Welcome to Parkview Podiatry at Northern California Medical Associates

The office of Alanna Wargula, DPM and Adelina Stateva, DPM
175 Park Street, Lakeport, CA 95453 707-263-9595 Fax: 263-5576
3536 Mendocino Ave Suite 300, Santa Rosa, CA 95403 707-575-6033 Fax: 568-5942

Thank your for choosing our office for your foot and ankle care. We strive to provide you with efficient and courteous attention at each of your visits. We respect your time and make every effort to see you at your appointed time. It is our hope that the following information will answer any questions that you may have about our office, if you have any questions, please feel free to ask.

Our Lakeport office is located at 175 Park Street in Lakeport, between 1st and 2nd Streets across from Library Park on beautiful Clear Lake and in Santa Rosa on Mendocino Avenue.

Dr. Wargula (pronounced Wahrgooluh) is a "local" girl having grown up in Lakeport, graduating with honors from Clear Lake High. She attended Podiatry school in Miami, Florida and completed a 3 year residency program in Foot and Ankle surgery in Orange County, California after which she began her practice in 2008 with her friend and mentor Dr. James Hagan. Board Certified in Wound Care in 2015. She has been involved in many research studies and has published in orthopedic, podiatric, and wound journals. She is involved in multiple community projects including Habitat for Humanity, Russian River Cleanup, and Rebuilding Together. She resides in Santa Rosa with her husband and daughter, most of her family continues to reside here in Lake County.

Dr. Stateva was born and raised in Bulgaria. She moved to the United States when she was 15 years old. Upon graduation from high school in Brooklyn, NY, she graduated with a Bachelor of Arts in Biochemistry at Connecticut College. She graduated from temple University School of Podiatric Medicine in 2002 and began residency at Palo Alto VA where she also taught at Stanford University and continued residency at Hahnemann University Hospital in Philadelphia. Returning to California in 2005 where she began her practice in Santa Rosa. She lives with her husband who is a professional chef in Santa Rosa and enjoys traveling and the outdoors. She and her husband also go on mission trips where they enjoy working with young children from all walks of life.

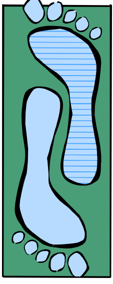
Office Hours: We have 2 offices to serve you. Hours are by appointment. Appointments are available Monday thru Thursday in Lakeport (closed Wednesday) and in Santa Rosa on Friday. Dr. Hagan continues to see patients in the Lakeport office on some Fridays. Urgent appointments are available at both locations. We do not have an answering service. Voicemail is provided for your convenience, you may leave a message for a return call. If you have an after hours emergency, please call 911 or go to the nearest emergency room.

Cancellations: If you are unable to keep an appointment, kindly notify our office at least 24 hours in advance. There is a $25 charge for no shows and short notice cancellations.

Co-pays, Deductibles, and Billing: All co-pays and deductibles are due at the time of service. We also accept major credit cards. All billing is performed by Northern California Medical Associates.

Office Procedures: Our office utilizes government certified electronic medical record software. Most of our charting is done in the exam room. The appointment time you are given allows for 15 minutes of charting before you see the doctor.

We look forward to getting to know you and helping you improve and maintain your health



Alanna L. Wargula, DPM and Adelina Stateva, DPM

Please have your insurance cards and photo id available and complete these forms in their entirety.

Patient Information

Patient Name: ______________________ Gender: [] Male [] Female SS:_____/_____/_____

Date of Birth: _____/_____/_____ Address: ______________________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Where do you prefer to receive calls?: Work [ ] Home [ ] Cell [ ] Drivers License #: ______________

Email Address: ______________________

Primary Care Physician: ______________________ Date Last Seen: _____/_____/_____

Language: __________ Race: [] Amer.Indian [] Asian [] Black/Afr-Am [] White Ethnicity: [] Hispanic/Latino [] Other

Referred By: ______________________ Marital Status: [] Single [] Married [] Divorced [] Other

Name of Spouse:______________________ Spouse's Employer ______________________

Employer: ______________________ Occupation: ______________________

Pharmacy: ______________________

Minors Only

Mother's Full Name: ______________________Phone: ______________

Father's Full Name: ______________________Phone: ______________

Contact Information

In case of emergency who should we contact?

Name: ______________________Relationship:______________________

Work #:______________Home #: ______________Cell #: ______________

Address: ______________________

Guarantor information

Who is responsible for this account?

Name:______________________Relationship:______________________

DOB:______________ SSN:______________DL#:______________

Address:______________________

Employer:______________________

Work#:______________Home#:______________Cell#:______________

Insurance Information

Please provide a copy of your card(s)

Primary Insurance: ______________________ Insured's Name: ______________________

ID# or SS#: ______________________ Group#: __________

Secondary Insurance: ______________________ Insured's Name: ______________________

ID# or SS#: ______________________ Group#: __________

Signature: ______________________ Date: ______________

Patient Medical History

Patient Name: ______________________________ Height:_______ Weight:_______

Allergies: ____

Medications (Please print names from your medicine bottles or attach list):

____

____

Do you have or have you ever been treated for any of the following?

[ ] Anxiety
[ ] Arthritis
[ ] Asthma
[ ] Back Pain
[ ] Blood Clots
[ ] Cancer ___________
[ ] Circulation problems
[ ] COPD
[ ] Depression
[ ] Diabetes—last glucose ____________
[ ] Fibromyalgia
[ ] GERD
[ ] Gout
[ ] Headache

[ ] Heart Disease or Attack
[ ] Hepatitis Type ___
[ ] High Blood Pressure
[ ] High Cholesterol
[ ] HIV/AIDS
[ ] Kidney Disease
[ ] Liver Disease
[ ] Multiple Sclerosis
[ ] Neck Pain
[ ] Neuropathy
[ ] Osteoporosis
[ ] Pacemaker
[ ] Pain Syndrome

[ ] Parkinson's disease
[ ] Psoriasis
[ ] Psychiatric Disorder _______________
[ ] Raynaud's
[ ] Rheumatoid Arthritis
[ ] Seizures
[ ] Sleep Apnea
[ ] Stomach Ulcer
[ ] Stroke
[ ] Thyroid (Hyper/Hypo)
[ ] Atrial Fib
[ ] Other: ____

____

____

Surgical History

Please list all major surgeries.

____

____

Family History

Do/Did either of your parents have any of the following? Please indicate Mother (M) or Father (F).

[ ] Diabetes ()M ()F
[ ] Cancer __________________ ()M ()F
[ ] Coronary Artery Disease ()M ()F
[ ] Heart Disease ()M ()F
[ ] High Blood Pressure ()M ()F
[ ] Stroke ()M ()F
[ ] Thyroid Disease ()M ()F
[ ] Rheumatoid Arthritis ()M ()F
[ ] Blood Clots ()M ()F
[ ] Other: ________________________________ ()M ()F

Social History

Tobacco Use: [ ] No; Quit Date: ________ [ ] Yes; Type: ___________________ Duration/Amount: _________________

Alcohol Use: [ ] No [ ] Yes; Amount: __________________ Frequency: ______________________________

Recreational Drug Use: [ ] No [ ] Yes Type and Frequency: ______________________________

Patient/Guardian Signature: ____ Date: _________________________

Review of Systems Tell us how you have been feeling lately. Name: ___________________________

General Overall: [ ] Fever [ ] Chills [ ] Headache [ ] None

Other: ____

Eyes: [ ] Blurred vision [ ] light sensitivity [ ] watery eyes [ ] foreign body [ ] None

Other: ____

Ear/Nose/Mouth/Throat: [ ] Congestion [ ] Drainage [ ] Difficulty swallowing [ ] Ringing in ears [ ] Pain [ ] Bleeding [ ] None Other: ____

Skin: [ ] Rash [ ] Itchy Skin [ ] Thick, discolored nails [ ] Dry skin [ ] Wound [ ] Callus [ ] None

Other: ____

Allergic/Immune System: [ ] Seasonal Allergies [ ] Red painful joints [ ] None

Other: ____

Musculoskeletal: [ ] Back Pain [ ] Muscle Pain [ ] Joint Pain [ ] Joint Swelling [ ] None

Other: ____

Neurological: [ ] Tremors [ ] Numbness [ ] Tingling [ ] Dizziness/Fainting [ ] None

Other: ____

Urinary: [ ] Frequent Urination [ ] Diarrhea [ ] None

Gastrointestinal: [ ] Heartburn [ ] Acid reflux [ ] Nausea/Vomiting [ ] None

Other: ____

Endocrine: [ ] Excessive thirst [ ] Hot/Cold Intolerance [ ] Hot Flashes [ ] Fatigue/sluggish [ ] None

Other: ____

Respiratory: [ ] Wheezing [ ] Frequent cough [ ] Shortness of breath [ ] Snoring [ ] None

Other: ____

Cardiovascular: [ ] Chest pain [ ] Palpitations [ ] Leg/ankle swelling [ ] shortness of breath [ ] None

Other: ____

Hematologic System: [ ] Bloating [ ] Swelling [ ] Easy Bruising [ ] Easy Bleeding [ ] Difficulty to stop bleeding [ ] None

Other: ____

Psychiatric: [ ] Depression [ ] Mood Swings [ ] Anxiety [ ] Nervousness [ ] Eating disorder [ ] None

Other: ____

Initials: ___________

History of Current Foot/Ankle Problem Name: ______________________

What is your complaint? ____

____

Where is your pain/problem located? [ ] Toe [ ] Heel [ ] Ankle [ ] Ball of foot [ ] Arch [ ] Left [ ] Right [ ] Both [ ]

Other: ____

How long have you had this complaint/condition? ____

____

Did the problem result from a specific injury? [ ] No [ ] Yes Please describe: _______________________

____

Please rate your pain on a scale of 1-10 (10 being the most painful):

At rest: 1 2 3 4 5 6 7 8 9 10 At its worst: 1 2 3 4 5 6 7 8 9 10

Is the pain: [ ] Constant [ ] Occasional [ ] Sharp [ ] Dull [ ] Aching [ ] Stabbing [ ] Throbbing [ ] Radiating/Traveling

Other: ____

What symptoms are you experiencing?

[ ] Locking [ ] Numbness [ ] Giving Away [ ] Popping [ ] Tingling [ ] Burning [ ] Grinding [ ] Swelling [ ] Bruising

Other: ____

Does anything make your symptoms feel better? ____

Does anything make your symptoms feel worse? ____

Have you seen another physician for this problem? __________ Doctor's Name: ______________________

What treatments have you tried? [ ] Nothing [ ] Physical therapy [ ] injections [ ] Bracing [ ] Icing [ ] Compression

[ ] Medications [ ] Shoe change [ ] Arch support [ ] Massage [ ] Other______________________

Have you had any of the following tests/studies for this condition/complaint? [ ] Xrays [ ] Blood test [ ] MRI [ ] CT scan

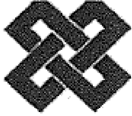
If so, where were the tests performed? ____

Signature: _______________________________________ Date: ___________

Thank you for completing these forms. We appreciate your efforts in filling them out completely. Please sign the HIPAA form and ePrescribing consent as these are a federal requirement to protect all disclosure of your health information. If you would like a copy of the "Notice of Privacy Practices" please let us know, there is a copy in our lobby for you to review.

Name:
Chart:
Date:

Northern California Medical Associates
ePrescribing Consent



NORTHERN
CALIFORNIA
MEDICAL
ASSOCIATES

Northern California Medical Associates, Inc. utilizes ePrescribing in each of our offices.

ePrescribing is a federally mandated initiative by the Center for Medicare and Medicaid Services (CMS) that requires all physicians prescribe in this manner by 2011.

ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information. ePrescribing software allows your physician to see important information, like drug interactions and your prescription history.

By signing the consent below, you will benefit from a safer, faster and easier way to get your prescriptions filled.

I agree that Northern California Medical Associates may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

Patient's Signature ______________________________ Date ______________
Signature of Patient or Responsible Party

Patient's Name (Please Print) ______________________________
First Name Last Name

Expiration Date: 5 Years) Unless otherwise indicated

Name:
Chart:
Date:

Northern California Medical Associates Financial Policy

The physicians and staff of Northern California Medical Associates (NCMA) are committed to providing you with the best possible health care. The following is a statement of the NCMA Financial Policy.

- **Patients must complete all Information Forms prior to seeing the physician. A copy of your insurance card(s) and your ID will be made for your chart**
- **By law, we must collect your insurance copayment at the time of service. Be prepared to pay your copay at each visit**
- **For uninsured patients, payment is expected at the time of service, unless other financial arrangements have been made prior to your visit**

Health Coverage and Insurance

As a courtesy, we submit insurance claims for insured patients. To insure accurate claims processing, please provide your complete health plan or insurance information (and an original claim form if required). Your health plan, insurance company or Medicare may not cover some or all of the services provided. If there is any reason to believe that a service may not be covered or (for HMO Patients) a service has not been authorized, we will ask that you sign a waiver, outlining the medical benefits and costs of choosing to have or decline the services.

Payment on Balances Due:

Timely payment of your balance is required. Your balance is due upon receipt of your statement. We may require personal financial information in order to make a determination regarding a payment arrangement (up to 90 days). Self-pay accounts are due at the time of service, unless other financial arrangements are made. If payment is not made at the time of service, and financial arrangements are not made, your account will be considered past due once you leave the office.

If payment is not received, your account will be reviewed for possible outside collection follow up. An administrative fee of $15.00 will be applied to each account referred for collections.

If your payment by check is returned, be advised your account will be assessed a $25.00 returned check fee. The balance due from returned checks are payable by cash, credit card, money order or cashiers check.

Narrative Reports and Forms:

Reports and forms completed by physicians are subject to a fee (verify with the office staff the fee charged for each report/form). Payment is expected at the time you drop your form off to be completed.

Cancellations/Missed Appointments:

If you are unable to keep your appointment, please give our office at least 24 hours notice. Failure to do so may result in a missed appointment/procedure charge (fee is determined on the length of the appointment time scheduled). Insurance does not cover this expense and you are responsible for payment of this fee. Frequent missed appointments and cancellations interrupt the process of your treatment and may result in discharge from our office.

Patient Relations:

The physicians and staff of NCMA are committed to providing you with the best possible health care. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions regarding our fees or your financial responsibility.

Good doctor/patient relations are based on understanding and open communication. Our staff will make every possible effort to clarify any questions or concerns you may have regarding your account balance. If you have any questions concerning your bill, contact the Billing Department at 707-573-6150 or 1-800-773-6150 immediately.

Assignment of Benefits:

I hereby give authorization for payment of Medicare/Health Plan benefits to be made directly to Northern California Medical Associates for services rendered. I understand that I am responsible for all charges not covered by insurance including but not limited to: all claims denied, unpaid due to deductibles, co-insurance partially paid due to arbitrary determination of usual and customary, non-covered supplies, and all other charges denied from a completed review for medical necessity.

I authorize NCMA to release all information necessary to secure benefit payments. I agree that a photocopy of this agreement shall be valid as the original.

X ______________________________ ____________________

Signature of Patient or Responsible Party — Date

Patient's Name (Please print): ______________________________

Revised 10-27-06

Name:
Chart:
Date:

NORTHERN CALIFORNIA MEDICAL ASSOCIATES, INC.
PATIENT RECORD OF DISCLOSURES AND
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided with the right to request confidential communication or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Home Telephone: ______________________

- ☐ O.K. to leave message with detailed information with spouse, family member, domestic partner, caregiver, or on answering machine
- ☐ Leave message with call back number only

Work Telephone: ______________________

- ☐ O.K to leave message with detailed information
- ☐ Leave message with call back number only

Written Communication:

- ☐ Mail to my home address
- ☐ Mail to my work/office address: ______________________
- ☐ O.K. to fax to this number: ______________________

Please note, it is the patient's responsibility to inform our office of any change of information.

My signature below also acknowledges that I have received the Notice of Privacy Practices for Northern California Medical Associates, Inc.

______________________ Signature of Patient/Parent/Legal Guardian/Personal Representative (Please Circle)

______________________ Print Patient's Name

______________________ Print Your Name

______________________ Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosure made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosure. (Note: Uses and disclosures for treatment, payment or operations (TPO) are permitted without consent.)

Record of Disclosures of Protected Health Information

Date	Disclosed to whom (address or fax)	Authorized in writing	Description of disclosure	Disclosed by whom	Reason	How disclosed*

*Fax, Telephone, E-Mail, Mail or Other