Welcome to Parkview Podiatry

The office of Alanna Wargula, DPM and Adelina Stateva, DPM
175 Park Street, Lakeport, CA 95453 707-263-9595 Fax: 263-5576
1255 N. Dutton Ave, Santa Rosa, CA 95401 707-596-2660 Fax: 263-5576

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 Dutton 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 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 in Cloverdale 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.

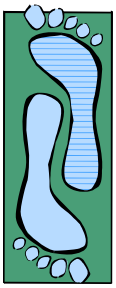
Office Hours: We have 2 offices to serve you. Hours are by appointment. Appointments are available Monday thru Thursday in Lakeport (closed Wednesday) and in Santa Rosa on Friday. Voicemail is provided for your convenience, you may leave a message for a return call. If you have an after hours emergency, 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.

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.

Parkview Podiatry Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.
- There is a $25 fee for cancelations without 24 hour notice and missed appointments, your insurance does not cover this fee.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party _____ Date: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT,
CONSENT TO PHOTOGRAPH, VIDEO AND/OR OBTAIN DIGITAL IMAGES,
And CONSENT TO SEND PRESCRIPTIONS ELECTRONICALLY

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been given an opportunity to read the Notice of Privacy Practices, which is kept in the patient lobby and contains a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that Parkview Podiatry will retain ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in the policy of Dr. Wargula and Stateva. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I give permission to Parkview Podiatry to contact me by phone and it is ok to leave detailed message related to my medical condition.

I authorize Parkview Podiatry to discuss my medical history with the following people:

[ ] spouse
[ ] children: _____
[ ] other: _____

I agree that Parkview Podiatry may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes and consent to the use of electronic prescribing as federally mandated.

_____

Responsible Party's Signature Date