WELCOME!

RICHARD H. GRAVES, DPM
MIE SHIRAI, DPM
304 CHERRY AVENUE, LONG BEACH, CA 90802
5406 E. VILLAGE ROAD, LONG BEACH, CA 90808

PHONE: (562) 433-0478 FAX: (562) 438-3690

Thank you for trusting us with your foot and ankle care. We pride ourselves on providing a warm and friendly office environment where every patient is respected. We provide the highest level of expertise in podiatry while addressing the individual needs of each patient.
If you have any questions, please do not hesitate to ask.

Date: _____

PATIENT INFORMATION

Female
Male

Name: _____ Birth date: _____

Social Security #: _____ Marital Status: _____

Street Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Phone:_____ Cell phone: _____

Work phone: _____ E-mail: _____

Employer:_____

Guardian's name (if patient is a minor): _____

Address (if different): _____

Person to contact in case of emergency: _____

Relationship to patient:_____Phone: _____

How were you referred to our office? (please circle)

Sign/Location Internet Yelp Insurance Friend/Family Doctor Other

Please provide name so that we may personally thank them for referring you:_____

MEDICAL INSURANCE

Insurance Co.: _____ Member ID: _____

Name of insured: _____ Relationship to patient _____

Insured's date of birth_____ Insured's social sec# _____

Group# _____ Insured's employer _____

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MEDICAL HISTORY

Name: _____ Age: _____

Please briefly describe your foot/ankle problem(s): _____

_____

_____

How long have you had the problem(s)? _____

Did you injure your foot? _____

What type of treatment have you received? _____

Have you seen a podiatrist previously? _____

If yes, for what problem? _____

Occupation: _____

Type of shoe worn at work: _____ Shoe size: _____

Family physician: _____ Phone: _____

Location: _____

Medical Conditions: _____

_____

Current Medications: _____

Previous surgeries:_____

Allergies: _____

Do you: Use tobacco? No Yes, Amount: _____
Drink alcohol? No Yes, Amount: _____

I hereby authorize Dr. Richard Graves and/or Dr. Mie Shirai to evaluate and provide treatment for my foot/ankle problem(s).

Patient's Authorized Signature _____

Date _____

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MEDICAL QUESTIONNAIRE

Name:_____ Date: _____

Please check (x) any medical symptoms you have recently experienced or "NONE" at the end of each category.

General:

___ Fever
___ Chills
___ Fatigue
___ Weight Loss
___ NONE

Skin:

___ Rash
___ Itching
___ Scars
___ Bruising
___ NONE

Neurologic:

___ Dizziness
___ Numbness
___ Weakness
___ Fainting
___ NONE

Head:

___ Headache
___ Vision Problems
___ Hearing Loss
___ Nose Bleeds
___ Sore Throat
___ Dental Problems
___ Cough
___ NONE

Cardiovascular:

___ Stroke
___ Heart Attack
___ Chest Pain
___ High Blood Pressure
___ NONE

Lungs:

___Shortness of breath
___Wheezing
___Bronchitis
___Pneumonia
___NONE

Abdominal:

___Abdominal Pain
___Heartburn
___Constipation
___Diarrhea
___NONE

Genitourinary:

___ Urinary Frequency
___ Burning on Urination
___ Kidney Problems
___ Sexually Transmitted Diseases
___ NONE

Psychiatric:

___Depression
___Anxiety
___Substance Abuse
___NONE

Muscles/Joints:

___Arthritis
___Back Pain
___Muscle Pain
___Weakness
___ Broken Bones
___ Head Injuries
___ Osteoporosis
___ Joint Pain
___ NONE

Please list any other concerns or problems you have experienced and/or would like to discuss with the doctor:

_____

_____

_____

Sol Foot & Ankle Centers

Richard H. Graves, DPM ~ Mie Shirai, DPM

Office Policies

Cell phones

As a courtesy to others, please silence your cell phone upon entering the office and step out of the waiting room before making or receiving any phone calls. Once you are in the treatment room please immediately end all calls when the doctor or assistants enter the room. If you remain on the phone the doctor may move on to another patient causing your wait to increase.

Financial

Please note that, unless other arrangements have been made, payment is due at the time services are rendered. We accept cash, checks, and all major credit cards. For complete details please review our Financial Policies.

Authorizations

If the patient's insurance requires an authorization or written referral prior to treatment by a specialist, it is his/her responsibility to obtain the initial authorization. We will submit to the insurance any necessary requests for follow-up care. The patient accepts financial responsibility for any treatment that is rendered without prior authorization.

Missed appointments

While we understand that emergencies do arise, we ask that you reschedule/cancel appointments at least 24 hours in advance. This will make your appointment time available to another patient. It is not our policy to impose a "missed appointment fee". However, patients who miss appointments may be asked to remit a deposit to hold future appointment times and also risk being discharged from our care.

Please do not hesitate to ask should you have any questions regarding this notice. By signing below you acknowledge that you have read and understand our office policies as stated above.

X_____ _____

Patient or responsible party Date

Sol Foot & Ankle Centers

Richard H. Graves, DPM ~ Mie Shirai, DPM

Financial Policies

Sol Foot & Ankle Centers will submit claims to your insurance company for all medical services rendered. We will attempt to verify eligibility and benefits with your insurance company. However, this verification is not a guarantee of payment. **The patient accepts responsibility for any expenses not covered by the insurance company and/or not paid within sixty (60) days of billing.**

All monies owed by the patient, including deductibles, co-payments, co-insurances and payment for non-covered services or supplies are due at the time of service.

In order to properly treat our patients it is often necessary for the physician to perform in-office procedures and/or diagnostic tests. These may include, but are not limited to: x-rays, injections, taping procedures, skin lesion treatment, and nail procedures or other minor surgeries. These services are billed as a charge in addition to your office visit and additional co-insurance and/or deductible may apply. Although provided in the office these services are often labeled as "surgery" on payment information you may receive from your insurance company. **If you have any questions regarding the necessity of these services and your potential financial responsibility please ask our staff prior to the services being rendered.**

Please be aware that Sol Foot & Ankle Centers will bill only for services rendered in our office and/or by our physicians. Any other services related to your care, including laboratory, radiology, pathology, hospital or surgery center services, will be billed by the facility providing those services. Additionally, while we try to refer you to facilities that are contracted with your particular insurance, this cannot always be guaranteed.

Sol Foot & Ankle Centers accepts the following forms of payment: cash, money orders, most major credit cards (VISA, Mastercard, American Express and Discover), Care Credit, and personal checks. There is a $25 charge for any returned checks.

If, after billing your insurance, you have a balance due to our office you will receive a billing statement in the mail. Payment is due immediately upon receipt of your billing statement. **All accounts not paid in full within thirty (30) days of the initial billing statement will be charged interest in the amount of twelve percent (12%) per year or one percent (1 %) per month**. It is your responsibility to provide our office with a current address to ensure that you receive your billing statement.

By signing below I acknowledge that I have read and understand the above financial policies of Sol Foot & Ankle Centers and that I am entitled to a copy of these policies.

Patient Name Signature of Responsible Party Date

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ACKNOWLEDGMENT 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.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (applicable)

_____

Signature

NOTICE OF PRIVACY PRACTICES (FOR PATIENT TO KEEP)

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 Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse that personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical record only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example of this would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a request to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request