Newport Family Podiatry

MICHAEL J. HATTAN, D.P.M. – SAHAR GHOLAM, D.P.M.

SPECIALIST IN SURGERY, DISEASES AND INJURIES OF THE FOOT AND ANKLE

Telephone
(949) 650-1900

Mariners Medical Plaza
355 Placentia Ave., Ste. 101
Newport Beach, CA 92663

Welcome to our office

Please print and complete the following information for your case history file

Last Name	First	Middle Initial	Birth Date
Nickname/Preferred Name	Generation	Age	Sex: Male ☐ Female ☐ Sexual Orientation:
Billing Address: (If different than Mailing Address)			Marital Status: Common law ☐ Separated ☐ Single ☐ Married ☐ Domestic Partner ☐ Widowed ☐ Divorced ☐
Mailing Address: City State Zip			

Home Phone:	Cell Phone (circle preferred #)	Work Phone	E-mail Address

Employment Status (check one) Occupation Work (Name of Company)
Full Time ☐ Part Time ☐ Not employed ☐
Retired ☐ Student ☐

Primary Language: English ☐ If Other Specify:_____ Ethnicity/Race: _____ Specify Origin:_____

Emergency Contact	Phone	Relationship

Primary Insured: (Name, Date of Birth, if different than patient) How did you find us?

Relationship to Insured (Self, Spouse/DOB or Child):	Primary Insurance Name	Subscriber/Member ID #	Group #
Relationship to Insured (Self, Spouse/DOB or Child):	Secondary Insurance Name	Subscriber/Member ID #	Group #

Are you currently under a primary physician's care? Yes ☐ No ☐	May we contact your physician with health records? Yes ☐ No ☐

Primary Physician (First & Last Name)	City	Phone
Have you had previous treatment by a podiatrist? Yes ☐ No ☐	When?	For what?

How long has this current condition existed?	Height	Weight	Shoe Size

My chief foot complaint is (attach a sheet for additional space)	Provide name of preferred Pharmacy (note Street name and City)

List **medications** do you take regularly? (attach a sheet for additional space)/

To which medication(s), food(s) or anesthetics do you have **allergies**? Please list the effects.	Do you drink? If yes, how many drinks per week?	Do you smoke? If yes, how long and how much per day?

Do you have or have you had any of the following: (*do not know=DNK)

	Yes	No	*DNK
AIDS/HIV	☐	☐	☐
Alzheimer's Disease	☐	☐	☐
Anemia	☐	☐	☐
Aneurysm	☐	☐	☐
Asthma	☐	☐	☐
Atrial Fibrillation	☐	☐	☐
Birth Trauma	☐	☐	☐
Bleeding Disorders	☐	☐	☐
Blood Disease	☐	☐	☐
Bronchitis	☐	☐	☐
Bursitis	☐	☐	☐
Cancer	☐	☐	☐
Circulation Problems	☐	☐	☐

Circle Type:	Yes	No	*DNK
Diabetes Type: 1 2	☐	☐	☐
DVT's/Embolism	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting	☐	☐	☐
Foot or Leg Cramps	☐	☐	☐
Foot or Leg Injuries	☐	☐	☐
Foot or Leg Surgery	☐	☐	☐
Gout	☐	☐	☐
Heart Disease	☐	☐	☐
Hepatitis	☐	☐	☐
High Blood Pressure	☐	☐	☐
Kidney Disease	☐	☐	☐
Liver Disease	☐	☐	☐
Lower Back Pain	☐	☐	☐

	Yes	No	*DNK
Osteoarthritis	☐	☐	☐
Peripheral Neuropathy	☐	☐	☐
Pneumonia	☐	☐	☐
Polio	☐	☐	☐
Psychiatric Disorder	☐	☐	☐
Rheumatic Fever	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐
Stomach Ulcers	☐	☐	☐
Stroke	☐	☐	☐
Substance Abuse	☐	☐	☐
Thyroid Disease	☐	☐	☐
Tuberculosis	☐	☐	☐
Varicose Veins	☐	☐	☐

List any implants or blood transfusions	Do you have a pacemaker? Yes ☐ No ☐	Do you take any blood thinning medication? Yes ☐ No ☐

List previous **surgical history** with dates

I hereby give Michael Hattan and/or Sahar Gholam permission to examine, evaluate and provide treatment.

Patient (or Guardian's) Signature (If patient is a child please print/sign Guardian's name)

Print **Sign** **Date**

NEWPORT FAMILY PODIATRY
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

A copy of the Notice of Privacy Practices for Newport Family Podiatry can be accessed online at: www.newportfamilypodiatry.com/privacy.html or in-person at our office at: 355 Placentia Ave, Suite 101, Newport Beach, CA 92663. Last update August 2024.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read or been given the opportunity to read and understand the Notices.

_____ _____

Patient Name (Please Print) Patient Signature

_____ _____

Parent or Authorized Representative (if applicable) Date

INSURANCE POLICY AND ASSIGNMENT OF BENEFITS

Dear Patient,

We understand that you have a choice in healthcare and we thank you for choosing us to serve you and your family's foot care needs. We are committed to providing you with the best possible care and we are pleased to discuss professional fees with you at anytime. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your responsibility. You may ask for an estimate of your charges before a procedure is performed. Please note that all procedures have additional costs and are not included in an office visit fee.

INSURANCE (Please check with your carrier before your visit to confirm coverage). Please note it is your responsibility to know your insurance plan and to verify coverage. There are numerous insurance companies, even more individual health plans and variable benefits. Our office does not know your individual health plan and is not authorized to make any guarantees regarding individual insurance coverage.

PPO INSURANCE Dr. Michael J. Hattan has Preferred Provider Organization (PPO) contracts with several insurance companies including: Aetna, Anthem, Blue Cross Blue Shield, Blue Shield, Cigna, Oscar, United Healthcare, Health Net and Medicare Advantage programs through above listed insurances to name a few. (Please check with your carrier prior to your visit to confirm coverage.) Dr. Sahar Gholam is currently working on getting credentialed on the same plans (please check for active coverage prior to your appointment).

NOT IN NETWORK

ANY HMO PLAN, HOAG Affiliated Physicians, Greater Newport Physicians. If your Anthem insurance falls under Podiatry Plan of California or Teachers Association PPO or EPO Plans or Health Net-IFP Enhanced Care Health Net you will not be covered. Medi-Cal, CalOptima, ARTA nor Medicaid.

CO-PAYS Your insurance plans legally and contractually obligate all health care providers to collect the set co-pay at each visit. (Please be prepared to pay your co-pay due at the end of each office visit).

DEDUCTIBLES & CO-INSURANCE We will bill your insurance carrier but you will receive a statement from us regarding any deductibles or co-insurance that your insurance company has deemed your responsibility as designated on your explanation of benefits. (Unless these fees are known based on prior visits, fees will be collected at the end of office visit.)

X-RAYS, LAB TEST/PATHOLOGY CHARGES If your visit includes x-rays, biopsies, lab tests, or cultures, you understand that you will receive separate billing from the company performing these outside services for you. All biopsies and some surgeries result in a specimen being sent to pathology for examination, and therefore, additional charges. If any pathology specimen requires a second opinion, the consulting lab will bill your insurance separately.

HMO INSURANCE (MONARCH/Greater Newport Physicians (GNP)) Dr. Hattan is not contracted with HMO plans. If you should decide to be seen outside of your plan, your visit will be considered self-pay and full payment for all services is due at the time of your visit.

UNPAID ACCOUNTS I understand that my insurance we will be billed as a courtesy and if they have not responded to the claim within 90 days, it will be my responsibility to pay the doctor and follow-up on my own with my insurance company. **ALL BILLS ARE TO BE PAID IN FULL IN 120 DAYS (4 MONTHS).** We will take further action on unpaid accounts in bad standing. Returned bad checks require a $35 fee.

SPECIAL NOTE (ALL PATIENTS) I understand that insurance coverage is a special contract between me and my insurance company. I understand that Newport Family Podiatry/**Michael J. Hattan, DPM/Sahar Gholam, DPM**, is not a party to this contract and has no authority to become involved in insurance carrier disputes other than to supply factual information as necessary. I understand that if my insurance is not effective, if my insurance refuses coverage for what they deem "not medically necessary" or if my insurance demands a refund on a previously paid claim, I will need to pay for all medical services performed. I

understand that I am always responsible for medical services which I choose to receive, and the timely payment of my account. I have read and understand the above information.

I authorize payment of medical benefits directly to Newport Family Podiatry/Michael J. Hattan, DPM/Sahar Gholam, DPM for services rendered. I also authorize Dr. Michael J. Hattan and Dr. Sahar Gholam to furnish my insurance company with my medical records describing his treatment. I understand that I will be informed of items not covered by my insurance at the time service is given and such items will be paid for on the day they were dispensed.

Patient Name (Print)	Patient Signature
Parent or Authorized Representative (if applicable)	Date

MEDICARE PATIENTS ONLY

We are participating providers of Medicare and Railroad Medicare and we will accept assignment on all claims. Patients are responsible for meeting their annual deductible (which increased every year) and paying for the 20% co-payment. We do file with secondary/supplemental carriers, however, in the event that the secondary does not pay, patients will be responsible for the balance. **Dr. Michael J. Hattan and Dr. Sahar Gholam are not contracted with HMO Plans nor CalOptima/Medi-Cal**.

This office is required to keep your signature on file authorizing us to file claims on your behalf to Medicare and to release information to that payer if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature as it appears on Medicare Card:

Print	**Sign**	**Date**