

New Patients

**Thank you for choosing the office of Dr. Ashleigh E. Korves,
DPM, FASPS**



Please plan to arrive 15 minutes before your appointment time for check-in.

Check-in requirements:

- Valid Photo ID
- Insurance cards
- This paperwork packet fully completed

Unable to print the forms?

Call our office at (707) 575-6033 to have them mailed, or arrive 30 minutes early to complete them. Incomplete forms at check-in may require your appointment to be rescheduled.

Phone: (707) 575-6033

Ashleigh E. Korves, DPM, FASPS
4750 Hoen Avenue Suite B
Santa Rosa, CA, 95405

Fax: (707) 573-6157

Welcome to our Practice

Please complete the New Patient Forms attached before your scheduled appointment time. Additionally, please refrain from mailing them, as we can't guarantee receipt. If your forms are not complete by your appointment time, your appointment may need to be rescheduled.

If you need to cancel or reschedule your appointment, we require 24 hour notice. If we do not receive proper notice, you may be charged a fee ranging from \$50-\$85 depending on appointment type. This is not payable by your insurance company.

We ask that you bring a list of all of your medications and supplements with you to your first visit with us. This includes prescription medications, vitamins and supplements, and any over-the-counter medications you take on a regular basis.

We are the brown building located directly on the corner of Summerfield and Hoen Ave, and share a building with All Tails Wagging Veterinary Clinic.

Prescription Renewals:

For prescription refills, please contact your pharmacy at least 3 business days before you run out of your medication.

Prescriptions will only be refilled for patients who are under continuous care. No narcotic prescriptions will be ordered during non-office hours without a patient evaluation by a physician.

Fees, Payments, and Insurance:

We are participating physicians with Medicare. We are also contracted with many various insurance plans. Please refer to the customer service number on the back of your insurance card and call them to verify we are participants in your plan. You should be aware of your medical costs. Upon your request, our staff will provide an estimate of the fees for your visit in advance.

Please note: The agreement you have with your insurance company does not affect your responsibility of payment- all fees are ultimately due from you.

You will be held financially responsible for copays, deductibles, balances, and non-covered services. We will bill the insurance carriers for you. It is essential for you to provide the most current and correct insurance information to us. If your insurance changes during your care in our office- please let us know immediately.

Our Commitment:

We are committed to upholding the utmost standard of patient care. We value and respect each patient and aim to provide compassionate, personalized, and high-quality care in a safe and supportive environment.

Ashleigh E. Korves, DPM, FASPS
4750 Hoen Avenue Suite B
Santa Rosa, CA, 95405

Phone: (707) 575-6033

Fax: (707) 573-6157

Patient Name: _____ Date of Birth: _____

Age: _____ Gender: _____ Preferred Pronouns: _____

Home Address:

Mailing Address:

Home Phone: _____ Work Phone: _____

Mobile Phone: _____

Preferred Contact (check one) ☐ Home ☐ Work ☐ Mobile

Email:

Primary Care Physician: _____ Referring
Provider: _____

Ethnicity (check one):

- ☐ Hispanic/Latino
☐ Not Hispanic/Latino

Race (check one):

- ☐ White ☐ Black/African American
☐ Asian ☐ Native Hawaiian/Pacific Islander
☐ American Indian/Alaska Native

Preferred Language: _____ ☐ Other: _____

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

MINORS ONLY

Mother's Full Name: _____ Phone: _____

Father's Full Name: _____ Phone: _____

Guarantor Information (Who is responsible for payment, if other than yourself?):

Name: _____ DOB: _____ Relationship: _____

Address: _____

Phone Number: _____

Signature: _____ Date: _____

Phone: (707) 575-6033

Ashleigh E. Korves, DPM, FASPS
4750 Hoen Avenue Suite B
Santa Rosa, CA, 95405

Fax: (707) 573-6157

HIPAA
Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical service providers and payers to disclose and release my protected health information described below to:

Name: _____ Relationship: _____

Contact information: _____

Health information to be disclosed upon the request of the person named above (Check A or B):

- A. Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions

OR

- B. Disclose my health record, as above, but do not disclose for the following (Check as appropriate):

- ☐ Mental Health Records
☐ Communicable Diseases (including HIV and AIDS)
☐ Alcohol/Drug Abuse Treatment
☐ Other (Please specify):

Form of Disclosure (Unless another format is mutually agreed upon between my provider and designee:

- ☐ An Electronic record or access through an online portal
☐ Hard Copy

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods

OR

- ☐ Date or event:

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying you health care providers, preferably in writing.)

Name of the Individual giving this authorization

Date of Birth

Signature of the Individual giving this authorization

Date

NOTICE OF PRIVACY PRACTICES - Effective September 14, 2026

Attenda Medical Group, Inc. ("Attenda," "we," "us," or "our") is required by law to protect the privacy of your protected health information (PHI), provide this notice of our legal duties and privacy practices, and follow the notice currently in effect.

HOW WE MAY USE AND SHARE YOUR INFORMATION

Treatment, payment, and health care operations. We may use or share PHI to treat you and coordinate your care; bill you, your health plan, or other responsible parties; and operate our practice. Operations include quality improvement, staff training, audits, credentialing, compliance, business management, and contacting you about appointments, follow-up care, treatment alternatives, or health-related services.

Other uses or disclosures permitted or required by law. We may use or share PHI when allowed or required for public health and safety activities; reporting abuse or neglect; health oversight; workers' compensation; organ donation; coroners, medical examiners, and funeral directors; research that meets legal requirements; certain judicial or administrative proceedings; law enforcement and other government functions; and other disclosures required by federal, state, or local law.

Family, friends, and others involved in your care. Unless you object, we may share relevant information with a family member, friend, or other person involved in your care or payment for your care when permitted by law. If you cannot tell us your preference, we may share information when legally permitted and we believe it is in your best interest or necessary to address a serious and imminent threat.

Written authorization. We will obtain your written authorization for uses or disclosures that are not otherwise permitted by law, including marketing when authorization is required, the sale of PHI, and most uses or disclosures of psychotherapy notes. You may revoke an authorization in writing, except to the extent we have already relied on it.

YOUR RIGHTS

- Access your records. You may inspect or obtain an electronic or paper copy of your medical record and other PHI we maintain about you. We will respond within the time required by law and may charge a reasonable, cost-based fee when permitted.
- Ask us to correct your records. You may request correction of information you believe is incorrect or incomplete. We may deny a request in some circumstances and will explain a denial as required by law.
- Request confidential communications. You may ask us to contact you in a particular way or at a different location. We will accommodate reasonable requests.
- Ask us to limit use or disclosure. You may ask us not to use or share certain PHI for treatment, payment, or operations. We are not always required to agree. If you pay in full out-of-pocket for an item or service, you may ask us not to disclose information about that item or service to your health plan for payment or operations; we will honor the request unless disclosure is required by law.
- Receive an accounting of certain disclosures. You may request a list of certain disclosures made during the six years before your request. The list does not include every disclosure, including many made for treatment, payment, or operations.
- Get a paper copy of this notice at any time, even if you agreed to receive it electronically.
- Choose someone to act for you. A legally authorized personal representative may exercise your privacy rights, subject to verification of that authority.

- File a complaint. You may complain to our Privacy Officer or to the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you for filing a complaint.

ADDITIONAL PRIVACY PROTECTIONS

Some information may receive greater protection under California or other applicable law. When another law provides greater privacy protection than HIPAA, we will follow the more protective law. To the extent Attenda receives, creates, or maintains substance use disorder records protected by 42 CFR Part 2, those records are subject to additional confidentiality protections, including limits on their use in legal proceedings against a patient unless authorized as required by law.

OUR RESPONSIBILITIES

We must maintain the privacy and security of your PHI, notify you following a breach when required by law, and follow the duties and privacy practices described in the notice currently in effect. We may change this notice and make the revised notice effective for PHI we already have and information we receive in the future. The current notice will be available in our office, on request, and on any website we maintain that describes our services.

QUESTIONS OR COMPLAINTS

Privacy Officer Linda Smith
Phone 707-575-6033
Email linda@attendamed.com
Address Attenda Medical Group, Inc., 4750 Hoen Avenue, Suite B, Santa Rosa, CA 95405

You may also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling 1-877-696-6775. Attenda will not retaliate against you for filing a complaint.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received, or have been offered the opportunity to receive, a copy of Attenda Medical Group, Inc.'s Notice of Privacy Practices. My signature acknowledges receipt or the opportunity to receive the notice only; it does not authorize any use or disclosure of my health information beyond what is permitted by law.

_____ Patient Name (print)	_____ Date of Birth
_____ Signature of Patient	_____ Date
_____ Parent/Legal Guardian/Personal Representative (if applicable)	_____ Relationship to Patient
_____ Signature of Parent/Legal Guardian/Personal Representative	_____ Date

Attenda Medical Group, Inc Financial Policy

The physicians and staff of Attenda Medical Group, Inc. are committed to providing you with the best possible health care. The following is a statement of our Financial Policy.

- Patients must complete all forms. A copy of your insurance card(s) and your ID will be made for your chart
- Your insurance copayment is due at the time of service. Be prepared to pay your copayment 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 ensure accurate claims processing, please provide your health plan or insurance information. Your health plan 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 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.

Copayments are due at the time of your visit. If you have unmet deductible, we may pre-collect 60% of the charges incurred that insurance will apply towards your deductible.

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.

Assignment of Benefits:

I hereby give authorization for payment of Medicare/Health Plan benefits to be made directly to Attenda Medical Group, Inc. for services rendered. I understand that I am responsible for all charges not covered by insurance, including but not limited to, claims denied, unpaid due to deductibles, co-pays, 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 Attenda Medical Group, Inc. to release all information necessary to secure benefit payments. I agree that a photocopy of this agreement shall be valid as original.

Telephone Calls:

You may be charged for telephone calls of 5 minutes or longer with your physician. Insurance does not cover this charge. You will be responsible for payment in full.

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 notify our office at least 2 business days in advance. Failure to do so may result in a fee of \$50 for an office visit and \$85 for a procedure. Insurance does not cover this charge. You will be responsible for payment in full. Frequent missed appointments and cancellations interrupt your treatment and may result in discharge from our office.

Patient Relations:

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 physician/patient relations are based on understanding and open communication. Our staff will make every effort to answer questions or concerns you may have regarding your account balance. For billing questions, please call 209-522-7128.

Signature of Patient or Responsible Party

Date

Patient's Name (Please print): _____

Patient DOB: _____

Ashleigh E. Korves, DPM, FASPS
4750 Hoen Avenue Suite B
Santa Rosa, CA, 95405

Phone: (707) 575-6033

Fax: (707) 573-6157

Reason for visit: _____

Date of injury, if applicable: _____

Onset (circle): Began all of a sudden Gradually developed over time

Description of pain (circle all that apply): No pain Sharp Dull Aching
 Radiating Itching Stabbing
 Electrical Other: _____

Pain Level: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain possible)

What makes your problem worse: _____

What makes your problem better: _____

Previous treatments: _____

Where is the pain/problem located? Please mark on the photos below:



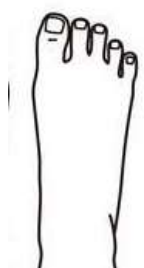
Left foot



Left foot



Right foot



Right foot



Left inside foot/ankle



Left outside foot/ankle



Right inside foot/ankle



Right outside foot/ankle



Left back of ankle



Right back of ankle



Right front of ankle



Left front of ankle

PATIENT NAME: _____ DOB: _____

ALLERGIES (check all that apply):

	MEDICATION	REACTION
	No known drug allergies	
	Adhesives	
	Latex	
	Iodine	
	Ibuprofen/NSAIDS	
	Penicillin	
	Sulfa	
	Morphine	
	Other:	
	Other:	

MEDICATIONS AND SUPPLEMENTS:

Name	Dosage	Frequency

PAST MEDICAL HISTORY (Check all that apply)

Acid Reflux		Osteoporosis/Osteopenia		Fibromyalgia
Atrial Fibrillation		Heart Attack		High Cholesterol
Anemia		Congestive Heart Failure		High Blood Pressure
Arthritis		COPD		Hyper or Hypo Thyroid (circle one)
Asthma		Emphysema		Diabetes Type 1 or Type 2 (circle one)
Back Pain/Issues		Depression		Sleep Apnea
Blood Clots (DVT or PE)		Anxiety		Stroke
HIV/AIDS		PTSD		TIA
Dementia/Alzheimer's		Parkinson's		Other (list below):
Kidney Disease		Cancer (list types below):		
Ulcerative Colitis/Crohn's				

PATIENT NAME: _____ DOB: _____

PAST SURGICAL HISTORY

Year	Type of Surgery

FAMILY HISTORY (check all that apply)

☐	Adopted					
	Diabetes	Hypertension	Cancer	Heart Disease	High Cholesterol	Other:
Mother						
Father						
Sibling						

SOCIAL HISTORY:

Employment: _____

Hobbies: _____

Alcohol use (Select one): ☐None ☐Rare/Holidays ☐Daily, amount: _____

☐Weekly, amount: _____ ☐Former

Tobacco use (Select one): ☐None ☐Current Smoker ☐Former Smoker, year quit: _____

☐Smokeless, type: _____

Vape use (Select one): ☐None ☐Rare ☐Daily ☐Former

Type: ☐Nicotine ☐THC ☐CBD ☐Flavor

Recreational drug use (Select one): ☐None ☐Current ☐Former

Type: ☐Marijuana ☐Cocaine ☐Methamphetamine ☐Benzodiazepines ☐Hallucinogens ☐Heroin

☐Other: _____

Height: _____ feet _____ inches

Weight: _____ pounds