

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

Thank you 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.

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, daughter, cat, and dog. 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. Board Certified in Podiatric Medicine by the ABPM. She and her husband along with their daughter and dogs live in Cloverdale.

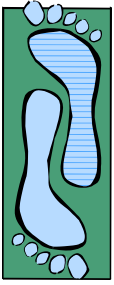
Office Hours: Hours are by appointment. Appointments are available Monday thru Thursday. Urgent appointments are available. We do not have an answering service. Voicemail is provided for your convenience; you may leave a message for a return call. If you have an after-hours emergency, please call 911 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.

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. **Please limit your initial visit to one primary complaint to receive the most efficient and comprehensive care.**

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 available and complete these forms in their entirety.

Patient Information

Patient Name: _____ Preferred Name: _____

Gender: Male Female SS: ____/____/____ Date of Birth: ____/____/____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

How would you like to receive appointment reminders? phone text email

Where do you prefer to receive calls?: Work Home Cell Driver's License #: _____

Email Address: _____

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

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

Marital Status: Single Married Divorced Other

Name of Spouse: _____ Spouse's Employer _____

Your Employer: _____ Your Occupation: _____

Pharmacy: _____

Contact Information

In case of emergency who should we contact?

Name: _____ Relationship: _____

Work #: _____ Home #: _____ Cell #: _____

Address: _____

Guarantor information

Who is responsible for this account? Same as patient

Name: _____ Relationship: _____

DOB: _____ SSN: _____ DL #: _____

Address: _____

Employer: _____

Work #: _____ Home #: _____ Cell #: _____

Insurance Information

Please present your insurance cards to the front desk.

Signature: _____ Date: _____

Medication Allergies: _____

Medications: (Please print names, mg, and directions from your medicine bottles or attach list):

Family History

Do/Did either of your parents and/or immediate family have any of the following?

- | | | | |
|--|---|-----------------------------------|--|
| <input type="checkbox"/> Blood Clot | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Other: _____ | | | |

Patient Medical History

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

- | | | |
|--|--|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Post-traumatic Stress disorder |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Psoriasis NOS |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> GERD | <input type="checkbox"/> Raynaud's Disease |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Gout | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Back Problem | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Bipolar disorder | <input type="checkbox"/> Headache | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Blood Clot | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Cardiac pacemaker | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Cholesterol High | <input type="checkbox"/> MS-Multiple Sclerosis | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Chronic liver disease NOS | <input type="checkbox"/> Neuropathy | |
| <input type="checkbox"/> Chronic neck pain | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Parkinson's disease | |

Social History

Do you smoke? No; Quit Date: _____ Yes; Cigarette Cigar Pipe How many years?/Amount: _____

Do you drink alcohol? No Yes If yes, what type? Beer Wine Hard Liquor

Frequency: Socially Occasionally Light Heavy 3+ drinks/day

Do you use "recreational" drugs?: No Yes Type and Frequency: _____

Surgical History

Please list all major surgeries.

Patient/Guardian Signature: _____ **Date:** _____

Patient Name Printed: _____ **Height:** _____ **Weight:** _____

Tell us how you have been feeling lately. Have you had any problems in the following areas?

Check "none" if the answer is no.

Patient Name: _____

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Patient Initials: _____

Please Tell Us About Your 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.

**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

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 \$35.00 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: _____