



Personal message from Dr. Cachia, President and Founder of Aloha Foot and Ankle Associates

It is our goal and mission that you receive the best care possible, and that your care is personalized to meet your specific needs. We treat all problems of the foot and ankle, from simple toenail problems to major reconstructive surgery, treatment of fractures, broken bones and acute tendon ruptures. We specialize in bunion surgery, flat-foot surgery, sports injuries, performance enhancement, ankle fractures, wound management and limb preservation. We utilize the most appropriate technology and equipment, and practice in state-of-the-art facilities. We do our best to assure that every patient is given the personalized care that they deserve.

It is our hope that we will meet your expectations and that you will be eager to refer your friends and family. We want you to feel like family, and leave with your foot and ankle conditions resolved. Thank you for placing your trust in us. We look forward to serving the needs of you, your friends, and family.

Sincerely,

Victor V Cachia, DPM, FACFAS
Founder and Director

Prior to your appointment

- Please complete the attached New Patient paperwork. Be sure to read the Financial Policy and Notice of Privacy Practices prior to completing the acknowledgement. Please gather any pertinent medical records, imaging studies, x-rays, and lab work and bring them with you.
- You will receive a phone call and an e-mail before your appointment reminding you of your appointment time.
- If for any reason, you are unable to keep your confirmed appointment, please call our office to re-schedule your visit to suit your needs.

Please call (949) 364-2525 to schedule your appointment. Our telephone hours are 8:00am – 5:00pm M-F. We will be happy to assist you in any way possible.

The day of your appointment

- There are additional steps to the registration process that must be completed at the office on your first visit, so please be sure to arrive 15-minutes early with your completed paperwork so that you can make your appointment time. Please gather any pertinent medical records, imaging studies, x-rays, and lab work and bring them with you.
- Bring your insurance card(s) or a legible copy. If for any reason you do not have a copy of your insurance card, please contact your insurance carrier prior to your arrival and have proof of eligibility faxed to (949) 364-3322, or e-mail to ohana@alohafootandankle.com
- Means for satisfying the co-payment required by your insurance company or un-met deductible.



Financial Policy

We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and agree to prior to any treatment.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS.

Insurance Billing

We will bill your insurance company as a courtesy. Your insurance policy is a contract between you and your insurance company. It is your responsibility to know your benefits and how they will apply to your treatment by the doctor. We are not a party to that contract. If your insurance company has not paid your account in full within 30 days, the balance will be transferred to you and/or the guarantor listed on the Patient Information form.

HMO Plans (With which we are contracted)

All co-pays must be satisfied at every visit. Due to contractual and uniform compliance issues with your insurance company, there are no exceptions to the policy of collecting co-pays at every visit. You are responsible for obtaining authorization and approval for treatment with your Medical Group or Primary Care Physician (PCP) prior to initial treatment.

PPO Plans (With which we are contracted)

We have negotiated rates with your insurance company. Your co-insurance and un-met deductible is your responsibility and payment is due at time of treatment. In the event your insurance coverage changes to a plan where we are not a participating provider, you will be responsible for any out of network deductible or coinsurance amounts.

Medicare We accept assignment with Medicare. Medicare pays 80% of the allowed amount after satisfaction of the annual deductible. We will bill your secondary insurance for the remaining 20% of the Medicare allowed payment as a courtesy; however, you are responsible for any remaining balance regardless of payment from a secondary insurance.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Cash patients

All services must be paid in full at time of treatment. Our office can provide you with an estimate of the cost of treatment prior to your visit with the Physician.



WWW.ALOHAFOOTANDANKLE.COM



Returned checks

A \$25.00 fee will be charged for any returned checks.

Durable Medical Equipment

Aloha Foot and Ankle Associates, Inc., provides Durable Medical Equipment (DME) as ordered by your physician. Your insurance will be billed in accordance to your insurance coverage guidelines; however, you will be responsible to pay for unpaid balances and coinsurance rates. Some DME products are not covered by insurance, in which case, you will be notified of the item and its cost. For better understanding of you DME coverage, contact your Insurance Provider. DME is intended for single patient use only. As that is the case, DME is not subject to returns.

Medical Records

All Medical Record requests are subject to a clinical preparation fee of \$15.00. The actual cost of shipping and handling will be added if applicable. Copying of digital images are subject to an additional fee of \$10.00.

Notice of Privacy Practices

We understand that medical information about you and your health is personal. As the custodians of the information in your medical record, we are committed to protecting the privacy of your information as required by law, professional accreditation standards and our internal policies and procedures.

The Notice of Privacy Practices explains your rights, our legal duties and our privacy practices. It also describes how medical information about you may be used and disclosed and how you can get access to this information. The policy in its entirety can be requested from the receptionist or found on our web-site. Please review it carefully. For your convenience the following is a summary of the information discussed in the notice.

- Our Pledge
- Your Personal Information
- Our Privacy Practices
- How We May Use or Share Your Information for:
 - Treatment
 - Payment
 - Health Care Operations
 - Notifications and Special Circumstance and the Law
 - Research and Marketing
- Your Written Permission
- Other Restrictions
- Your Rights
- Changes
- Questions or Complaints

Your agreement only acknowledges that we have made available for your review a paper copy of our Notice of Privacy Practices and have retained a copy of this acknowledgement as required by law.



Patient Acknowledgement of Policies

Thank you for choosing Aloha Foot and Ankle Associates, Inc. as your health care provider. We ask that you carefully read the attached copies of our policies prior to agreeing to them. If you have any questions about these policies, an employee will be happy to help explain them to you.

Financial Policy (attached)

I have read the Financial Policy. I understand and agree to this Financial Policy.

Signature of Patient or Responsible Party

Printed Name

Date

Notice of Privacy Practices (attached)

I hereby acknowledge the receipt of the Notice of Privacy Practices. A personal copy of the Privacy Practices will be available per my request.

Signature of Patient or Responsible Party

Printed Name

Date

I authorize the release of my patient health information to the following personal contacts (Spouse, Child, Assistant, etc). I understand it is my responsibility to notify Aloha Foot and Ankle Associates, Inc., of any changes in the information below.

- Appointment Information
- Treatment Information
- Billing Information

Name Relationship

- Appointment Information
- Treatment Information
- Billing Information

Name Relationship



DME: Acknowledgment of Driving Impairment

While you are under the care of your Physician, you may be fitted into Durable Medical Equipment, or DME (Cam Walking Boots). While the DME is to be utilized to protect or support your condition, by wearing the DME, it might impair your ability to operate automotive vehicles, machinery, or heavy equipment. You might not be able to operate a vehicle safely due to the use of your DME, so please arrange for proper transportation and use the proper precautions. If you have any questions regarding this matter, please contact Aloha Foot and Ankle Associates, Inc., or your physician.

Signature of Patient or Responsible Party

Printed Name

Date

Medication Acknowledgement of Driving Impairment

While you are under the care of your Physician, you may be prescribed medication that could impair your ability to operate a motor vehicle, heavy machinery or equipment.

Please refrain from operating a motor vehicle under the influence of prescribed medications that impair judgment. Arrange for proper transportation and use the proper precautions when taking prescribed medications. If you have any questions, please ask your Physician or your pharmacist.

Signature of Patient or Responsible Party

Printed Name

Date

Diagnostic Testing Results

While under the care of a Physician/Provider with Aloha Foot and Ankle Associates, Inc. you may be sent to have diagnostic testing performed (MRI, CT scan, bone scan, lab work, etc.). It is the patient's responsibility to return to the office to receive the results of any diagnostic testing. Most testing is completed at an outside facility. It is the patient's responsibility to obtain the results of all tests in addition to ensuring all outside results are sent to the Physician's office prior to the follow up appointment. Reports may be faxed to (949) 364-3322

Signature of Patient or Responsible Party

Printed Name

Date