MARK COSTOPOULOS, D.P.M.

Diplomate, American Board of Ambulatory Foot Surgery

608 N. Sepulveda Boulevard
Manhattan Beach, CA 90266
TEL. 310-376-3668
FAX. 310-376-8777

WELCOME TO OUR OFFICE

TODAY'S DATE: _____ AGE:_____

PATIENT NAME: _____ BIRTH DATE: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____

TELEPHONE #: (_____)_____ CELL PHONE #: (_____) _____

SOCIAL SECURITY #: _____ CA DRIVER'S LICENSE/ID #: _____

CIRCLE ONE: FEMALE / MALE **CHECK ONE: 0** SINGLE **0** MARRIED **0** WIDOWED **0** DIVORCED

PATIENT SHOE SIZE: _____ HEIGHT: _____ WEIGHT: _____

EMAIL ADDRESS: _____

EMPLOYED BY: _____ OCCUPATION: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____WORK PHONE #: _____

EMERGENCY CONTACT: _____ TEL. #: _____

PRIMARY INSURANCE NAME: _____

IDENTIFICATION #: _____ GROUP #: _____

PATIENT RELATIONSHIP TO PRIMARY CARD HOLDER: **0** SELF **0** SPOUSE **0** CHILD **0** OTHER

NAME OF PRIMARY CARD HOLDER: _____

SOCIAL SECURITY #: _____ BIRTH DATE: _____

ADDRESS (IF DIFFERENT): _____

CITY: _____ STATE: _____ ZIP:_____

TELEPHONE #: _____EMPLOYED BY: _____

OCCUPATION: _____ WORK PHONE #: _____

ADDRESS: _____

SECONDARY INSURANCE NAME: _____

RELATIONSHIP TO PRIMARY CARD HOLDER: **0** SELF **0** SPOUSE **0** CHILID **0** OTHER

NAME OF PRIMARY CARD HOLDER: _____ DOB: _____

IDENTIFICATION #_____ GROUP #: _____

Whom may we thank for referring you to this office? NAME: _____

ADDRESS: _____

_____

FAMILY DOCTOR: _____ LAST VISIT: _____

ADDRESS: _____

TELEPHONE #: _____

MEDICATIONS: _____

_____

Preferred Pharmacy(ADDRESS, TELEPHONE#)_____

Are you in General Good Health? YES _____ NO _____

Any Personal or Family History of Diabetes? NO ___ YES ___ WHOM?

_____

Diabetic Doctor: _____ Date last seen: _____

Have you had any serious Illnesses or Operations? IF YES, LIST? _____

_____

Any allergies to medications? NO ____ YES ____ LIST: _____

INDICATE WHICH OF THE FOLLOWING YOU HAVE HAD OR HAVE AT PRESENT:

Anemia: ____
Arthritis/Rheumatism: ____
Artificial Joints: ____
Asthma: ____
Epilepsy: ____
Fibromyalgia: ____
Glaucoma: ____
Gout: ____
Heart Murmur: ____
Heart Problems: ____
Hepatitis A, B, C: ____
HIV Positive: ____
High Blood Pressure: ____

Liver Disease: ____
Motion Sickness: ____
Neurological Disorder: ____
Phlebitis: ____
Psychiatric/Psychological Care: ____
Rash: ____
Rheumatic Fever: ____
Stomach Problems/Reflux/Heartburn: ____
Ulcers (Diabetic): ____
Varicose Veins: ____
Cancer: ____ Type: _____

BRIEFLY, TELL US WHY YOU CAME TO SEE THE DOCTOR TODAY:

_____

_____

MARK COSTOPOULOS, D.P.M.
Diplomate, American Board of Ambulatory Foot Surgery
608 N. Sepulveda Boulevard
Manhattan Beach, CA 90266
TEL. 310-376-3668
FAX. 310-376-8777

I certify that the information provided is correct and accurate. The office of Dr. Mark Costopoulos reserves the right to charge for appointments cancelled or broken without 24 hours advance notice. The fee for a cancelled or broken appointment without 24 hours is $55.00.

I understand that I am financially responsible to the above parties for that part of my bill not covered by my insurance company. Deductibles, coinsurance and co-payments will be due at time of visit. A good faith estimate will be given to you. After your insurance has been billed for the procedure and an Explanation of Benefits is received by you and Dr. Costopoulos, there may be a balance due or you may be due a partial refund from Dr. Costopoulos. In-network deductibles, coinsurance and co-payments cannot be written off since this is an act of fraud. Returned checks have a fee of $15.

I understand that payment is due in full within 30 days unless previous financial arrangements are made. A $5.00 or 1.5% billing fee will be added to accounts 60 days overdue, whichever amount that is higher. Accounts 91 days overdue may be transferred to an outside collection agency.

PRINT NAME: _____

SIGNATURE: _____ TODAY'S DATE: _____
PATIENT/GUARDIAN

MARK COSTOPOULOS, D.P.M.
Diplomate, American Board of Ambulatory Foot Surgery
608 N. Sepulveda Boulevard
Manhattan Beach, CA 90266

TEL. 310-376-3668
FAX. 310-376-8777

ASSIGNMENT & CONSENT TO RELEASE

I assign the right to payment for all medical benefits directly to Dr. Costopoulos in consideration for medical services and suppliers provided pursuant to my health insurance plan.

In the event my health insurance plan refuses to pay for provided, medically necessary services, I also assign all my rights to Dr. Costopoulos for a full and fair review of any and all denied claims. This assignment is in consideration for the unpaid services provided and in consideration for the continued willingness of Dr. Costopoulos to see patients, including myself, on an insurance assignment basis. I understand that if my treating doctor prevails in any such payment dispute, I may be liable for co-payment for the contested services.

I hereby give consent to release medical information to Dr. Costopoulos. I hereby give consent to Dr. Costopoulos to release medical information to other healthcare providers for the purpose of treatment, when necessary for my care. I hereby give consent to Dr. Costopoulos to send medical information, as necessary, to my insurance plan.

Print Patient Name: _____

Patient/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

MARK COSTOPOULOS, D.P.M.
Diplomate, American Board of Ambulatory Foot Surgery
608 N. Sepulveda Boulevard
Manhattan Beach, CA 90266

TEL. 310-376-3668
FAX. 310-376-8777

New HIPAA Privacy Regulations

Federal law, the Health Insurance Portability and Accountability Act of 1996, authorized the Department of Health and Human Services to adopt new rules to protect patient privacy.

Notification is therefore given that the office of Dr. Mark Costopoulos will not reveal to any person, personal information about you or about a family member (i.e. name, address, Social Security Number, as well as other health information) without permission. Your information will never be sold, or listed for the purpose of advertisement, solicitation or fund raising.

It is however understood, that within the realm of doing business and for general patient care purposes, your personal information will be necessary and used in the following context:

- Patient registration
- Procure medical records from former physicians
- Converse with colleagues for opinions/care
- Insurance: verifications, billing, paper and wire (includes fax transmissions), Insurance company follow up or interaction with billing services relating to patient care
- Pursue collection of unpaid bills
- Hospital workers, nurses, aides and medical records department
- Emergency officials, Paramedic, fire personnel, emergency room physicians, nurses, or technicians
- Personal Religious designate
- Pharmacists, drug program personnel/workers
- Completion of disability forms
- Computer and electronically stored information (i.e. related business vendor and service persons)

I authorize the release of this necessary information.

_____
Print Patient Name

_____ _____
Patient or Guardian Signature Date