FALLBROOK PODIATRY INC.
407 Potter Street, Suite A • Fallbrook, CA 92028 • (760) 728-4800 • softtoesmile@gmail.com • fallbrookfootdoctor.com

PATIENT INTAKE FORM

Please complete all sections as accurately as possible.

PATIENT: _____ _____ _____
FIRST NAME M.I. LAST NAME

DEMOGRAPHICS

HEIGHT: _____ ____ ft ____ in **WEIGHT:** _____ ___ lbs **SHOE SIZE:** _____ **GENDER:** ☐ M ☐ F ☐ OTHER: _____

OCCUPATION: _____ **FORMER OCCUPATION:** _____

DATE OF BIRTH: _____ **AGE:** _____ **SOCIAL SECURITY #:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME PHONE: _____ **WORK:** _____ **CELL:** _____

EMERGENCY CONTACT: _____ **PHONE:** _____

EMAIL: _____

HEALTHCARE PROVIDERS

PRIMARY CARE PHYSICIAN: _____ **PHONE:** _____

CARDIOLOGIST: _____ **ENDOCRINOLOGIST:** _____

NEPHROLOGIST: _____ **RHEUMATOLOGIST:** _____

INSURANCE INFORMATION

Please skip this section if we already have a copy of your insurance card.

PRIMARY INSURANCE

INSURANCE COMPANY: _____

POLICY HOLDER NAME: _____ **DOB:** _____

MEMBER ID / SSN: _____

SECONDARY INSURANCE

INSURANCE COMPANY: _____

POLICY HOLDER NAME: _____ **DOB:** _____

MEMBER ID / SSN: _____

HOW DID YOU FIND US?

☐ FRIEND/RELATIVE ☐ GOOGLE ☐ YELP ☐ CHATGPT/AI
☐ FRIENDS OF FALLBROOK ☐ YELLOW PAGES ☐ OTHER:____

ARE YOU PREGNANT? ☐ YES ☐ NO _____

If yes, how many months? _____

(Congratulations!)

PATIENT: _____ _____ _____
FIRST NAME M.I. LAST NAME

HISTORY OF PRESENT FOOT / ANKLE PROBLEM

Check all that apply:

- ☐ INGROWN NAILS
- ☐ NAIL FUNGUS
- ☐ WARTS
- ☐ GOUT
- ☐ HEEL PAIN
- ☐ JOINT PAIN/STIFFNESS
- ☐ LEG/ANKLE SWELLING
- ☐ ATHLETE'S FOOT
- ☐ BUNIONS
- ☐ HAMMERTOES
- ☐ FLAT FEET
- ☐ YOU THINK YOUR FEET ARE UGLY

TRAUMA/OTHER: _____

_____

WHICH SIDE: ☐ RIGHT ☐ LEFT ☐ BOTH

WHICH TOE: _____

HOW LONG HAS THE PROBLEM BEEN PRESENT? _____

☐ DAYS ☐ WEEKS ☐ MONTHS ☐ YEARS

HAVE YOU HAD ANY TREATMENT OR TAKEN ANYTHING FOR IT?

_____

_____

HAVE YOU SEEN SOMEONE FOR THIS ALREADY? ☐ NO ☐ YES, WHOM: _____

ALLERGIES

FOOD ALLERGIES: _____ **TAPE ALLERGIES:** _____

☐ ASPIRIN	☐ LIDOCAINE	☐ NOVOCAIN	☐ PENICILLIN	☐ CIPRO	☐ IODINE
☐ CODEINE	☐ VICODIN	☐ SULFA DRUGS	☐ SHELLFISH	☐ SHRIMP	☐ CITRUS
☐ HAY FEVER	☐ TAPE	☐ ADHESIVE	☐ LATEX	☐ LONG INTAKE FORMS	☐ OTHER:____

OTHER REACTIONS / SENSITIVITIES: _____

CURRENT MEDICATIONS

List all current medications and dosages (or hand your medication list to the front office):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____

PREFERRED PHARMACY: _____ **PHONE:** _____

PATIENT: _____ _____ _____

FIRST NAME M.I. LAST NAME

MEDICAL HISTORY

Check all conditions that apply to you now or have applied in the past:

- ☐ ANEMIA/BLOOD DISORDERS
- ☐ ARTHRITIS
- ☐ ASTHMA/HAY FEVER/SOB
- ☐ BLOOD CLOTS
- ☐ CHEST PAIN ON EXERTION
- ☐ CEREBRAL PALSY/POLIO
- ☐ DIABETES TYPE I
- ☐ DIABETES TYPE II
- ☐ DIALYSIS
- ☐ DRUG/ALCOHOL ABUSE
- ☐ EAR/NOSE/THROAT DISORDER
- ☐ EMOTIONAL PROBLEMS
- ☐ SKIN PROBLEMS
- ☐ EMPHYSEMA
- ☐ EPILEPSY/SEIZURES
- ☐ EYE PROBLEMS
- ☐ GOUT
- ☐ HEADACHES/MIGRAINES
- ☐ HIV
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ KIDNEY DISEASE
- ☐ LIVER DISORDER
- ☐ PNEUMONIA
- ☐ PROLONGED BLEEDING
- ☐ PROSTATE DISORDER
- ☐ PSYCHIATRIC TREATMENT
- ☐ RHEUMATIC/SCARLET FEVER
- ☐ STD
- ☐ STOMACH/ULCER DISORDER
- ☐ STROKE
- ☐ TUBERCULOSIS
- ☐ THYROID DISEASE
- ☐ TUMOR/CANCER
- ☐ HEART PROBLEMS
- ☐ OTHER:____

IF DIABETIC: _____ **YEARS:** _____ **AVG BLOOD SUGAR:** _____ **HbA1C:** _____

SURGICAL HISTORY

PROCEDURE / INJURY / ILLNESS	YEAR	PHYSICIAN	HOSPITAL

FAMILY HISTORY

	Cancer	Heart	Blood Pr.	Stroke	Clots	Kidney	Diabetes	Mental	Emphys.
MATERNAL	☐	☐	☐	☐	☐	☐	☐	☐	☐
PATERNAL	☐	☐	☐	☐	☐	☐	☐	☐	☐

SOCIAL HISTORY

DO YOU SMOKE CURRENTLY? ☐ YES ☐ NO _____

YEARS SMOKED: _____ **PACKS/DAY:** _____ **QUIT DATE (IF FORMER):** _____

CAFFEINE DRINKS/DAY: _____ **ALCOHOL DRINKS/WEEK:** _____

ILLICIT DRUGS? ☐ YES ☐ NO _____

VAPING? ☐ YES ☐ NO _____

PATIENT: _____ (FIRST NAME) _____ (M.I.) _____ (LAST NAME)

COMPREHENSIVE REVIEW OF SYSTEMS

Check all symptoms that currently apply to you:

CONSTITUTIONAL

- ☐ APPETITE DECREASE
- ☐ APPETITE INCREASE
- ☐ CHILLS
- ☐ CONVULSIONS/SEIZURES
- ☐ FEVER
- ☐ MALAISE
- ☐ NIGHT SWEATS
- ☐ SLEEP PROBLEMS
- ☐ WEIGHT GAIN
- ☐ WEIGHT LOSS

CARDIOLOGICAL

- ☐ ANKLE SWELLING
- ☐ CALF CRAMPING
- ☐ CHEST PAIN
- ☐ HEART PALPITATIONS
- ☐ JAW PAIN
- ☐ MURMUR
- ☐ PACEMAKER
- ☐ SHORTNESS OF BREATH

ENDOCRINE

- ☐ COLD INTOLERANCE
- ☐ DRY HAIR
- ☐ DRY SKIN
- ☐ EXTREME THIRST
- ☐ HEAT INTOLERANCE
- ☐ HOT FLASHES
- ☐ HYPERGLYCEMIA
- ☐ RECENT HAIR LOSS
- ☐ UNUSUAL FATIGUE

ENT

- ☐ CHRONIC COUGH
- ☐ HEARING DIFFICULTY
- ☐ SWALLOWING DIFFICULTY
- ☐ LOST SENSE OF SMELL
- ☐ POST-NASAL DRIP
- ☐ NOSE BLEED
- ☐ RINGING IN EARS
- ☐ SINUS PROBLEMS
- ☐ SORE THROAT
- ☐ SWOLLEN GLANDS
- ☐ TINNITUS

EYES

- ☐ BIFOCALS
- ☐ BLURRED VISION
- ☐ DOUBLE VISION
- ☐ FARSIGHTED
- ☐ LOSS OF VISION
- ☐ NEARSIGHTED
- ☐ PHOTOSENSITIVITY

GASTROINTESTINAL

- ☐ ABDOMEN PAIN
- ☐ BLOOD IN STOOL
- ☐ CONSTIPATION
- ☐ DIARRHEA
- ☐ GASTRIC REFLUX
- ☐ NAUSEA

GENITOURINARY

- ☐ BLADDER SPASM
- ☐ BLOOD IN URINE
- ☐ BURNING URINATION
- ☐ UTI
- ☐ KIDNEY PROBLEMS
- ☐ OVARIAN CYSTS
- ☐ PROSTATE PROBLEMS
- ☐ URINARY FREQUENCY
- ☐ URINARY URGENCY
- ☐ UTERINE FIBROIDS

IMMUNOLOGIC

- ☐ ARTHRITIC FLARE-UP
- ☐ RECENT ASTHMA ATTACK
- ☐ SNEEZING
- ☐ ENVIRONMENTAL ALLERGIES
- ☐ EYES WATERING
- ☐ SEASONAL ALLERGIES

INTEGUMENTARY

- ☐ BURNING SKIN
- ☐ DANDRUFF
- ☐ DERMATITIS
- ☐ ECZEMA
- ☐ EXCESSIVE SCARRING
- ☐ RASH
- ☐ NON-HEALING WOUNDS
- ☐ PSORIASIS FLARE-UP
- ☐ TINGLING SENSATION

LYMPHATIC

- ☐ ANEMIA
- ☐ ANKLE EDEMA
- ☐ BLEEDING TENDENCY
- ☐ BRUISE EASILY
- ☐ LEG SWELLING
- ☐ SICKLE CELL CRISIS
- ☐ RECENT TRANSFUSION
- ☐ SWOLLEN LYMPH NODES

MUSCULOSKELETAL

- ☐ BACK PAIN
- ☐ JOINT PAIN
- ☐ JOINT REDNESS
- ☐ JOINT SWELLING
- ☐ LEG CRAMPS
- ☐ MORNING STIFFNESS
- ☐ MUSCLE TENDERNESS
- ☐ NECK PAIN
- ☐ STIFFNESS
- ☐ MUSCLE WEAKNESS
- ☐ DIFFICULTY WALKING

NEUROLOGICAL

- ☐ BURNING TOES/FINGERS
- ☐ HYPERSENSITIVITY
- ☐ NEUROLOGICAL PROBLEMS
- ☐ NUMBNESS
- ☐ TREMORS
- ☐ PARALYSIS
- ☐ RECENT SEIZURE
- ☐ STOCKING/GLOVE NUMBNESS
- ☐ TINGLING EXTREMITIES
- ☐ UNCONTROLLED MOVEMENTS

PSYCHIATRIC

- ☐ ADDICTIVE TENDENCIES
- ☐ ANGER ISSUES
- ☐ ANXIOUSNESS
- ☐ ATTEMPTED SUICIDE
- ☐ CLAUSTROPHOBIA
- ☐ OVEREATING
- ☐ DEPRESSION
- ☐ DISORIENTATION
- ☐ IRRITABILITY
- ☐ LIBIDO DECREASE
- ☐ MEMORY LOSS
- ☐ MENTAL STATUS CHANGES
- ☐ PANIC ATTACKS
- ☐ PARANOIA
- ☐ POOR SLEEP PATTERN
- ☐ SUICIDAL THOUGHTS

RESPIRATORY

- ☐ BREATHING DIFFICULTIES
- ☐ RESPIRATORY SYMPTOMS
- ☐ CHEST PAIN/INSPIRATION
- ☐ WHEEZING
- ☐ SNORING
- ☐ RECENT ASTHMA ATTACK
- ☐ TB EXPOSURE
- ☐ SHORTNESS OF BREATH
- ☐ SLEEP APNEA

PATIENT: _____ _____ _____
FIRST NAME M.I. LAST NAME

SIGNATURES & CONSENT

SIGNATURE OPTIONS: (1) Print and sign with pen OR (2) Use Adobe Acrobat Reader (free) "Fill & Sign"

1 ASSIGNMENT OF BENEFITS, FINANCIAL RESPONSIBILITY & AUTHORIZATION TO RELEASE INFORMATION FOR BILLING

I, the undersigned patient (or authorized representative), hereby make the following declarations, assignments, and authorizations:

Assignment of Insurance Benefits. I hereby assign and authorize direct payment to Fallbrook Podiatry Inc. (Dr. Grigoriy N. Patish, D.P.M.) of any and all insurance benefits, Medicare benefits, Medi-Cal benefits, or benefits payable under any other third-party health plan for services rendered to me. This assignment applies to all current and future claims arising from treatment provided by this practice, unless I revoke this assignment in writing.

Financial Responsibility. I understand and agree that I am personally responsible for all charges incurred for services provided to me by Fallbrook Podiatry Inc., regardless of insurance coverage. This includes, but is not limited to, copayments, coinsurance, deductibles, non-covered services, services denied by my insurance carrier, and any balance remaining after insurance payment. I understand that my insurance policy is a contract between me and my insurance company, and that Fallbrook Podiatry Inc. is not a party to that contract.

Good Faith Estimate Notice (No Surprises Act). If I am uninsured or choose to self-pay, I understand that I have the right to receive a Good Faith Estimate of the expected charges for scheduled services, as required by federal law (42 USC §300gg-111). I may request a Good Faith Estimate at any time before or after receiving services.

Authorization to Release Information for Billing. I authorize Fallbrook Podiatry Inc. to release any medical information — including diagnosis, treatment records, clinical notes, and diagnostic imaging results — necessary to process insurance claims, obtain preauthorization, or determine benefit eligibility. This authorization permits disclosure to my insurance company, Medicare, Medi-Cal, workers' compensation carriers, or any other entity responsible for payment of my healthcare services.

Collection Costs. In the event that my account becomes past due and is referred to a collection agency or attorney for collection, I agree to pay all reasonable collection costs, attorney's fees, and court costs incurred in the collection effort, to the extent permitted by California law.

Accuracy of Information. I certify that all personal, demographic, and insurance information I have provided on this form is true and correct to the best of my knowledge. I understand that providing false or misleading information may result in denial of coverage, and I agree to notify Fallbrook Podiatry Inc. promptly of any changes to my insurance coverage, address, or contact information.

SIGNATURE: _____ **DATE:** _____

PRINTED NAME: _____

IF NOT PATIENT — RELATIONSHIP TO PATIENT:

☐ Parent/Legal Guardian ☐ Legal Rep/Power of Attorney ☐ Conservator ☐ Other: _____

2 HMO / MANAGED CARE REFERRAL ACKNOWLEDGMENT

Referral Requirement. I understand that if my insurance is an HMO (Health Maintenance Organization) or other managed care plan, I must obtain a valid referral and/or prior authorization from my primary care physician (PCP) before each visit to Fallbrook Podiatry Inc. It is my responsibility — not the responsibility of this office — to verify that a current referral is on file and that the authorization has not expired.

Financial Responsibility Without Valid Referral. If I arrive for an appointment without a valid, current referral or authorization when one is required by my plan, I understand that I will be personally responsible for the full cost of that visit and any services rendered. Fallbrook Podiatry Inc. may, at its discretion, attempt to obtain a referral on my behalf, but is under no obligation to do so and makes no guarantee that such efforts will be successful.

Coordination of Care. I authorize Fallbrook Podiatry Inc. to communicate with my primary care physician and/or referring provider regarding my treatment plan, clinical findings, and ongoing care, as necessary for proper coordination of my healthcare.

SIGNATURE: _____ **DATE:** _____

3 APPOINTMENT CANCELLATION & NO-SHOW POLICY

I understand and agree to the following appointment policies of Fallbrook Podiatry Inc.:

Cancellation Notice. If I need to cancel or reschedule an appointment, I agree to provide at least 24 hours' advance notice by calling (760) 728-4800. Cancellations made less than 24 hours before the scheduled appointment, or failure to arrive for a scheduled appointment without prior notice (a "no-show"), may result in a no-show fee.

No-Show Fee. A fee of up to $150.00 may be charged for missed appointments or late cancellations. This fee is not billable to insurance and is my personal responsibility. Repeated no-shows may result in discharge from the practice.

Late Arrival. If I arrive more than 15 minutes late for a scheduled appointment, the office may need to reschedule my visit to avoid disrupting the care of other patients.

Emergencies. I understand that genuine emergencies and unavoidable circumstances will be taken into consideration, and that I should contact the office as soon as possible in such situations.

SIGNATURE: _____ **DATE:** _____

4 ACKNOWLEDGMENT OF RECEIPT — NOTICE OF PRIVACY PRACTICES (HIPAA)

Federal law (45 CFR §164.520) requires that we provide you with a copy of our Notice of Privacy Practices.

I acknowledge that I have been offered a copy of the Notice of Privacy Practices of Fallbrook Podiatry Inc. (Dr. Grigoriy N. Patish, D.P.M.). This Notice describes how my medical information (Protected Health Information, or "PHI") may be used and disclosed by Fallbrook Podiatry Inc. for the purposes of treatment, payment,

PATIENT: _____ (FIRST NAME) _____ (M.I.) _____ (LAST NAME)

and healthcare operations, as well as other uses and disclosures permitted or required by law. The Notice also explains my rights regarding my medical information, including the right to:

- Request restrictions on how my PHI is used or disclosed (although the practice is not required to agree to all requests)
- Request to receive communications by alternative means or at alternative locations (for example, contacting me only at a specific phone number)
- Inspect and obtain a copy of my medical records
- Request amendments to my medical records
- Receive an accounting of certain disclosures of my PHI
- File a complaint with the practice or with the U.S. Department of Health and Human Services if I believe my privacy rights have been violated

I understand that Fallbrook Podiatry Inc. reserves the right to change the terms of its Notice of Privacy Practices and to make the new provisions effective for all PHI that it maintains. A current copy of the Notice will be posted in the office and is available at www.fallbrookfootdoctor.com.

☐ I have received a copy of the Notice of Privacy Practices.

☐ I decline to receive a copy of the Notice of Privacy Practices at this time, but I understand I may request one at any future date.

Other Instructions or Restrictions (optional): _____

SIGNATURE: _____ **DATE:** _____

PRINTED NAME: _____

5 AUTHORIZATION TO RELEASE MEDICAL RECORDS & INFORMATION

IMPORTANT: This is a separate HIPAA authorization as required by 45 CFR §164.508 and California Civil Code §56.11.

I hereby authorize Fallbrook Podiatry Inc. (Dr. Grigoriy N. Patish, D.P.M.) to obtain and/or release my medical records and health information — including clinical notes, diagnostic imaging (X-rays), laboratory results, treatment plans, surgical reports, photographs, and pathology or biopsy results — to and from the following categories of recipients:

- My referring physician(s) and primary care provider(s)
- Other treating healthcare providers involved in my care
- My insurance company, Medicare, Medi-Cal, or other third-party payers
- Laboratories, imaging centers, hospitals, and surgical facilities
- Pharmacies (for prescription verification)
- Legal representatives I have designated in writing

Purpose of Disclosure: The purpose of this release is to facilitate my medical treatment, coordinate my care among providers, process insurance claims, and/or as otherwise requested by me.

Expiration. This authorization does not expire unless I specify an expiration date here: _____.

Right to Revoke. I understand that I may revoke this authorization at any time by submitting a written request to: Fallbrook Podiatry Inc., 407 Potter Street, Suite A, Fallbrook, CA 92028. Revocation will not affect any disclosures already made in good-faith reliance on this authorization prior to receipt of my written revocation.

Treatment Not Conditioned on Signing. I understand that Fallbrook Podiatry Inc. will not condition my treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

Redisclosure Notice. I understand that once my health information is disclosed to a recipient under this authorization, it may be subject to redisclosure by that recipient and may no longer be protected by HIPAA or California law, unless the recipient is independently bound by such laws.

Right to a Copy. I understand that I am entitled to receive a copy of this signed authorization upon request.

SIGNATURE: _____ **DATE:** _____

PRINTED NAME: _____

IF SIGNED BY PERSONAL REPRESENTATIVE:

☐ Parent/Legal Guardian ☐ Healthcare Power of Attorney ☐ Conservator ☐ Court-Appointed Guardian ☐ Other: _____

6 CONSENT FOR COMMUNICATIONS — PHONE, TEXT, EMAIL & VOICEMAIL

I authorize Fallbrook Podiatry Inc. and its agents to contact me for appointment reminders, follow-up care, billing inquiries, test results, and other healthcare-related communications using any of the following methods (check all that apply):

☐ PHONE CALLS — HOME
☐ PHONE CALLS — CELL
☐ PHONE CALLS — WORK
☐ VOICEMAIL MESSAGES
☐ TEXT MESSAGES (SMS/MMS)
☐ EMAIL
☐ PATIENT PORTAL MESSAGES
☐ OTHER:

If Other, specify: _____

PATIENT: _____ _____ _____
FIRST NAME M.I. LAST NAME

MAY WE DISCUSS YOUR CARE WITH ANOTHER PERSON? ☐ YES

Name / Relationship: _____ **Phone:** _____

I understand that these communication methods are not fully secure and that my health information could be seen or heard by others. I accept this risk. I may change my preferences at any time by notifying the office in writing.

SIGNATURE: _____ **DATE:** _____

7 INFORMED CONSENT FOR EXAMINATION, TREATMENT & DIAGNOSTIC PROCEDURES

I, the undersigned patient (or authorized representative), voluntarily consent to examination and treatment by Dr. Grigoriy N. Patish, D.P.M. and/or the clinical staff of Fallbrook Podiatry Inc. I understand that podiatric medicine encompasses the diagnosis, medical, surgical, mechanical, manipulative, and electrical treatment of the human foot, ankle, and tendons that insert into the foot, as well as the nonsurgical treatment of the muscles and tendons of the leg governing the functions of the foot (per California Business & Professions Code §2472).

Scope of This Consent. This consent covers routine outpatient examinations, evaluations, and treatments, which may include but are not limited to:

- Physical examination of the feet, ankles, and lower extremities
- X-ray and other diagnostic imaging
- Diagnostic ultrasound
- Laboratory testing (blood work, cultures, biopsy specimens)
- Administration of local anesthesia
- Wound care and debridement
- Injection therapies (corticosteroid, anesthetic, regenerative medicine)
- Nail procedures (including partial or total nail removal)
- Minor in-office surgical procedures
- Casting, splinting, strapping, and padding
- Orthotic and prosthetic device fitting and dispensing
- Prescription of medications
- Physical therapy and rehabilitation exercises

Separate Surgical Consent. I understand that any major surgical procedure will require a separate, procedure-specific informed consent that will be discussed with me in detail prior to surgery, including the nature of the procedure, expected benefits, material risks, alternatives, and risks of refusing the procedure, in accordance with California informed consent law (Cobbs v. Grant, 8 Cal.3d 229; CACI 532-535).

Right to Refuse. I understand that I have the right to refuse any examination, treatment, or procedure at any time. If I refuse recommended treatment, the risks of that refusal will be explained to me, and I may be asked to sign a separate “Informed Refusal” document.

No Guarantee of Results. I understand that medicine is not an exact science and that no guarantee has been made to me regarding the outcome of any examination, treatment, or procedure.

Tissue Specimens. I consent to the examination and disposal of any tissue, body parts, or specimens removed during the course of my treatment, including submission to a laboratory for pathological study when deemed medically appropriate by my treating physician.

Questions. I have had the opportunity to ask questions about my care, and my questions have been answered to my satisfaction. I understand that I may ask additional questions at any time.

SIGNATURE: _____ **DATE:** _____

PRINTED NAME: _____

IF NOT PATIENT — RELATIONSHIP TO PATIENT:

☐ Parent/Legal Guardian ☐ Legal Rep/Power of Attorney ☐ Conservator ☐ Other: _____

PATIENT: _____ _____ _____
FIRST NAME M.I. LAST NAME

8 AUTHORIZATION FOR PHOTOGRAPHY, VIDEO & USE IN MARKETING MATERIALS

THIS IS A VOLUNTARY AUTHORIZATION. YOUR TREATMENT WILL NOT BE AFFECTED IF YOU CHOOSE NOT TO SIGN.

Who May Take and Use Images. I authorize Dr. Grigoriy N. Patish, D.P.M. and the clinical staff of Fallbrook Podiatry Inc. ("the Practice") to take clinical photographs, videos, and/or audio recordings of my feet, ankles, lower extremities, and related areas during the course of my examination and treatment.

Description of Information. The images and recordings may include photographs or video of my feet, ankles, lower extremities, wounds, surgical sites, and/or conditions before, during, and after treatment. These images may be considered Protected Health Information (PHI) under HIPAA if they include identifiable features.

Permitted Uses — Clinical Purposes (No Additional Consent Needed). I understand that clinical photographs taken for the purpose of documenting my treatment are part of my medical record and may be used for treatment, payment, and healthcare operations without this separate authorization.

Permitted Uses — Marketing & Educational Purposes (This Authorization Required). By signing below, I give my specific, voluntary consent for the Practice to use my photographs, videos, likeness, voice recordings, and/or my patient testimonial (if given) for the following purposes:

- The Practice's website (www.fallbrookfootdoctor.com), including both English and Spanish pages
- Social media accounts operated by the Practice (including but not limited to Facebook, Instagram, YouTube, TikTok, X/Twitter, LinkedIn, and any future platforms)
- Printed marketing materials (brochures, flyers, mailers, office displays, posters)
- Digital marketing and advertising (online ads, email newsletters, digital signage)
- Educational presentations, lectures, and professional conferences
- Before-and-after case presentations for prospective patients
- Internal staff training and quality improvement

De-Identification Efforts. The Practice will make reasonable efforts to de-identify images by cropping faces and removing identifying features when clinically feasible. However, I understand that certain photographs (including but not limited to full-face photos, images showing distinguishing marks such as tattoos or scars, and before-and-after series) may make me recognizable, and I accept that risk.

No Compensation. I understand that I will not receive any payment, royalty, or other compensation for the use of my images or testimonial, either now or in the future.

Ownership. I understand that all photographs, videos, and recordings taken by the Practice are the property of Fallbrook Podiatry Inc.

Digital Replicas. Pursuant to California Civil Code §3344 as amended by SB 683 (2025), I understand that this authorization covers only actual photographs and recordings of me and does not authorize the creation of any AI-generated digital replica of my likeness, voice, or identity for any purpose.

California Right of Publicity. I waive any claim under California Civil Code §3344 (Right of Publicity) for the specific uses authorized above, while reserving all rights for any unauthorized uses.

Two-Party Recording Consent. To the extent that any audio or video recording is made in connection with my care, I consent to such recording pursuant to California Penal Code §632.

Duration. This authorization does not expire unless I specify an expiration date here: _____.

Right to Revoke. I may revoke this authorization at any time by submitting a written request to: Fallbrook Podiatry Inc., Attn: Privacy Officer, 407 Potter Street, Suite A, Fallbrook, CA 92028. I understand that:

- Revocation will be effective upon receipt of my written request
- The Practice is not required to retrieve or delete images already published, printed, or distributed prior to receiving my revocation, as those disclosures were made in good-faith reliance on this authorization
- Revocation does not apply to images that have been de-identified and are no longer individually identifiable

Treatment Not Conditioned on Signing. Fallbrook Podiatry Inc. will not refuse to treat me, and will not condition my treatment, payment, enrollment, or eligibility for benefits on whether I sign this marketing authorization.

Redisclosure Notice. I understand that images or information published on the internet, social media, or in printed materials may be copied, shared, or redistributed by third parties, and once published, may no longer be protected by HIPAA or California privacy laws.

Right to a Copy. I am entitled to receive a copy of this signed authorization.

PLEASE INITIAL YOUR CHOICES:

_____ I CONSENT to the use of my clinical photographs/videos for marketing purposes as described above.

_____ I DO NOT CONSENT to the use of my photographs/videos for marketing purposes.

_____ I consent to marketing use ONLY IF my face and identifying features are not visible.

_____ I consent to the use of a written testimonial I may provide, with my first name and last initial only.

_____ I consent to the use of a written testimonial I may provide, with my full name.

_____ I consent to the use of video testimonial.

SIGNATURE: _____ **DATE:** _____

PRINTED NAME: _____

IF SIGNED BY PERSONAL REPRESENTATIVE:

☐ Parent/Legal Guardian ☐ Healthcare Power of Attorney ☐ Conservator ☐ Court-Appointed Guardian ☐ Other: _____

PATIENT: _____ _____ _____
FIRST NAME M.I. LAST NAME

IN-PERSON VERIFICATION & ATTESTATION

I, the undersigned, hereby attest and confirm the following:

1. All electronic signatures, initials, and selections appearing on the preceding pages of this intake form were made by me (or by my authorized representative identified above) and accurately reflect my intentions.

2. I have read, or had read to me, each section of this form and I understand the content, rights, obligations, and authorizations described herein.

3. I have had the opportunity to ask questions about any section I did not understand, and all of my questions have been answered to my satisfaction.

4. I am signing this attestation voluntarily and in the presence of a staff member of Fallbrook Podiatry Inc.

This signature is provided in person at the office and serves as witness verification that all preceding consents and authorizations are genuine.

PATIENT SIGNATURE: _____ **DATE:** _____

PRINTED NAME: _____

WITNESSED BY (Office Staff):

Staff Signature: _____ **Date:** _____

Staff Printed Name: _____

YOU MADE IT. YOU ARE AWESOME.

Thank you for taking the time to complete this form thoroughly.