



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 _____

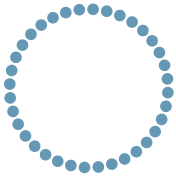
Medical Insurance Information

Primary Insurance Subscriber _____ Secondary Insurance Subscriber _____

Insurance Co. _____ Insurance Co. _____

Identification No. _____ Identification No. _____

Group No. _____ Group No. _____



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PATIENT HISTORY

PODIATRY INTAKE

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

SOCIAL HISTORY

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

PAST MEDICAL HISTORY

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

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:

SURGERIES	DATE
<input type="checkbox"/> Abdominal	_____
<input type="checkbox"/> Appendix	_____
<input type="checkbox"/> Breast	_____
<input type="checkbox"/> Broken Bones	_____
<input type="checkbox"/> Gall Bladder	_____
<input type="checkbox"/> Heart	_____
<input type="checkbox"/> Prostate	_____
<input type="checkbox"/> Tonsils	_____
<input type="checkbox"/> Uterus and/or Ovary	_____
<input type="checkbox"/> Other	_____

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?

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)								

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 <hr/> Place Sticker Here <hr/>
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Product Description <hr/> Place Sticker Here <hr/>
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Product Description <hr/> Place Sticker Here <hr/>
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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 _____

License# _____ NPI# _____ Physician Signature _____

Patient Sticker Here <hr/>



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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



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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 _____

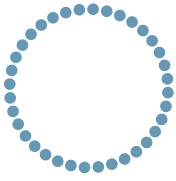
No one but patient _____

Patient Name(Print)

Signature

Relationship to Patient

Date



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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 _____



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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



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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 copay amount, at the time of each visit.

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 contact our insurance department.

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

Patient Name(Print)

Patient Signature / Guarantor

Date

