

Welcome to
Monterey Bay Podiatry
Cosette Standridge-Folsom, DPM, Inc
1011 Cass St. STE 201
Monterey, CA 93940
(831)648-1011

New Patient Registration Form:

Personal Information:

- Name: _____
- Age: _____ Date of Birth: ____ / ____ / ____
- Billing Address: _____
- City: _____ State: _____ Zip Code: _____
- Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____
- Work Phone: (____) _____ - _____
- Employer: _____
- Occupation: _____
- Gender: ☐ Male ☐ Female ☐ Non-binary
- Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other: _____
- Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered
- Partner's Name: _____
- Email: _____
- Social Security Number: _____ - _____ - _____
- Primary Care Doctor: _____ Date Last Seen ____ / ____ / ____
- Emergency Contact: _____
- Relationship to patient: _____
- Emergency Contact Phone: (____) _____ - _____
- Guarantor (if different from patient): _____
- Relation to Patient: _____
- Guarantor Phone: (____) _____ - _____
- Referred By: _____
- Reason for Visit: _____
- Current Height: _____
- Current Weight: _____
- Current Shoe Size: _____

Patient Signature or Legal Representative: _____

Please Print Name of Patient or Legal Representative and Relationship to Patient:

Date: ____ / ____ / ____

Insurance Information:

- Primary Insurance: _____
- Policy Number: _____
- Group Number: _____
- Policy Holder's Name: _____
- Relationship to Patient: _____

- Secondary Insurance (if applicable): _____
- Policy Number: _____
- Group Number: _____
- Policy Holder's Name: _____
- Relationship to Patient: _____

Notice of Patient Responsibility:

Some services provided in this office are considered non-covered by certain insurance companies, for example, *custom orthotics, routine nail and callus care without specific medical qualifications, foot pads, non-custom inserts, shoes, toe spacers, MLS laser, and clinic-dispensed medications*. Ultimately, it is the patient's responsibility to determine whether a particular service is covered by their insurance carrier, or not. If you, the patient/guarantor, choose to receive non-covered services, it will be your responsibility to pay for those services at the time they are provided. Should your insurance company pay at a later date, the patient/guarantor will be reimbursed for over-payment.

Patient Signature or Legal Representative: _____

Cancellation and No Show Policy:

I acknowledge the 24-hour cancellation policy and understand that a \$50 fee will be charged for no-shows.

Patient Signature or Legal Representative: _____

Late Policy:

I acknowledge that arriving more than 10 minutes late for an appointment may require rescheduling. This policy ensures that all patients receive the appropriate attention and maintains courtesy for everyone.

Patient Signature or Legal Representative: _____

Zero Tolerance Policy:

We strive to maintain a respectful and professional environment for all patients and staff members. Monterey Bay Podiatry will be a safe and non-judgmental space for all. Any foul language against or inappropriate comments or behavior towards staff members or fellow patients will not be tolerated and may result in dismissal from the office. We appreciate your understanding and cooperation in helping us provide a safe and welcoming atmosphere for everyone.

Patient Signature or Legal Representative: _____

Date: ____ / ____ / ____

**HIPAA Privacy Rule Receipt of Notice of Privacy Practices Written
Acknowledgment Form:**

Acknowledgement of receipt of information practices notices (s164.520(a)).

I, _____ (patient's name), understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of the health information. I understand that:

- I have the right to review this facility's Notice of Privacy Practices prior to signing this acknowledgement.
- This facility reserves the right to change their Notice of Privacy Practices and prior to implementation will mail a copy of any revised notice to the address I've provided if requested.

Patient Signature or Legal Representative: _____

Printed Patient's Name or Legal Representative: _____

Date: ____ / ____ / ____

Past Medical History:

Please **circle** any of the following current or past medical problems and elaborate below if yes:

- Diabetes _____
- HIV _____
- Hepatitis _____
- Cancer _____
- Depression _____
- Anxiety _____
- Heart Disease _____
- High Blood Pressure (Includes
Current Treatment) _____
- Kidney Problems _____
- Dialysis _____
- Liver Disease _____
- Stroke _____
- Dementia/Alzheimers _____
- _____
- Circulation problems _____
- _____

- Wounds on the Feet or Legs _____
- _____
- Stomach Ulcers _____
- _____
- Neuropathy _____
- _____
- Gout _____
- _____
- High Cholesterol _____
- _____
- Arthritis _____
- _____
- Autoimmune Disease _____
- _____

Other medical problems currently being treated or in the past:

Past Surgeries: _____

Allergies:

- List any known allergies: _____

Preferred Pharmacy:

- Pharmacy Name: _____
- Pharmacy Location: _____

Medications:

- Please list all current medications and dosage:

Lifestyle:

- Tobacco Use: ☐ Yes ☐ No
If yes, for how many years _____
When did you quit? _____
- Alcohol Use: ☐ Yes ☐ No.
If yes, how often? _____
- Caffeinated Beverages: ☐ Yes ☐ No
If yes, what kind and how often? _____
- Marijuana use: ☐ Yes ☐ No
If yes, how often? _____
- Current on Flu Vaccine: ☐ Yes ☐ No
- Current on COVID Vaccine: ☐ Yes ☐ No
- Current on Pneumonia Vaccine: ☐ Yes ☐ No

For those over 65 years of age:

- Do you have an advance care plan or someone to make decisions on your behalf? ☐ Yes ☐ No

If yes, please elaborate: _____

Patient Signature or Legal Representative: _____

Date: ____/____/____

Consent for Ambient Scribe Technology for your Physician's Medical Documentation:

DeepScribe is a 100% free service being provided to you in order to improve your patient experience. DeepScribe is an Ambient medical scribe technology developed at the University of California, Berkeley AI Research Lab. **DeepScribe prepares medical notes for your clinician by simply listening to your visit.**

Quality Care: Improve the quality of care by increasing facetime with your clinician. By using DeepScribe, your clinician can give you their undivided attention without worrying about documenting your encounter during the visit.

Productive: With the advent of Electronic Health Records (EHRs), clinicians spend more time documenting patient visits than actually delivering them. This leads to less efficient clinics, burnt-out doctors, and longer wait-times. Using DeepScribe means more time for substantive work and less clerical work for clinicians.

Secure: DeepScribe is 100% HIPAA compliant. To ensure your data is secure as possible, DeepScribe has implemented multi-factor authentication, data encryption, and de-identification of all patient data, and extensively limited access to your information.

Patient Consent for Ambient Scribe Documentation:

I, _____ (the "Patient"), give my permission, as indicated below, to be audio recorded during my medical visit.

I consent to using DeepScribe Inc.'s medical scribe services to use these recordings and personal information collected during the recordings, including health information, for the following services, which include but are not limited to medical documentation and medical transcription.

Patient Signature: _____ Date: ____ / ____ / ____

Please fill out the form completely and bring it with you to your appointment.
Thank you

A Note to Our Valued Patients:

We understand that your time is valuable, and we strive to run on schedule to respect your day. However, there are times when other patients' appointments may take longer than expected due to unforeseen complications. Our doctors see patients of all ages and needs, including children and the elderly, who may require additional time for explanations or assistance with mobility. Some patients may not process information quickly or they may not hear or remember well, and we need more time to ensure they fully understand their care.

As podiatry is a procedure-based specialty, unexpected situations can arise during routine visits. We address routine care, non-healing ulcers and infections, dermatologic concerns, musculoskeletal injuries, biomechanics, among other things. We are often the first physicians to discover blood flow concerns and neurologic changes.

Patients may also book an appointment for one concern and then present a list of several problems that were unexpected during booking. Additionally, if a patient presents with an *urgent* issue such as an active infection, fracture, or wound, the doctor will address these concerns immediately, even if they were not part of the otherwise routine visit that was booked. We will not ask patients with *critical needs* to come back on another day. **Emergencies in podiatry can be limb or life-threatening and require immediate attention and may require an emergent procedure, direction to the emergency room, or immediate contact with a primary care doctor.**

If the doctor is running late, the front staff can give you a time estimate if you ask. Please know that our doctors do not double book appointments and do not take breaks while there are patients waiting to be seen. She will never rush your appointment to try to “catch up” and will honor your allotted appointment duration and give you the same caring attention that she strives to provide to all of her patients. We appreciate your patience and understanding as we work to provide the best care possible to each of our patients.

Thank you for your trust and cooperation.