LORELEI C. ACHOR, DPM

Achor Foot and Ankle, Inc.
24953 Paseo de Valencia, Suite 15C
Laguna Hills, CA 92653
P 949.305.8333 F 949.305.6333

Welcome to Dr. Achor's Practice!

Please find attached the new patient paperwork for your upcoming appointment. Please do not print the forms double sided but single pages. Please have all pages filled out and signed upon arriving at our office.

Please bring your Photo identification and insurance card(s) and arrive 15 minutes before your appointment time. Should you need assistance or do not have your paperwork completed, please arrive at least 30 minutes earlier to allow ample time.

We do accept Medicare, most PPO Insurances and cash payment. We are not contracted with any HMOs or Medical.
If you have a PPO Insurance, we will collect $125 deposit at the time of your first visit. The deposit will be allocated toward your deductible and any overpaid amount will be refunded once the billing is processed.

Our office address is listed as Paseo de Valencia, but our building is located on Beckenham. We are in the third medical building on the left side of the street. Parking is in front of the building and can be reached via the third driveway on the left.
Our office is located on the second floor just to the left of the elevator. The elevator can be reached from the courtyard at the center of the building.

In order to best help you, please come prepared for your visit. If you have any XRays, MRIs, or other images please bring copies of both the reports and the images. If you have had any vascular studies or neurologic studies bring the results. If you wear any types of braces, splints or orthotics, please bring them with shoes (custom or otc) that you wear them in.

Please do not hesitate to call with any questions you may have.

We look forward to working with you during your health care journey…

Best Regards,

Lorelei C. Achor, DPM

PODIATRIC REGISTRATION AND HISTORY – LORELEI C. ACHOR, DMP

1 PATIENT INFORMATION

Last Name _____

First Name _____

Address_____

City_____

State_____ Zip_____

E-mail_____

Sex □ M □ F Age_____ Birthdate_____

□ Married □ Widowed □ Single □ Minor

□ Separated □ Divorced □ Partnered for _____years

Patient Employer/School_____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's, Partner, etc. Name_____

Birthdate _____ Phone _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Primary Care Physician: _____

Phone: _____

Date of last physical examination: _____

What is your reason for today visit? _____

_____

2 PATIENT PHONE NUMBERS

Home Phone _____

Cell Phone _____

CONTACT IN CASE OF EMERGENCY

Name _____

Relationship _____

Home Phone _____

Cell Phone _____

Work Phone _____

3 MEDICATIONS / ALLERGIES

List **medications** you are currently taking including vitamins, supplements, herbal remedies & over the counter meds (**attach additional pages if needed**):

_____

_____

_____

_____

_____

List **allergies to medications or substances** with reaction:

_____

_____

_____

Pharmacy_____ Phone _____

Address: _____

4 TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacements) to administer and perform such procedures upon me as the doctor deems necessary.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient

PODIATRIC REGISTRATION AND HISTORY – LORELEI C. ACHOR, DMP

5 INSURANCE

1) Primary Insurance Co. _____ Group # _____

Who is responsible for this account? _____ Relationship to Patient: _____

Subscriber's Name: _____ Relationship to Patient: _____ Birthdate: _____

2) If patient covered by **additional Secondary Insurance** what Insurance Co. _____ Group # _____

Who is responsible for this account? _____ Relationship to Patient: _____

Subscriber's Name: _____ Relationship to Patient: _____ Birthdate: _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with _____ and assign directly to Dr. Lorelei C. Achor, DPM, Achor Foot and Ankle, Inc., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Compan(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or ten years from the date signed below.

MEDICARE/MEDIGAP AUHORIZATION

I REQUEST THAT PAYMENT OF AUTHORIZED Medicare benefits and, if applicable, Medigap benefits, be made on my behalf to Dr. Lorelei C. Achor, DPM, Achor Foot and Ankle, Inc. for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits for related services.

_____

Signature of Beneficiary, Guardian, or Personal Representative Date

_____

Please print name of Beneficiary, Guardian, or Personal Representative Relationship to Beneficiary

6 FAMILY HISTORY

ALIVE DECEASED	FATHER □ □	Present Health or Cause of Death	MOTHER □ □	Present Health or Cause of Death	SPOUSE □ □	Present Health or Cause of Death
BROTHERS	No. Alive	Health		How many deceased		Cause of death
SISTERS	No. Alive	Health		How many deceased		Cause of death
CHILDREN	No. Alive	Health		How many deceased		Cause of death

Check illnesses which have occurred in any of your IMMEDIATE BLOOD RELATIVES:

□ Allergy □ Bleeding Tendency □ Cancer □ Diabetes □ Difficulty with Anesthesia □ Kidney Disease

□ Heart Disease □ High Blood Pressure □ Mental Health Issues □ Stroke □ Tuberculosis □ Other

7 MEDICAL HISTORY Circle symptoms you currently have or have had in the past year. (All information is strictly confidential)

GENERAL
- Chills
- Depression/Anxiety/Excess Stress
- Dizziness
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight
- Numbness
- Sweats

GASTROINTESTINAL
- Appetite changes
- Bloating/Gas/Stomach pain
- Bowel changes
- Constipation
- Diarrhea
- Excessive thirst
- Hemorrhoids/Rectal bleeding
- Indigestion
- Nausea
- Vomiting

MUSCLE/JOINT/BONE
- Pain, weakness, numbness in:
  - Arms
  - Back
  - Feet
  - Hands
  - Hips
  - Legs
  - Neck
  - Shoulders
- Difficulty walking
- Recent falls
- Changes in balance

CARDIOVASCULAR
- Chest pain
- High/Low blood pressure
- Irregular/Rapid heartbeat
- Poor circulation
- Swelling of ankles
- Varicose veins

EYE, EAR, NOSE, THROAT
- Bleeding gums
- Blurred vision/Double vision
- Difficulty swallowing
- Earache/Ear discharge/Hearing loss
- Hay Fever/Allergies (seasonal)
- Hoarseness
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision – Flashes/Halos/Floaters

SKIN
- Bruise easily
- Hives
- Itching/Rash
- Change in mole(s)
- Scars
- Wounds/Cuts that will not heal
- Sores

MEN ONLY
- Penal issues
- Other: _____

WOMEN ONLY
- Vaginal issues
- Menopause issues

Date of last menstrual period _____
Date of last Pap Smear _____
Have you had a mammogram? _____
Are you pregnant? _____
Number of Children _____

GENITO-URINARY
- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

PODIATRIC REGISTRATION AND HISTORY – LORELEI C. ACHOR, DMP

MEDICAL HISTORY **Circle conditions you have had in the past:**

- Arterial/Venous Disease
- Arthritis
- Asthma
- Bleeding Disorders
- Breast lump
- Cancer
- Cataracts
- Chemical Dependency
- Chicken Pox
- Chronic Swelling
- Diabetes
- Emphysema
- Epilepsy
- Fibromyalgia
- Glaucoma
- Heart Disease/Heart Attack
- Hepatitis
- Herpes
- High Cholesterol/High Blood Pressure
- HIV Positive/AIDS
- Kidney Disease
- Liver Disease
- Measles
- Migraine Headaches
- Multiple Sclerosis
- Mumps
- Pacemaker
- Peripheral Neuropathy
- Pneumonia
- Polio
- Prostate Problems
- Rheumatic Fever/Scarlet Fever
- Stroke
- Thyroid Problems
- Tuberculosis
- Ulcers
- Venereal Disease
- Other_____

8 DESCRIBE SERIOUS ILLNESS

_____

9 SURGICAL HISTORY OR OPERATIONS

Describe each surgery and provide date of surgery:

_____

_____

10 HEALTH HABITS

Circle which you use and how much:

- Alcohol _____
- Caffeine _____
- Illegal Drugs _____
- Tobacco/Marijuana _____
- Other_____

Circle if your work or life exposes you to:

- Stress
- Heavy Lifting
- Hazardous Substances
- Other _____

11 SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient

_____ _____

Reviewed by Date

PATIENT FINANCIAL POLICY

Achor Foot and Ankle, Inc.
Lorelei C. Achor, DPM
24953 Paseo de Valencia, Suite 15 C, Laguna Hills, Ca 92653
P 949.305-8333 F 949 305-6333

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our office staff.

- As our patient, you are responsible for all authorizations/referrals required to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for treatment and services are due at the time service is provided. We will accept Visa, MasterCard, Discover, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not provide payment within a reasonable period, you will be responsible of any balance due.
- We have made prior arrangements with certain insurers and health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.
- If you have insurance plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due and the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not obtained authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you remain responsible for any charges from service rendered.
- You must inform this office of all insurance changes and authorization/referral requirements. In the event this office is not informed you will be responsible, or any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if the procedure being performed requires pre-payment. In these cases, payment will be due one week prior to surgery.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.
- Appointment cancellations require a minimum **24-hour notice**. If less than that, there will be a **$75.00 charge**. Your insurance company does not cover this fee.

_____	_____	_____
Signature of Patient/Responsible Party	Printed Name of Patient/Responsible Party	Date

_____Initial to indicate received copy

HIPAA NOTICE OF PRIVACY PRACTICES

Achor Foot and Ankle, Inc.

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and relates to your past, present or future physical or mental health or condition and related healthcare services.
Uses and Disclosures of Protected Health Information
Our protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for you health care services. For example, obtaining approval for the hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of you physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may disclose your protected health information, as necessary, to contact you to remind you of your appointment.
We may use or disclose your protected health information in the following situations without your authorization. These situations include as Required By Law. Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164-500.
Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.
You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.
You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes: information compiled in a reasonable anticipation of, or use it, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in you care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.
You may have the right to have your physician amend your protected health information. If we deny your request for amendment you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.
This notice was published and becomes effective on or before April 14, 2003
We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

_____	_____	_____
Print Name	Signature	Date

PATIENT PARTNERSHIP AGREMENT

Achor Foot and Ankle, Inc.
Lorelei C. Achor, DPM
24953 Paseo de Valencia, Suite 15C
Laguna Hills, CA 92653
P 949.305.8333 F 949.305.6333

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your ***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 give her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to another type of specialist, prescribe medication or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect 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 Labs or 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 Her Recommended Treatment Plan
I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to another type of specialist, 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 to that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

_____ _____ _____
Print Patient Name Patient Signature Date

_____
Physician Signature

SYSTEM REVIEW - LORELEI C. ACHOR, DPM

GENERAL:

Do you eat a well balanced diet?_____NO YES
Approx. weight now_____1 yr. ago_____
Maximum weight _____
Exercise? Frequency/WK _____
Activities _____
Height _____ Shoe Size _____
Year of your last Complete Physical _____
Headaches_____NO YES
Glasses/Contacts _____NO YES
Double vision _____ NO YES
Eye disease or injury_____NO YES
Year last checked for glaucoma_____
Itching eyes or nose/hay fever_____NO YES
Septal deviation/ polyps (circle)_____NO YES
Nosebleeds _____NO YES
Sinus trouble _____NO YES
Ear disease _____NO YES
Impaired Hearing_____NO YES
Ringing in the ear_____ NO YES
Hoarseness _____NO YES

NECK:

Stiffness_____ NO YES
Enlarged glands_____ NO YES
Injury _____ NO YES

RESPIRATORY:

Coughing up blood _____ NO YES
Chronic cough (including smoker's cough) NO YES
Wheezing _____ NO YES
Shortness of breath _____NO YES
How many blocks can you walk without having to stop to catch your breath?_____
Night sweats_____NO YES
Skin test for tuberculosis _____NO YES
If yes, year tested and results _____
Year of last chest x-ray _____

CARDIOVASCULAR:

Chest pain or angina pectoris _____NO YES
Shortness of breathing when lying flat_____NO YES
Pain in legs on walking/relieved by rest____NO YES
Varicose veins_____ NO YES
Ankles often badly swollen _____NO YES
Heart murmur _____ NO YES
Rapid, hard or skipped heart beats_____NO YES
Year of last EKG _____
Have you had a stress treadmill? Year_____NO YES

GENITORURINARY:

Loss of urine when cough or sneeze ____NO YES
Kidney or bladder infection (circle)_____NO YES
Burning or frequent urination (circle)_____NO YES
Feeling must go immediately?_____NO YES
Do you have to get up at night to urinate? #_____
Blood in urine _____NO YES
Kidney stones _____NO YES
Swelling of hands and feet _____NO YES
Difficulty starting urination _____NO YES
Decreasing in strength of stream_____NO YES

MUSCULOSKELETAL:

Significant Arthritis/ Joint pain _____NO YES
Low back pain _____NO YES
Difficulty walking _____NO YES
Fractures (list)_____NO YES

SKIN:

Skin disorders (list) _____NO YES

NEUROLGIC /PSYCHIATRIC:

Numbness/ Paralysis (circle)_____NO YES
Fainting spells _____NO YES
Memory loss _____NO YES
Dizziness _____NO YES
Do you have trouble sleeping?_____NO YES
Are you often depressed? _____NO YES
Are you often anxious or nervous?_____NO YES
Do you ever wish you were dead and away from it all _____NO YES
Do you often worry?_____NO YES
Have you ever been under psychiatric care? NO YES

HEMATOLOGIC:

Excessive bleeding or abnormal bruising NO YES

ENDOCRINE:

Crave large amounts of fluids_____NO YES
Intolerance to slightly warm room _____NO YES
Intolerance to slightly cold room _____NO YES
Change in textures of hair or skin _____NO YES
Change in Voice (as an adult) _____NO YES
Hair loss _____NO YES
Darkening of skin _____NO YES

Patient Signature:_____

Reviewing Physician: _____

Patient Acknowledgement to Receive Treatment during COVID-19

Achor Foot and Ankle, Inc.

The CDC recommends postponing all nonessential or elective healthcare visits and group-related activities, and states are mandating the provision of emergency services only.

- While our office complies with Federal, State Health Department, and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees about your health and safety.
- I hereby acknowledge and understand that there may be an increased risk that COVID-19 may be transmitted in any place of public accommodation, which includes my physician's office. I have been informed by my physician of their desire to protect their patients, staff and the community at large.

To the best of our knowledge, Dr. Achor and her staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of healthcare services, other persons (including other patients) could be infected, with or without their knowledge.

As a prerequisite to receiving care/treatment, we are asking out patients and their accompanying party(s) to complete the screening attestation form below.

Attestation: Circle if you are: **Patient or Accompanying Party**
Each complete their own Attestation

In the last 48 hours have you experienced:	Yes	No
Fever	☐	☐
Any shortness of breath	☐	☐
Dry cough	☐	☐
Runny nose	☐	☐
Sore throat	☐	☐
Loss of taste and/or smell sensation	☐	☐
WITHIN THE LAST 14 DAYS have you:		
Travelled to a foreign country	☐	☐
Have you travelled within the US via:		
Airplane	☐	☐
Cruise ship	☐	☐
Train	☐	☐
Public transportation	☐	☐

If yes, to any of the above questions, please explain:_____

I have been practicing all current CDC guidelines with respect to "social distancing" and have NOT been in contact with a person who had a positive test for COVID-19 or suspected to be positive.

Accompanying Party name: _____ **Accompanying Party signature:** _____ Date: _____

I have been practicing all current CDC guidelines with respect to "social distancing" and have NOT been in contact with a person who had a positive test for COVID-19 or suspected to be positive.

I hereby consent to the treatment proposed by my physician.

Patient's name: _____ **Patient's signature:** _____ Date: ____

Physician's name: Dr. Lorelei C. Achor **Physician's signature:** _____ Date: _____