRINT NAME:___________________________

SIGNATURE:____________________________ **DATE:**______________

WITNESS:______________________________

1200 Rosecrans Ave. Suite 208, Manhattan Beach, CA 90266
(310) 416-9700 (310) 416-1144- fax

Member Authorization Form for a Designated Representative to Appeal a Determination

Date: _______________

Member Name: ____

Member Number: ____

I hereby authorize Keith Feder M.D., Carol Frey M.D., West Coast Center for Orthopedic Surgery and Sports Medicine and Associates to appeal determination concerning:

____
____
____
____

on my behalf, as my Designated Representative, and as part of the appeal I hereby authorize in its decision letter and in connection with the processing of my appeal, to communicate with my Designated Representative in all aspects of the appeal. I understand that these communications may contain the following:

All medical and financial information contained in my insurance file, including but not limited to treatment for vernal disease, alcoholism and drug abuse, abortion, mental disorder and HIV status relating to my examination, treatment and hospital confinement in connection with determination which is being appealed.

I understand this information is privileged and confidential and will only be released as specified in the authorization, or as required or permitted by law. This authorization is valid for a period of one year.

×____

Signature of Member or Legal Guardian/Representative

×____

__Signature of Witness **__Designated Representative** (check one)

×____

Name of Witness/ Designated Representative (Please Print)

×____

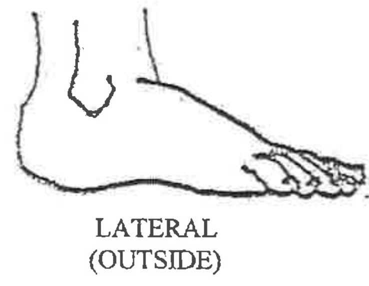
Title (if on provider's staff of relationship of Member)

Patient's Name ______________________________

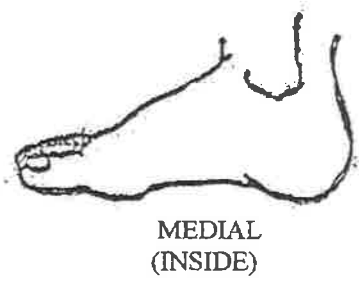
Date ______________________

CIRCLE AREA OF SYMPTOMS (label pain, swelling, weakness, stiffness, numbness, lumps, etc.)

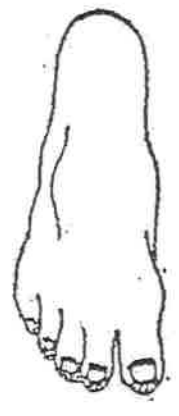
RIGHT



LATERAL
(OUTSIDE)



MEDIAL
(INSIDE)

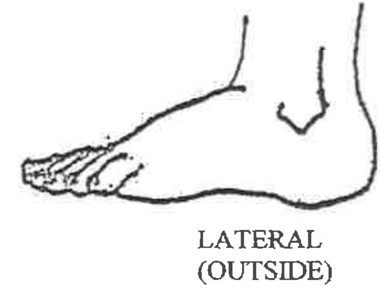


DORSAL
(TOP)

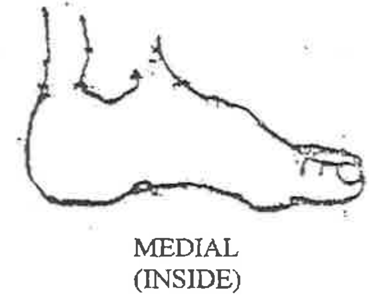
RIGHT

PLANTAR
(BOTTOM)

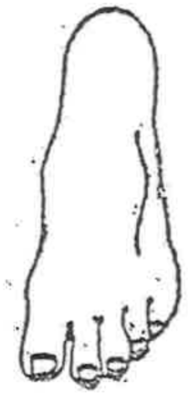
LEFT



LATERAL
(OUTSIDE)



MEDIAL
(INSIDE)



DORSAL
(TOP)

LEFT

PLANTAR
(BOTTOM)

GENERAL FOOT AND ANKLE HISTORY

NAME:_____________________________________Age:_________Date:_____________________

XRAYS: I have brought in xrays today. Yes_________No___________

REFERRING PARTY: (please give name)

Physician_________________________Phone(____)______________FAX(____)___________
Address____
City___________________________________State_________Zip_______________________
Friend____
Family Member____
Other____

PERSONAL PHYSICIAN________________Phone(____)____________FAX(____)_________
Address____
City___________________________________State_________Zip_______________________
Date of last visit____

PRESENT GOAL IN SEEKING EVALUATION: Check one or more.

Correction of deformity and improvement of appearance_______
Relief of pain_________ Second Opinion__________Other____________

MAIN PROBLEM: Check one or more.

Pain or aching____Swelling____Weakness_____Stiffness_____Deformity______Lump______
Instability or giving out___Other____

LOCATION & DURATION OF MAIN PROBLEM: Check one or more. Number according to severity.

PROBLEM:		DURATION of SYMPTOMS: or	DATE OF ONSET
Leg:	R__L___	___weeks __months ___years	__________________
Ankle:	R__L___	___weeks __months ___years	__________________
Heel:	R__L___	___weeks __months ___years	__________________
Bunion:	R__L___	___weeks __months ___years	__________________
Top of Arch:	R__L___	___weeks __months ___years	__________________
Sole of Arch:	R__L___	___weeks __months ___years	__________________
Ball of Foot:	R__L___	___weeks __months ___years	__________________
Great toe:	R__L___	___weeks __months ___years	__________________
2nd toe:	R__L___	___weeks __months ___years	__________________
3rd toe:	R__L___	___weeks __months ___years	__________________
4th toe:	R__L___	___weeks __months ___years	__________________
5th toe:	R__L___	___weeks __months ___years	__________________

BREIFLY DRAW LOCATION OF MAIN PROBLEM ON THE DIAGRAM ON THE NEXT PAGE.

DESCRIPTION OF ONSET: Check one or more.

Congenital_____ Crush_____ Repetitive use_____ Sudden onset_____ Work related_______
Fall_____ Twist______ Direct Blow_____ Gradual onset______ Sports related_______
Other____

Specify your location (home, work etc.) and briefly describe what happened when symptoms started.

____
____
____
____
____

Office use only ____
____

PREVIOUS TREATMENT: NONE______(If none, skip to SELF CARE)

1. FIRST doctor I saw for this problem:

Name_______________________________________City___________________________________
Emergency Room Doctor_______ Podiatrist______ Company doctor______ Family doctor_______
Orthopaedic surgeon _________ Other____
Date of First Exam_____________________________Date of last visit___________________

TESTS: xrays_____ blood tests______ nerve tests_____ CT scan______ bone scan_____MRI_______

TREATMENT:

steroid injections______how many_____date of last one________ Helped? Yes____ No____
anti-inflammatory pills____drug names____________________ Helped? Yes____ No____
pain pills______ drug names_____________________________ Helped? Yes____ No____
physical therapy______ type______________________________ Helped? Yes____ No____
pads/shoe modifications_________________________________ Helped? Yes____ No____
orthotics____ Helped? Yes____ No____
cast______how long?_____________________________________ Helped? Yes____ No____
surgery______(only recommended surgery did not do_____) Helped? Yes____ No____
other____ Helped? Yes____ No____

2. SECOND doctor I saw for this problem:

Name_______________________________________City___________________________________
Emergency Room Doctor_______ Podiatrist______ Company doctor______ Family doctor_______
Orthopaedic surgeon _________ Other____
Date of First Exam_____________________________Date of last visit___________________

TESTS: xrays_____ blood tests______ nerve tests_____ CT scan______ bone scan_____MRI_______

TREATMENT:

steroid injections______how many_____date of last one________ Helped? Yes____ No____
anti-inflammatory pills____drug names____________________ Helped? Yes____ No____
pain pills______ drug names_____________________________ Helped? Yes____ No____
physical therapy______ type______________________________ Helped? Yes____ No____
pads/shoe modifications_________________________________ Helped? Yes____ No____
orthotics____ Helped? Yes____ No____
cast______how long?_____________________________________ Helped? Yes____ No____
surgery______(only recommended surgery did not do_____) Helped? Yes____ No____
other____ Helped? Yes____ No____

IF YOU SAW MORE THAN TWO DOCTORS FOR THIS PROBLEM PLEASE CHECK AND DESCRIBE TESTS AND TREATMENT ON THE BACK SIDE OF THIS PAGE. ____

FOOT AND ANKLE SURGEY: list earliest surgery first. **NONE_______**

1. Date_______Doctor____________________Hospital_______________________________________
   Type of surgery____
   Helped? Yes_____No____Complications?(list)______________________________________
2. Date_______Doctor____________________Hospital_______________________________________
   Type of surgery____
   Helped? Yes_____No____Complications?(list)______________________________________
3. Date_______Doctor____________________Hospital_______________________________________
   Type of surgery____
   Helped? Yes_____No____Complications?(list)______________________________________

SELF CARE: None______Other____
Changed shoes______ Trimmed callouses_______ Store bought pads or arch supports_________

ANTICIPATED SURGERY:

Would consider surgery if the doctor thinks it's necessary?________________________________
Would not consider surgery?____

FACTORS OF PAIN OR DISCOMFORT: check one or more.

Walking in shoes___________________
Walking barefooted_________________
First getting up in the morning________
Walking after resting or sitting________
At rest or at night__________________
Being on my feet all day_____________
Cold damp weather_________________
Walking while carrying loads_________
Climbing stairs or ladders____________
Squatting__________________________
Other____

FACTORS OF RELIEF: check one or more.

Staying off my feet_________________
Elevating feet______________________
Applying ice_______________________
Rubbing my feet____________________
Removing shoes____________________
Hanging feet over side of bed_________
Special shoes(what type?)____________
Other_____________________________

FREQUENCY OF PAIN: check one or more. None_________

Some pain is always present________________________
Frequency of pain depends on activities______________

FREQUENCY OF SWELLING: check one or more. None_________

Some swelling is always present____________________
Frequency of pain depends on activities______________

FREQUENCY OF INSTABILITY: check one or more. None_________

(For patients with ankle problems: Instability means that the ankle feels as though it will give out, actually gives out, or "resprains.")

Walking on uneven surfaces_______ Playing sports_____ Type of sports?____________________
Instability occurs several times a week______ a month_______ a year_________
Instability is becoming more frequent_________ less frequent_________

AIDS FOR WALKING: (used frequently) check one or more. None__________

Wheelchair_______ Crutches________ Cane__________ Other____________________________

REGULAR ACTIVITIES PRIOR TO PAIN OR INJURY	**CURRENT LIMITATIONS**	
	Do with difficulty	**Unable to do**
Bicycling___________________________________	______________	______________
Bowling____________________________________	______________	______________
Golfing_____________________________________	______________	______________
Running____________________________________	______________	______________
Miles a week_______years of running_____		
Walking____________________________________	______________	______________
Miles a week_______years of running_____		
Other sports_________________________________	______________	______________
House/yard work_____________________________	______________	______________
Usual occupation_____________________________	______________	______________
Other______________________________________	______________	______________

PREVIOUS INJURIES RELATED TO THIS PROBLEM (same foot or ankle). None______

Date of previous injury________ Describe____
When present problem began was this previous problem completely resolved?________________

ORTHOPAEDIC PROBLEMS: None_________
Back_____ Neck_______ Shoulder______Arm______ Hand_______Hip_____Knee ________Leg________
Describe problem____

MEDICAL ILLNESSES: **Check as many as are applicable.** None_________

Diabetes, insulin yes___ no____	_______	age at onset	_______
Rheumatoid arthritis(type)	_______	age at onset	_______
Degenerative arthritis	_______	Lung disease	_______
Gout	_______	Stomach/intestinal (type)	_______
Psoriasis	_______	Liver disease(hepatitis)	_______
Heart disease(type)	_______	Kidney disease(type)	_______
High blood pressure	_______	Bladder problems	_______
Bad circulation in feet	_______	Seizures	_______
Bad leg veins	_______	Stroke	_______
Bleeding tendency	_______	Nerve disease(type)	_______
Anemia	_______	Psychiatric illness(type)	_______
Sickle cell trait	_______	Glaucoma	_______
Ankle Swelling	_______	Cancer(type)	_______
Other______________________	_______	Thyroid disease	_______
Other______________________	_______		

CURRENT MEDICATIONS: None_________

Name of medication	Dose	Times a day	Duration of use(months or years)
____________________	_______	______________	____________________________
____________________	_______	______________	____________________________
____________________	_______	______________	____________________________
____________________	_______	______________	____________________________
____________________	_______	______________	____________________________
____________________	_______	______________	____________________________
____________________	_______	______________	____________________________
____________________	_______	______________	____________________________

ASPIRIN (Anacin, Empirin etc.): I take more that 10 tablets a month Yes____No____
PAST MEDICATIONS: I have taken cortisone pills in the past Yes____No____

ALLEGIES: None_________
(include medicine, adhesive tape, iodine products, xray dyes, etc.)

Medication, etc.	**Reaction: A = anaphylaxis (unable to breathe)** **R = rash, N = nausea, O = other**
__________________________________	____
__________________________________	____
__________________________________	____
__________________________________	____
__________________________________	____

OPERATIONS: (other than foot and ankle) **None________**

1. Date______________Type____
   Complications?____
2. Date______________Type____
   Complications?____
3. Date______________Type____
   Complications?____
4. Date______________Type____
   Complications?____

HOSPILIZATIONS: (other than for surgery or childbirth) None_________

1. Date______________Diagnosis____
2. Date______________Diagnosis____
3. Date______________Diagnosis____
4. Date______________Diagnosis____

LUNGS AND LIVER:

_______I have never smoked. _______I am a smoker. (_______picks per day).
_______I have been a smoker and I stopped smoking in ________.
_______I drink more that 3 alcoholic beverages per day, several times a week.
_______I do not use alcohol.

FAMILY HISTORY: Do/did any "blood relatives" have any of the following?

Disease	Family relationship
Cancer__________________________	________________________________
Heart disease____________________	________________________________
Diabetes_________________________	________________________________
Arthritis_________________________	________________________________
Bone disease_____________________	________________________________
Sickle cell trait/anemia__________	________________________________
Foot and ankle problem___________	________________________________

SOCIAL HISTORY:

Present occupation: ________________________Duration:________________________________

Home members
_______Live alone
_______Live with family members (relationship)______________
_______Other____

HEIGHT____________ **WEIGHT___________** **SHOE SIZE____** **WIDTH______**

____ ____________________
Print Name of Patient Date

____ ____________________
Signature of Patient Date

____ ____________________
Print Name of person completing form, if other than patient Date

____ ____________________
Signature of person completing form, if other than patient Date