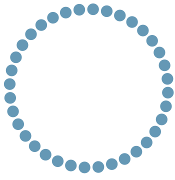


NewportCare®
MEDICAL GROUP
3300 WEST COAST HIGHWAY
NEWPORT BEACH, CA 92663

PATIENT INFORMATION FOR MEDICAL RECORDS

Today's Date ____________________

Patient Name ____________________

Birth Date ________ Age ________ Sex ________ Social Security No. ____________________

Address ____________________ City ____________________

State ________ Zip Code ________ Telephone No. ____________________

Occupation ____________________ Driver's License No. ____________________

Employer-Name ____________________ Employer Telephone No. ____________________

Employer Address ____________________

☐ Married ☐ Single ☐ Divorced ☐ Widow

EMAIL ADDRESS: ____________________

Spouse/or Responsible Parent ____________________

Birth Date ________ Age ________ Sex ________ Social Security No. ____________________

Address ____________________ Telephone No. ____________________

Occupation ____________________ Driver's License No. ____________________

Employer-Name ____________________ Employer Telephone No. ____________________

Employer Address ____________________

Emergency Contact(Other than husband or wife) person not living with you

Name ____________________ Relationship ____________________

Address ____________________ Telephone ____________________

- Please Complete if patient is under 21 years of age or a student

Father's Name ____________________ Mother's Name ____________________

Father's Occupation ____________________ Mother's Occupation ____________________

Father's Employer ____________________ Mother's Employer ____________________

Address ____________________ Address ____________________

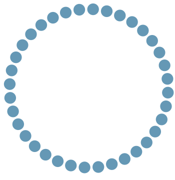
Medical Insurance Information

Primary Insurance Subscriber ____________________ Secondary Insurance Subscriber ____________________

Insurance Co. ____________________ Insurance Co. ____________________

Identification No. ____________________ Identification No. ____________________

Group No. ____________________ Group No. ____________________



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Newport Beach, CA 92663

Patient History
Podiatry Intake

Date ______
Name ______
Date of Birth ______
Please describe your problem (include date of injury if applicable) ______

PAST MEDICAL HISTORY

MEDICAL	DATE		DATE
☐ Anemia	____	☐ Hiatal hernia	____
☐ Arthritis	____	☐ High blood pressure	____
☐ Asthma	____	☐ Kidney infection	____
☐ Breast Lump	____	☐ Pneumonia	____
☐ Cancer	____	☐ Prostate problems	____
☐ Chronic Cough	____	☐ Rectal bleed	____
☐ Cystitis	____	☐ Rheumatic fever	____
☐ Diabetes	____	☐ Thyroid trouble	____
☐ Emphysema	____	☐ Tuberculosis	____
☐ Epilepsy	____	☐ Ulcer	____
☐ Hay fever	____	☐ Weight loss	____
☐ Heart Disease	____	☐ Other(specify) ____	
☐ Hepatitis - B,C	____	____	
☐ HIV	____	____	

SURGERIES	DATE
☐ Abdominal	____
☐ Appendix	____
☐ Breast	____
☐ Broken Bones	____
☐ Gall Bladder	____
☐ Heart	____
☐ Prostate	____
☐ Tonsils	____
☐ Uterus and/or Ovary	____
☐ Other ____	

Last Tetanus: ______

FAMILY HISTORY

	Age(if living)	Age at death	Cancer	Diabetes	Heart Disease	Hypertension	Stroke	Cause of death or major illness
Father (paternal)								
Grandmother								
Grandfather								
Mother (maternal)								
Grandmother								
Grandfather								
Brother(s)								
Sister(s)								

SOCIAL HISTORY

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other
Height: ______ Weight: ______ Shoe Size: ______
Occupation: ______
Exercise: Type, duration, frequency (Example: Walking 30 minutes 3 x/week) ______

Do you currently smoke? ☐ Yes ☐ No
How many packs per day? ______ How many years? ______
Did you smoke previously? ☐ Yes ☐ No
How many packs per day? ______ How many years? ______
Year quit: ______

Do you use recreational drugs? ☐ Yes ☐ No
If yes, How often: ______
Which Drugs are you using? ______

Drink coffee? ☐ Yes ☐ No Cups per day ______
Number of caffeine drinks per day? ______
Drink alcohol? ☐ Yes ☐ No
Alcohol(type): ______
Amount of alcohol consumed per week? ______

Race: ☐ Asian ☐ Black ☐ Caucasian ☐ Hispanic ☐ Other

Past Surgical History:
______

MEDICATIONS

Please list all prescription and over-the-counter medications and the dosages:
______

Please list all Allergies:
____ Medications: ______
____ Foods: ______
Tapes ______ Novocain ______ Anesthetics ______
Silver/Nickel/Costume Jewelry ______
Other: ______

What types of reactions have you experienced?
______

Physician Order Rx/Request for Authorization: Prescription Form/ Certificate of Medical Necessity

Patient Name ______________________________ Physician Name ______________________________

Surgery Center ____________________ Primary ICD-9 Code(s) ____________ DOI: ____________ ☐ Right ☐ Left

Product Description	Product Description	Product Description
Place Sticker Here	Place Sticker Here	Place Sticker Here

Narrative Report:
My signature below acknowledges that, in my judgment, the prescribed item is medically indicated & necessary and consistent with current accepted standards of medical practice and treatment of this patients physical condition. My signature also serves to confirm the veracity of all information included in this document.

Products: ☐ Compression Stocking ☐ Walker Boot ☐ Post-Op Shoe ☐ Knee Immobilizer ☐ Post-Op Knee ☐ LSO ☐ Abdominal Binder ☐ Sling ☐ Shoulder Immobilizer ☐ Cervical Collar ☐ Wrist Brace ☐ Crutches ☐ Thumb Spica ☐ Front Wheel Walker ☐ Other ______________________________

Pneumatic Intermittent Compression (PIC) Device with bilateral calf wraps

☐ **TAKE HOME PORTABLE DEVICE**

Place Label With Serial # Here

DEVICE: Pneumatic Intermittent Compression Device - Duration 1-30 Days

APPLIANCE(S): Segmental Gradient Pressure Pneumatic Appliance(s) X2 - Duration 1-30 Days

MEDICAL COMPLICATIONS: ☐ CVI ☐ Diabets ☐ DVT ☐ Lymphedema ☐ Other: ____________

Narrative Report: In my evaluation of this patient. I have noted there is a higher risk of developing Deep Venous Thrombosis (DVT), due to the type of surgery performed combined with other risk factors. I am Prescribing DVT Prophylaxis involving the use of a pneumatic compression device and the necessary appliances. This patient will have decreased ability and duration of ambulation following surgery, which will significantly increase the risk factors associated with DVT, Pulmonary Embolism (PE), DVT and PE can be major complications associated with these surgeries, resulting in significant morbidity and mortality rates, as stated by the American College of Chest Physicians.

Significant published data is available on the incidents of DVT/PE, the effectiveness of various prophylactic techniques and the risks of hemorrhage when heparin is used, all of which provide positive and compelling evidence in support for the use of intermittent compression devices in DVT prevention. The plantar and lower leg wraps have added the advantage of reproducing the physiological mechanism of venous return. Impaired venous blood flow in post abdominal/orthopedic surgeries, trauma, and other conditions that impede or significantly decrease ambulation of patients most certainly will decrease circulation which can result in edema, pain, delayed healing and increased risk of DVT and PE. The clinical trials show clear evidence that these complications and risk factors can be significantly minimized with the use of the PIC devices.

For these reasons, PIC device and compression wraps are prescribed for this patient to maximize the most positive outcome of surgery and minimize the potential for serious complications. I have successfully used this device in my practice and my patients tolerate the treatment protocol with a very high degree of compliance. I feel this protocol is the most beneficial and cost effective treatment of my patients in greatly reducing the development of DVT, which when ignored can result in significant increase in morbidity and mortality and increased utilization of health care resources and dollars.

Rental to Purchase Option

NewportCare Medical Group makes every effort to provide you with equipment that is yours to keep. However, from time to time your doctor may prescribe a rental piece of equipment such as T.E.N.S. If you need a T.E.N.S. prescribed by your doctor, you may know your insurance may help pay for it. T.E.N.S. are normally rented on a monthly basis. If you wish to purchase the T.E.N.S. because you may need it for extended use, we will apply any daily rental rates to the purchase price. In making your decision to rent or purchase this equipment, you should know that you will be responsible for 20% of the service charge. If you choose the purchase option, you will be responsible for the purchase amount less than the rental.

Option
☐ Rental
☐ Purchase

Patient Acknowledgment & Authorization to Assignment of Benefits(PA/AOB)

I acknowledge receiving instruction, have demonstrated or verbalized my understanding in the proper use and care of the equipment or supplies received today described on this document & will follow them. I understand company business hours and a NewportCare Medical Group representative will be contacting me regarding my financial responsibilities related to this agreement. I acknowledge receipt & understand the Company Patient Information Privacy Notice and that all information on this document is correct. I understand and agree that I am responsible for payment or products and services provided by NewportCare Medical Group. I agree to make payment, in full, upon receipt of payment from insurance company to policy holder if not endorsed and forwarded to NewportCare Medical Group. I authorize release of any medical information necessary to process this claim and certify the above information is correct. I authorize any and all payments of medical benefits to NewportCare Medical Group for the products and services rendered.

Patient Signature ______________________________ Date ____________

Product Delivery Acknowledgment (Required for Medicare Claims)

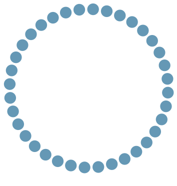
Patient Signature ______________________________ Date ____________

Patient Sticker Here

License# ____________ NPI# ____________ Physician Signature ______________________________

3300 West Coast Highway. Newport Beach, CA 92663
Office: (949)491-9991 Fax: (949)258-5858

NewportCare® Medical Group



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PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability and Accountability Act of 1966 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for the following:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations, such as quality assessments and physician certifications.

Only upon request you organization will provide a copy of Notice of Privacy Practices containing a more detailed description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at this address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are required to agree to my requests, and by agreeing to such requests: you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on the consent.

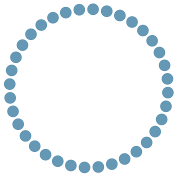
Patient Name(Print)

Signature

Relationship to Patient

Date

Phone: 949 / 491 - 9991 FAX: 949 / 258 - 5858
www.NewportCare.org



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Release of Records

I ____ , hereby give NewportCare Medical Group authorization to discuss my medical condition and test results with:

Please list all the names and phone numbers as appropriate.

Spouse ____

Mother ____

Father ____

Sister(s) ____

Brothers(s) ____

Son(s) ____

Daughter(s) ____

Caregiver ____

Answering machine at phone number ____

Other ____

No one but patient ____

____

Patient Name(Print)

____

Signature

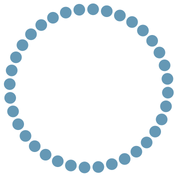
____

Relationship to Patient

____

Date

Phone: 949 / 491 - 9991 FAX: 949 / 258 - 5858
www.NewportCare.org



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NEWPORT BEACH, CA 92663

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The practice reserves the right to modify the privacy practices outlined in this notice.

I have received a copy of the Notice of Privacy Practices

Patient Name(Print) ______________________________

Signature ______________________________

Relationship to Patient ______________________________

Date ______________________________

DOCUMENTATION OF ATTEMPT TO OBTAIN ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

Attempt to Obtain Acknowledgment

An attempt was made to obtain an acknowledgment of Notice of Privacy Practices on

The Acknowledgment was not obtained because:

*The patient was undergoing emergency treatment

*The patient declined to sign the Acknowledgment

*Other ______________________________

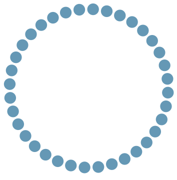
Patient Name(Print) ______________________________

Signature ______________________________

Relationship to Patient ______________________________

Date ______________________________

Phone: 949 / 491 - 9991 FAX: 949 / 258 - 5858
www.NewportCare.org



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Financial Interest Consent

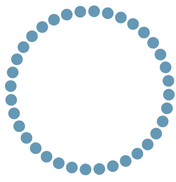
I, ____ (patient), acknowledge and accept that my physician(s) may have financial interest in hospitals, surgery centers, imaging centers, physical therapy and/or surgical devices that he/she chooses to utilize. I hereby recognize my rights to choose another physician or request the services of another facility or device be used.

Patient Name(Print)

Signature

Relationship to Patient

Date



NewportCare®
Medical Group
3300 West Coast Highway
Newport Beach, CA 92663

NewportCare Medical Group Office Financial Policy

Thank you for choosing NewportCare Medical Group. We are committed to the success of your treatment. We hope you understand that payment of your bills is considered part of your treatment. The following is a statement of our financial policy, which we require you read, agree to and sign, prior to any treatment. This financial policy applies to all services rendered by the doctors and physical therapists.

It is our policy that the patient, rather than the insurance company, is responsible for complete payment of our charges. All patients with insurance coverage are required to pay for non-covered services, any deductible amount not previously met and any copay amount due, at the time of services rendered. For patients with dual insurance coverage we will bill both the primary and secondary insurance if you have provided us with the necessary information.

Patients insured with plans which we are NOT contracted with will be required to pay for the first visit in full. For any follow-up visits you will need to pay 30% at the time services are rendered. There will be a 30% down payment prior to any surgery needed.

If you are insured with a plan which we ARE contracted with (including Medicare), you will need to pay for any non-covered services, any outstanding deductible and your copy amount, at the time of each visit. If for any reason the insurance company failed to pay, the patient will be responsible for the entire balance.

Patients with no insurance coverage are expected to pay for the services at the time services are rendered.

Failure to make payment arrangements, or pay outstanding balances within 60 days of notification of amount due, may result in termination of care from NewportCare Medical Group

Our accepted methods of payments are cash, check, Visa, MasterCard or Discover Card. If requested, a short payment schedule may be arranged for those patients who have special financial conditions.

Again, thank you for trusting us with your care. If you have any questions regarding financial responsibility of payment options, please contract our insurance department.

"I have read, understand and agree to the provisions of this policy"

____

Patient Name(Print)

____

Patient Signature / Guarantor

____

Date

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

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 were 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 of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any 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 bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any 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 mother's 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 employees, 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 patient shall not waive the right to compel arbitration of 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 by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata 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, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from 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 issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the 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 parties 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 Sections 340.5 and 667.7 and Civil Code Sections 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, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related 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 claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails 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 arbitrators 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 patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services ______________________

Patient's or Patient Representative's Initials

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 other 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: ______________________ ________

Patient's or Patient Representative's Signature Date

By: ______________________ ________

Physician's or Authorized Representative's Signature Date

By: ______________________

Print Patient's Name

NewportCare Medical Group

Print or Stamp Name of Physician,
Medical Group, or Association Name

____

(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

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