WELCOME TO OUR OFFICE!

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME:_____ MI _____

ADDRESS: _____ APT # _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: (_____) _____ WORK PHONE: (_____) _____

SEX: M F DATE OF BIRTH: _____ AGE: _____ MARITAL STATUS: S M D W

DRIVER'S LICENSE # _____ SOCIAL SECURITY NUMBER: _____ - _____-_____

EMAIL: _____

IN CASE OF AN EMERGENCY, CONTACT:
NAME: _____ PHONE NUMBER: (_____) _____ RELATIONSHIP: _____

EMPLOYER

EMPLOYER: _____ OCCUPATION:_____
WORK NUMBER: (_____) _____

(THIS AREA MUST BE COMPLETED IF PATIENT IS A MINOR)

SPOUSE / GUARANTOR

NAME: _____ PHONE NUMBER: (_____)_____
EMPLOYER: _____ OCCUPATION: _____
SSN: (OPTIONAL)_____ -_____ -_____ DRIVER'S LICENSE#_____ DATE OF BIRTH: _____

REFERRAL

☐ DOCTOR ☐ FRIEND ☐ OTHER

NAME: _____
ADDRESS: _____

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ALL CHARGES INCURRED ARE DUE AND PAYABLE AT THE TIME OF THE VISIT UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

I HEREBY GIVE MY PERMISSION FOR GARDENA PODIATRISTS GROUP TO RENDER THE PROPOSED PODIATRIC EXAMINATION AND TREATMENT. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO GARDENA PODIATRISTS GROUP FOR ALL CHARGES INCURRED BY ME OR MY DEPENDENTS. FURTHERMORE, I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ANY CLAIM AND THE REQUEST OF PAYMENT OF INSURANCE BENEFITS DUE TO BE PAID TO GARDENA PODIATRISTS GROUP.

SIGNATURE: _____ DATE: _____
PATIENT / INSURED

PF-2000 Consent for Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information
Your protected health information will be used by Lawrence I. Rubin D.P.M., Lisa Chu,D.P.M. and/or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use or disclosure of your protected health information.

Gardena Podiatrists Group may or may not agree to restrict the use or disclosure of your protected health information.

If Gardena Podiatrists Group agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices
Gardena Podiatrists Group reserves the right to modify the privacy practices outlined in the notice.

Signature
I have reviewed this consent form and give my permission to Lawrence I.Rubin, D.P.M. , Lisa Chu, D.P.M. to use and disclose my health information in accordance with it.

_____
Name of Patient (Type or Print)

_____ _____
Signature of Patient Date

_____
Signature of Patient Representative
(Required if the patient is a minor or an adult
who is unable to sign this form.)

_____
Relationship of Patient Representative to Patient

Acknowledgement of Receipt of Notice of Privacy Practices

Gardena Podiatrists Group reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices for Gardena Podiatrists Group.

_____
Name of Patient (Type or Print)

_____ _____
Signature of Patient Date

_____
Signature of Patient Representative
(Required if the patient is a minor or an adult
who is unable to sign this form.)

_____
Relationship of Patient Representative to Patient

Acknowledgement of Specialty Treatment

I understand the Gardena Podiatrists Group will only treat podiatric related problems and that I will be responsible for seeking non-podiatric care from a General Practitioner and/or Specialist.

_____
Name of Patient (Type or Print)

_____ _____
Signature of Patient Date

_____
Signature of Patient Representative
(Required if the patient is a minor or an adult
who is unable to sign this form.)

_____
Relationship of Patient Representative to Patient

South Bay Podiatry Group
20911 Earl St. #290 | Torrance, CA 90503 | 310-792-5670

Consent to Leave Voicemail / Share Info with Family & Friends

By signing this "Consent to Leave Voicemail", you consent to SBPG staff/doctors leaving voicemail messages containing detailed medical information on the phone number(s) listed below. This information may include, but not limited to, demographic information (partial or full name, date of birth, address, etc.), billing information, and medical information (diagnosis, medications, test results, etc.).

☐ Home # _____ Cell # _____

☐ Work # _____

☐ Do not leave information on any phone number

The name(s) listed below are family members or friends to whom I grant permission for SBPG doctors/staff to verbally discuss my care using their best judgment and grant them permission to disclose medical information that is relevant to my care or relevant for payment. ☐ **YES** ☐ **NO**

	NAME	RELATIONSHIP	PHONE #
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

I understand that I have the right to revoke this consent at any time by sending a written request to South Bay Podiatry Group. This "Consent to Leave Voicemail" is valid until such revocation is received by SBPG. My decision to revoke this consent does not apply to any information disclosed in a voicemail prior to the date of my revocation of this consent.

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Parent/Guardian Name (if applicable): _____