Foot and Ankle Surgeons of Northern California
Marc T. Claydon, D.P.M.
530-271-5879

Patient Registration

Patient First_____**Middle**_____**Last**_____
Parent/Guardian Name (if patient is under the age of 18)_____

Date of birth_____/_____/_____ **Patient Social Security Number** _____/_____/_____

Sex: Female Male **Marital Status**: S M W D **Race:** Caucasian, African American, Hispanic/Latino, Asian Other_____

Preferred Language: ☐ English, ☐ Other:_____

Mailing Address:_____
Street number street city state zip

Phone: Home( )_____**Cell** ( )_____May we leave messages on voicemail? Y/N

Email_____

Work: Full time/Part time/Self/Unemployed/Disabled/Retired **Retired?** When did you retire?_____

Working? On your feet a lot Y /N **What type of work:**_____

Insurance Carrier:_____**the Subscriber** is: Self/Spouse/Parent_____ ___/____/____
Name & D.O.B

Primary Care Dr.:_____

Pharmacy Name: _____**Pharmacy Location**(city & street):_____

HIPPA: Foot and Ankle Surgeons of Northern California has my permission to discuss my medical condition and financial information with the following person(s):

_____
Name Relationship to You Phone number

I understand that Foot and Ankle Surgeons of Northern California clinic follows the **health Insurance Portability and Accountability act (HIPAA)** of 1996. This is to keep my protected health information (PHI) private.My signature below authorizes the release of any medical information necessary to process claims and request that payment of all assigned benefits be made to the provider of services. I give permission to receive treatment for myself, my minor child, or a patient for whom I have Power of Attorney I have received and read the information and privacy Practices notice.

Emergency/alternate contact: Same as HIPPA? Yes / No

Name_____Phone ( )_____Relation_____

Signature:_____ Date:_____

Foot and Ankle Surgeons of Northern California

Medical History

Reason for visit?_____How long has this been going on:__Week(s)___Month(s)__Year(s)

Do you know what caused it?_____ Date of Injury:_____ **Height**:_____**Weight**:_____

(if your information below is in the sutter system please put a **X** in the box next to sutter & skip the next three questions.)

***Current Medication(s)/ Vitamins** **____NONE ___ In Sutter**

_____

***Relevant medical history** (diabetes, gout,neuropathy, heart disease, cancer, AIDS/HIV, High B.P etc.) **__NONE___ In Sutter**

_____

***Surgical History Type & Date:** (Any Surgeries or fractures of feet, ankles or Achilles) **__None___ In Sutter**

_____

***Allergies or adverse reactions to medications: List Medication & Reaction** **__NONE___In Sutter**

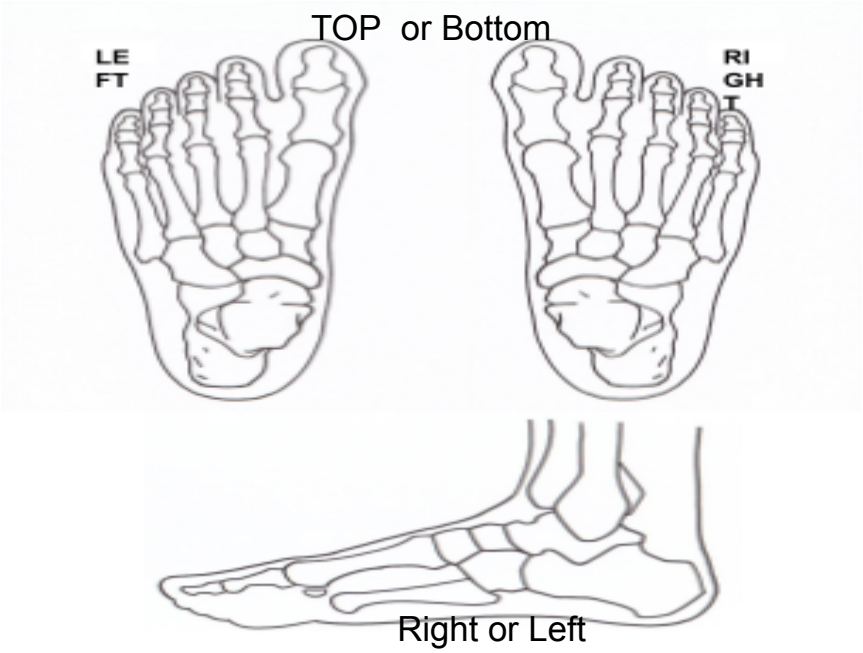
_____

Do you smoke tobacco? Y/N **Did you smoke tobacco in the past?** Y/N **Do you use chewing tobacco or vape?** Y/N **Have you used either in the past?** Y/N **Do you engage in recreational drugs?**(i.e weed, hallucinogens, narcotics etc.) Y/N **Have you used recreational drugs in the past?** Y/N **Do you currently drink?** Y/N **how many drinks per week?**____

Please circle where your pain is located & Right now On a scale 0 -10 how bad is the pain?(circle one)

No pain	Mild	Moderate	Severe	Very Severe	Worst Pain Possible
😀	🙂	😐	😞	😢	😫
0	1-3	4-6	7-9		10

Please circle where the pain is located



Foot and Ankle Surgeons of Northern California
Policy

Thank you for choosing Foot and Ankle Surgeons of Northern California. We are committed to providing you with the best care and fostering a strong physician-patient relationship. To ensure smooth billing and payment, please review our Policy carefully. If you have any questions, feel free to speak with our staff.

Payment Policies

Co-pays and Deductibles

We cannot waive co-pays, deductibles, or coinsurance amounts required by your insurance, as this violates insurance regulations. All co-pays, deductibles, and patient responsibility balances are due at the time of your appointment, unless prior arrangements have been made with our billing coordinator.

Accepted Payment Methods

We accept cash, check, debit card, VISA, MasterCard, Discover, and Apple Pay. For uninsured patients, we offer a discount for payments made in cash at the time of service.

Returned Payments

Returned checks, chargebacks, or returned payments will incur a minimum $35 penalty, in addition to the outstanding balance. After a returned payment, future payments must be made via cash, money order, or cashier's check.

Forms and Documentation

Form Completion Fees

If you require disability, FMLA, DMV, or other insurance-related forms, a $40 prepayment per form is required. This covers the time to review your medical records and complete the forms. Please allow 5 business days for completion, and be sure to provide necessary information, such as dates of disability and expected return to work.

Medical Records

Patients may request copies of their medical records free of charge, with up to 5 business days for processing. If expedited records are needed, a $10 fee applies. Electronic copies (e.g., CD) incur an additional $25 fee for X-ray records.

Insurance and Billing

Insurance Billing

While insurance is a contract between you and your insurer, we will file claims on your behalf as a courtesy. It is your responsibility to ensure that we have complete and accurate insurance information & your responsibility to make sure we are in network with your insurance before your arrival. Failure to provide correct information may result in you being billed directly for any unpaid balances.If your insurance pays you directly, you must forward that payment to us immediately.Please be aware that any services not covered by your insurance are your responsibility.

Referral and Pre-Authorization

If your insurance requires a referral or pre-authorization, you are responsible for obtaining it. If we do not receive the required authorization before your appointment, we may need to reschedule. Failure to obtain the necessary approval could result in reduced payment from your insurance, leaving you responsible for the balance.

Out-of-Network Insurance

If we are not an in-network provider for your insurance, you will be responsible for payment in full at the time of service. We will submit the initial claim to your insurance, but if the claim is not paid within 60 days, you will be responsible for the full amount.

Workers' Compensation

If your visit is related to a workers' compensation claim, you must provide authorization and claim details from your employer. If the claim is denied, you will be responsible for payment.

Self-Pay and Uninsured Patients

Self-Pay Patients

For uninsured patients or those with insurance we do not accept, payment in full is required at the time of service. Extended payment plans may be available on a case-by-case basis. Please speak with our practice manager for assistance.

Missed Appointments and Late Arrivals

Missed Appointments

If you miss an appointment without notifying us 24 hours in advance, a $40 fee will be applied. Please notify us in advance if you need to reschedule.

Late Arrivals

Arriving more than 5 minutes late may result in your appointment being rescheduled. Please ensure you arrive on time for your scheduled visit.

Refund Policy

Refunds

Due to the nature of our services, we cannot accept returns on items such as cam boots, ankle braces, or inserts. All sales are final.

Visits

Xrays

In accordance with our office policy, we conduct an updated X-ray during each visit at our Grass Valley location.

Noncovered services

This includes, but is not limited to, cutting or removal of corns and calluses,sweat glands and wart treatments. Our office charges $20 for this service, due upon arrival. Inserts are considered over the counter. Our office charges $65 for our medical grade inserts, payment due at time of purchase.

Other

I, as the patient or the parent/legal guardian, consent to the use of ambient listening technology and third-party audio recording during clinical encounters.

Acknowledgment

By signing below, you acknowledge that you have read and understood the Policy. You agree to assume responsibility for payment of services rendered, including any amounts not covered by your insurance. You authorize the release of medical information necessary to determine insurance benefits and agree to cooperate with any credit investigation if necessary.

Patient/Responsible Party Signature: _____Date: _____

Relationship to Patient (if applicable): _____