ANN M. HUDACEK, D.P.M.

Patient Name: _____ DOB: _____ Age: ____

Billing Address: _____

Home Phone: _____ Cell: _____Work:_____

Employer: _____ Occupation: _____

Gender: M/F SSN: _____ Married: Y/N/W Spouse's Name:_____

E-Mail Address: _____

Primary Care Physician: _____ Date last seen: _____

Emergency Contact _____ Phone: _____

Guarantor:_____Relation:_____Phone:_____

Referred by: _____ Office Use _____

Reason for visit: _____

Ethnicity (circle one): Hispanic/Latino or Non-Hispanic/Non-Latino
Race: American Indian-Asian-Black/African American-Hawaiian/Pacific Islander White – Other_____
Preferred Language: _____

INSURANCE INFORMATION

Primary Insurance: _____Subscriber Name: _____

Subscriber DOB: _____ Subscriber SSN: _____ Relationship: Self/Spouse/Child

Subscriber's Employer: _____

Secondary Insurance: _____Subscriber Name: _____

Subscriber DOB: _____ Subscriber SSN: _____ Relationship: Self/Spouse/Child

It is a requirement of our Insurance contracts to collect co-payments at the time of service. Physician and facility charges will be billed to you unless insurance information is provided to our office before the time of service. It is your responsibility to contact your insurance prior to services to determine if an authorization is required. Failure to obtain authorization will result in you being responsible for the services provided.

I consent to treatment for the care of the above patient. I authorize the release of all medical records to the referring and family physician and to the insurance carriers as needed to process a claim. I allow fax transmittal of medical records if necessary. I request insurance payments of medical benefits be made directly to the physician. I understand that I am financially responsible for all charges and that I will be expected to pay if my insurance has not paid within 90 days from the date of service.

Patient/Guarantor Signature: _____ **Date:** _____

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PATIENT QUESTIONNAIRE

(REQUIRED AT FIRST VISIT OR IF PATIENT HAS NOT BEEN SEEN FOR OVER 1 YEAR)

Patient Name: _____ Date: _____

Allergies: _____

Past Medical History: _____

Anxiety	Yes/No	Heart Disease	Yes/No
Arthritis	Yes/No	Hepatitis	Yes/No
Auto Immune Disease	Yes/No	High Blood Pressure	Yes/No
Bleeding Disorder	Yes/No	Kidney Problems	Yes/No
Cancer	Yes/No	Liver Disease	Yes/No
Chemical Dependency	Yes/No	Neuropathy	Yes/No
Circulatory Problems	Yes/No	Psychiatric Care	Yes/No
Depression	Yes/No	Respiratory Disease	Yes/No
Diabetes	Yes/No	Stroke	Yes/No
Gout	Yes/No	Ulcers	Yes/No
High Cholesterol	Yes/No		

Other: _____

Past Surgical History: _____
_____
_____

Tobacco Use: Yes/No

If yes, please check one: _____ Current every day _____ Current some days _____ Former

Alcohol Use: Yes/No

If yes, number of drinks per day: _____

Patient/Guarantor Signature: _____ **Date:** _____

ANN M. HUDACEK, D.P.M.

LIST OF MEDICATIONS

Patient Name: _____ Date: _____

Preferred Pharmacy & Location: _____

Allergies to Medications:

No ____ Yes ____ Please list: _____

NAME OF MEDICATION	**DOSAGE** **(mg)**	**DIRECTIONS** **(times per day)**

Ann M. Hudacek, DPM
1011 Cass Street, Suite 201 Monterey, CA 93940
831-648-1011

NOTICE OF PATIENT RESPONSIBILITY

To Our Patients:

Some Services provided in this office are considered non-covered by certain insurance companies, for example, custom orthotics and routine nail care.

Ultimately, it is the patients' responsibility to determine whether a particular service is covered by their insurance carrier, or not.

If you, the patient/guarantor chooses 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 overpayment.

I, _____am aware that I am responsible for any service deemed non-covered, not payable by my insurance company for the services provided.

Signature _____

Date:_____

Ann M. Hudacek, DPM

HIPAA Privacy Rule

Receipt of Notice of Privacy Practices

Written Acknowledgement Form

Acknowledgement of receipt of Information Practices Notice (§164.520(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 my 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 of this will mail a copy of any revised notice to the address I've provided if requested.

Signature of Individual or Legal Representative Witness_____

Printed Name of Individual or Legal Representative _____

Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Others (please specify) _____