New Patient Form

Patient Information (Please Print)

Name_____ Age_____ Sex _____ DOB_____

Address_____ City_____ State _____ ZIP_____

Phone: Home_____ Work_____ Cell _____

Email _____ Driver's License #_____ State_____

Employer_____ Occupation_____

Emergency Contact _____ Phone_____

Referred by _____

Person Responsible for Payment

Name_____ Relationship_____ DOB_____
If patient is a minor, name of Parent/Guardian

Address_____ City_____ State _____ ZIP_____

Phone: Home_____ Work_____ Cell _____

Email _____ Driver's License #_____ State_____

Employer_____ Occupation_____

Insurance: Primary_____ Secondary_____

Authorization for Medical Treatment, Release of Medical Information to Insurance Company and Assignment of Benefits

I/We do hereby consent to and authorize the performance of all treatments, surgery and medical services by Dr. Mansdorf, his assistant or his qualified designate which they may deem advisable. I consent to the taking and publication of photographs of my extremities during the course of this treatment for the purpose of advancing medical education, understanding that my name and personal information will not be disclosed.

I authorize Dr. Neil B. Mansdorf to furnish information concerning my illness or injury and direct the insurer to pay without equivocation any and all benefits due as a result of claims billed on my behalf. I am aware that I am personally responsible for all charges and/or balance due not covered by my insurance benefits. If insurance is not billed, I accept full responsibly for the payment of such services and agree to pay for them, in full, AT THE TIME OF SERVICE, unless other arrangements are made with the Financial Department.

Signature_____ Date_____
Patient or Parent/Guardian

Neil B. Mansdorf, D.P.M.
Podiatric Medicine • Diplomate American Board of Podiatric Surgery
555 N Tustin St, Orange, CA 92867 • Phone: (714) 633-0040 | Fax: 633-0045

“Covered California” Patients

If you are covered by any Covered California care insurance program, **you are responsible** for determining if Dr. Mansdorf is covered under the plan you have chosen.

Please be aware that while Dr. Mansdorf is a preferred/contracted provider for several of the plans, he is not a provider on all of them. The plan as well as the level/group you have chosen may determine provider coverage.

Dr. Mansdorf is out of network for Covered California exclusive IFP plans, Blue Shield PPO and EPO, Blue Cross PPO, EPO and Pathway X plans. Please note, these plans have higher copays, deductibles and out of pocket costs, and must be paid at time of service.

Signature_____ Date_____
Patient or Parent/Guardian

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Financial Policy

Thank you for choosing us as your podiatrist. We are committed to providing you with the highest quality of care. The following is a statement of our financial policy which we request that you review carefully and sign prior to treatment.

Insurance

If you would like us to bill your insurance, we require a photo ID as well as your insurance card at the time of your initial visit. You must bring all insurance cards at the time of your visit. Without them you will be required to pay cash.

You as the patient are responsible to know what insurance plan you have. You must know what podiatric medical benefits and coverage you have at the time of your appointment, including pre-authorization, deductible and co-payments. If you do not know what your coverage is, please call your insurance company prior to your appointment to get the information

For all patients with insurance plans for which we are providers, we will bill your insurance company. All co-payments and deductibles are due at the time of service. If we find after the appointment that your insurance was not valid, you will be responsible for all fees incurred.

If we are not a provider for your insurance company, we ask that you please pay at the time of service. We will provide you with a receipt to submit to your insurance for reimbursement.

Cash

Payment for all services is due at the time of service unless prior arrangements are made. We accept cash, checks, Master Card and Visa. A valid ID is required.

Appointments

Missed/Canceled: Any appointment not cancelled within 24 hours (working hours) will be assessed a non-insurance reimbursable fee and must be paid before or at your next appointment.

Fees are as follows:

- Office Visit: $25
- Office Surgery: $50
- Hospital/Surgery Center: $100

Emergency/After Hours: There is a $35 non-insurance reimbursable fee in additional to our normal fees due at the time of service.

I understand and agree to the above financial policy:

Print Name_____ Relationship_____
Patient or Parent/Guardian

Signature_____ Date_____

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Acknowledgement of Receipt of Notice of Privacy Practices

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

Patient Name _____

Parent or Authorized Representative (If applicable) _____

Signature _____ Date_____

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Patient Contact and Private Health Information (PHI)

Patient's Name_____ DOB_____

Please list the best way to contact you in order of preference.

Phone 1_____ _____Home _____Work _____Cell

Phone 2_____ _____Home _____Work _____Cell

Email_____

If we are unable to speak with you directly:

_☐_ Speak only to you
_☐_ Leave a message on voice mail/machine (greeting must be identifiable by name or number)
_☐_ Leave a message with authorized person(s) (see below)

Family to Facility Communication

At times, a spouse, parent, child or significant other may wish to contact our staff with questions about diagnosis, treatment plans mediations, test results, emergencies, etc.

_☐_ Do not discuss my personal health information with anyone
_☐_ You may discuss my personal health information with authorized person(s) (see below)

Authorized Person(s)

I authorize the following person(s) to receive Private Health Information (PHI) pertaining to my medical care other than myself or any Physician involved in my care.

Name_____ Relationship _____

Name_____ Relationship _____

Name_____ Relationship _____

Print Name_____ Relationship_____
Patient, Parent/Guardian

Signature_____ Date_____

You have the right to revoke any information by completing a new form.

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Medical History

Patient's Name_____

Primary Doctor _____ Date of Last Exam _____

Please check if you have or have had any of the following:

☐ Diabetes ☐ Feet Tire Easily ☐ Poor Healing ☐ Heart Trouble ☐ Thyroid Problems

☐ Blood Clots ☐ Arthritis/Gout ☐ Heart Trouble ☐ Lung Disease ☐ High/Low Blood Pressure

☐ Leg Cramps ☐ Low Back Pain ☐ Swelling Ankles ☐ Low Back Pain ☐ Cancer

☐ Other Illness/Disability

Current Medications

Pharmacy: Name_____ Phone_____ Fax_____

☐ No Medications ☐ See Attached List

Medication	Strength	Dosage	Last Dosage

Surgical History

☐ No Surgeries

Date	Procedure

Date	Procedure

Allergies

☐ No Allergies _____

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Patient Partnership Plan

Dear Patient:

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving you best possible health requires a “partnership” between you and your doctor. As our ‘partner in health” we ask you to help us in the following ways:

Keep Follow-up Appointments and Reschedule Missed Appointments
I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Lab and Other Tests
I understand that my physician’s goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician’s office within the time specified, I will call the office for my test results.

Inform My Doctor If I Decide Not to Follow His or Her Recommended Treatment Plan
I understand that after examining me, my doctor may make certain recommendations based on what her feels is best for my health. This might include prescribing medication, referring me to a specialist, or ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that not following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide not to follow his or her recommendations so that he may fully inform me of any risks associated with my decision to delay or refuse treatment.

NOTIFICATON TO CONSUMERS

MEDICAL DOCTORS ARE LICENSED AND REGULATED BY THE PODIATRIC MEDICAL BOARD OF CALIFORNIA
(800)633-2322
WWW.MBC.CA.GOV

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, at any time, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

Patient Signature _____ Date _____

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