

Dear Patient,

Welcome to Ankle & Foot Clinics Northwest, main office is: Ankle & Foot Clinic of Everett with a satellite office in Seattle. **PLEASE NOTE:** the Seattle office is currently open only for complex ankle consultations. All appointments after the first one will take place in the Everett office! To make your upcoming visit go smoothly, please review the following:

Please complete and sign all of the appropriate Registration forms and bring them with you to your first appointment along with your **1) Insurance card(s), 2) Driver's License and 3) Current Medication List (names & dosages).**

If you have previous X-rays, MRI's, CT Scans or other tests relating to your visit please have them sent to us ahead of time or bring them with you. You will also need to pay any applicable specialist co-payments at check in for your visit.

Please plan on arriving at the office at least 30 minutes prior to your appointment time so we may have time to enter your information into the computer and the medical assistant may review your history with you before your appointment with the Doctor. This is necessary so the doctor will have enough time for a complete and thorough exam.

Please review your **insurance card** and contact the insurance company's customer service department, if needed, to inquire if your plan requires a referral from your primary care provider before seeing our physicians and to verify your copays and deductibles.

We have included a copy of our 'Summary of Notice of Privacy Practices'. We have the complete detailed version available in our office. Please request a copy upon check-in.

Managed Care Plans

If needed, please contact your primary care physician to obtain a referral before your scheduled appointment. Your referral **must** arrive in our office before your scheduled appointment time via mail or fax. Our fax number is **425-258-6933**. If the referral is not received before your scheduled appointment time, your appointment most likely will have to be rescheduled. It is always best for you to make sure that your primary care physician has sent the written referral authorizing your visit before you come in.

If you request treatment to be rendered without the authorized referral, payment is due at the time of service and is not billable to your insurance company. You will be asked to sign a waiver of liability for the appointment prior to being seen.

Most insurance plans also require an insurance co-payment that is to be paid at the time of service. If your insurance is one that requires a co-payment, please pay this upon checking in with the receptionist for your appointment to avoid an additional billing fee.

We look forward to welcoming you as a patient to Ankle & Foot Clinics Northwest, P.S.

Do you have your completed and signed forms:

- Patient Registration
- Medical Health History
- Billing and Credit Policy
- Acknowledgement of Receipt of Privacy Practices
- Authorization to treat a minor (if applicable)
- Consent for Leaving Messages
- Insurance Card
- Drivers License
- Medication List

See MAP
(on reverse side)

Ankle & Foot
CLINIC OF EVERETT
3131 Nassau
#101

Providence Everett
Med Cntr-Pacific

Rucker Ave

Everett Ave

Exit
194

5

Pacific Ave

Maple
St

Hwy
2

32nd St

Exit
193

Nassau St

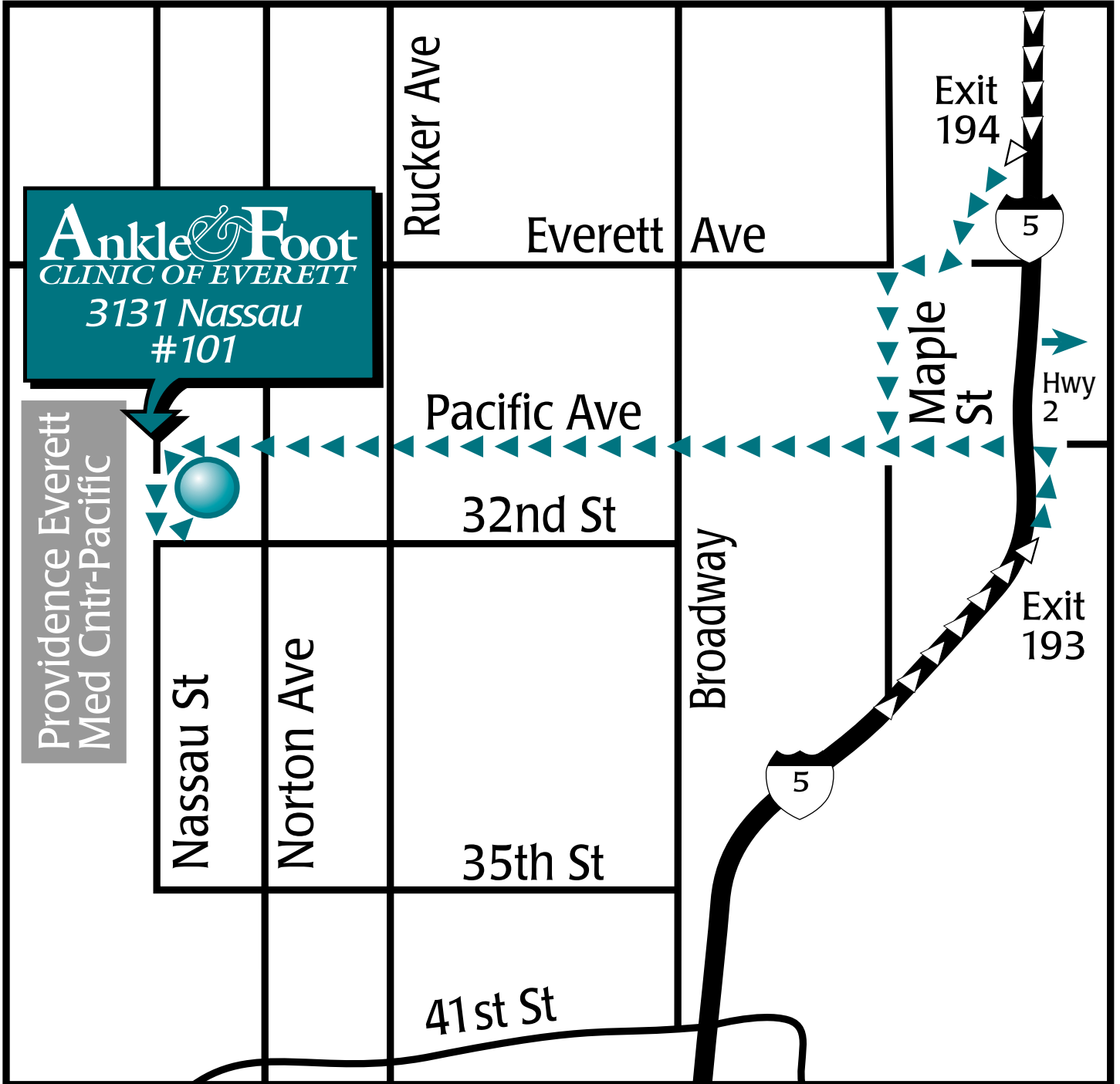
Norton Ave

Broadway

5

35th St

41st St





North

Virginia Mason
Medical Center

Swedish
Medical
Center

Harborview
Medical Center

Ankle & Foot
CLINICS NORTHWEST

Minor & James Building
515 Minor Ave, Suite 240
Seattle 98104
Phone: 206-707-4769

Broadway

12th Ave

E Cherry St

E Jefferson St

E Yesler Way

Minor Ave

Madison St

Boren Ave

Terry Ave

Cherry St

James St

Jefferson St

Yesler Way

From north of
downtown Seattle,
Exit 165A to
James Street



From south of
downtown Seattle,
Exit 164A to
James Street

Appointment date: _____ Check-in time: _____ Appointment Time: _____

Patient Information (Please Print)

Patient's Name: (Last) _____ (First) _____ (Middle Initial) _____
Address: (Street) _____ (City) _____ (State) _____ (Zip) _____
Social Security Number: _____ Birth date: ____/____/____ Age _____ Sex: M [] F []
Marital Status: Single [] Married [] Widowed [] Divorced [] Legally Separated [] Significant Other []
Email Address: _____
Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____
Employed: Yes [] No [] Retired [] If Yes, Full Time [] Part Time [] Occupation _____ Employer _____
Student: Yes [] No [] If Yes, Full Time [] Part Time [] Reason For Today's Visit _____
Primary Care Doctor: _____ Clinic Name: _____ (Date of last visit) ____/____/____
Primary Doctor's Phone (_____) _____ Referred By: (Doctor/Friend/Co-worker's name or Other Entity) _____

Person Financially Responsible For This Account (This is the Person Who Signs The Billing And Credit Policy)

Name: (Last) _____ (First) _____ Relation to Patient: Self [] Spouse [] Parent [] Other [] _____
Address: (Street) _____ (City) _____ (State) _____ (Zip) _____
Home Phone: (_____) _____ Birth date: ____/____/____ Social Security Number: _____
Drivers License: (Number) _____ (State) _____ Occupation: _____
Employer: (Name) _____ (Phone) (_____) _____

Insurance Information (Please Print)

Workers Comp: Yes [] No [] State Insured [] or, Self Insured [] Motor Vehicle: Yes [] No [] Date Of Injury: ____/____/____
Treatment Authorized by: Claims Manager [] Other [] New Claim [] Re-open Claim [] Claim Number: _____
Claims Manager: (Name) _____ (Phone) (_____) _____

Primary Insurance Company/ Subscriber Information (Please Print)

Insurance Company Name _____ (Address) _____ (Phone) (_____) _____
Does this insurance require a referral: Yes [] No [] if Yes Authorization number _____
Is this plan: Group [] Individual [] Self Insured [] Other [] _____ Effective Date of this plan: ____/____/____
Subscribers Name: (Last) _____ (First) _____ (Middle Initial) _____
Social Security Number: _____ Birth date: ____/____/____ Relation to Patient: Self [] Spouse [] Parent [] Other [] _____
ID/Policy Number: _____ Group Number: _____ Subscriber Employer: _____ Phone(_____) _____

Secondary Insurance Company/Subscriber Information (Please Print)

Insurance Company Name _____ (Address) _____ (Phone) (_____) _____
Does this insurance require a referral: Yes [] No [] if Yes Authorization number _____
Is this plan: Group [] Individual [] Self Insured [] Other [] _____ Effective Date of this plan: ____/____/____
Subscribers Name: (Last) _____ (First) _____ (Middle Initial) _____
Social Security Number: _____ Birth date: ____/____/____ Relation to Patient: Self [] Spouse [] Parent [] Other [] _____
ID/Policy Number: _____ Group Number: _____ Subscriber Employer: _____ Phone(_____) _____

Person to contact in case of emergency (Not living with you):

Name: _____ Relationship to patient: _____ Phone: (_____) _____

Private Insurance Authorization for Assignment of Benefits/Information Release:

I understand that the above information must be *complete, correct, and current* in order for my services to be billed to my insurance. I, the undersigned, authorize payment of medical benefits, both private and Medicare, to the Ankle & Foot Clinic of Everett for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company, their agent, or CMS, information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claims or benefits. I assign and transfer my rights to Ankle & Foot Clinic of Everett to act as my representative in obtaining benefit information.

Patient Signature (Parent or Guardian Signature If Child Under 18 Years)

Date

Patient Registration

WWW.ANKLEANDFOOTNORTHWEST.COM

**STATEMENT OF BILLING/CREDIT/NOTICE OF INFORMATION POLICIES
FOR THE BENEFIT OF OUR PATIENTS (Rev: 11/8/11)**

1. MEDICARE:

We accept assignment for our Medicare patients and will bill Medicare for you. Do not submit a claim yourself.

Medicare pays 80% of their allowable fee after you have satisfied your yearly deductible. If you have supplemental insurance we are **required** to provide Medicare with this information. In most cases Medicare will forward your claim directly to your supplemental insurance for you.

Medicare does not pay for routine foot/nail care or orthotics. They also can limit the number of visits per diagnosis. It is your responsibility to pay for services not covered by Medicare. You are required by Medicare to sign a waiver, when appropriate, indicating that you have been informed that Medicare may not cover certain services and that you accept the financial responsibility yourself.

2. FOR OUR CONTRACTED INSURANCE PLANS:

We accept payment based on insurance company's allowable fee structure and the contract your insurance group has with the carrier. Any allowable balances are the responsibility of the patient and are due in full upon receipt of statement.

It is the patient's responsibility to obtain any necessary referrals. If no referral is received by your appointment date, we will request you either reschedule or pay for your visit.

2nd insurance billed only if you supply us with the necessary information and will be billed only one time.

3. NON-CONTRACTED and/or OUT-OF-NETWORK PLANS:

We will do the billing from this office for your Primary Insurance as a courtesy. Please furnish us with a current insurance card. For insurances where payment **MUST** be made directly to you, we request payment at the time of service. Arrangements may be made for monthly payments of larger balances once your payment history has been established.

We request payment at the time of service for co-insurance/co-pays & deductible. 2nd insurances will be billed upon request as a courtesy.

Please understand, private insurance reimbursement is based on the contract between YOU and your carrier, so payment for our services is YOUR responsibility. We do not accept the responsibility for collecting an insurance claim or negotiating a disputed claim, however, we will assist you in this effort as a courtesy.

4. NO INSURANCE / AUTO / OTHER INJURY CLAIMS:

Payment in full is expected at the time of service. In some instances other payment arrangements, such as subrogation (3rd party), may be allowed; however, such arrangements must be made with our office prior to your first visit. A letter from your medical insurance carrier to accept subrogation would be required. In most circumstances, we do not accept 3rd party claims.

5. INSURANCE "SET" CO-PAYMENTS:

Co-payments are due at time of service and **it is your responsibility** to know the amount and when they are due.

There will be a \$10.00 billing charge for "set" co-payments not paid at time of service, and this alternative will be allowed only one (1) time. Additional requests may result in us asking you to reschedule your appointment.

6. METHODS OF PAYMENT / MONTHLY STATEMENTS:

We accept cash, personal checks, money orders and Mastercard/Visa. **For any balances, we expect payment in full, upon receipt of statement. If full payment is not made, applicable service charges will apply.**

For larger balances, we may consider reasonable monthly payments, with services charges applicable. However, this plan **must be** agreed to prior to treatment being rendered.

Monthly statements will include rebilling charges beginning with the second statement at a cost of \$10.00 for each statement beyond the first.

7. FAILED AND CANCELLED APPOINTMENTS:

Patients who fail to show or cancel their appointments without giving our office 24 hours notice may be charged \$25.00 for the first time and \$50.00 for each time thereafter.

8. INSURANCE / DISABILITY / MISC FORMS:

There will be a minimum \$10.00 fee for each form requiring physician completion if not requested or paid by your medical insurance carrier.

9. There will be a charge of \$25.00 for all checks returned due to insufficient funds, and a \$5.00 charge for a declined credit card.

10. Should my account, or an account for which I am financially responsible, be referred to a collection agency for non-payment, I am aware that I will be responsible for all charges transferred by Ankle & Foot Clinic to the collection agency, including any unpaid balances and re-billing fees. I also agree to be financially responsible for reasonable attorney fees. Non-payment may result in my being reported to a credit bureau.

11. Per HIPAA guidelines, you are not required to provide us with your social security # unless this is used as identification by your medical insurance carrier. If your social security # is used for that purpose, failing to provide it to us will entail you paying for all visits at time of service. We will ask for a copy of your drivers license to protect you and our clinic from identity fraud.

***Please refer to our Notice of Privacy Practice for all details regarding the use and disclosure of your private health information ***

I have read and understand this policy and acknowledge full responsibility for the payment of services rendered. This information provided by me is current, accurate and complete to the best of my knowledge.

I authorize all payments to be made directly to Ankle & Foot Clinic of Everett or my provider on my behalf for any services or supplies furnished by my doctor or Ankle & Foot Clinic of Everett and for my doctor to act as my agent to help obtain payment. I authorize the release of medical information or documentation in their possession about me to all my insurance companies as well as to Medicare in order to determine benefits or the benefits payable for related services, now or in the future.

Signature _____ Driver's License # _____

Name (please print) _____ Date _____

ANKLE & FOOT CLINIC OF EVERETT

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding
the attached Notice of Privacy Practices

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;

- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.

ANKLE & FOOT CLINIC OF EVERETT

3131 Nassau Street, Suite 101 * Everett WA 98201

Phone (425) 339-8888 Fax (425) 258-6933

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice. (Rev:8/26/05)

Patient Name (please print)

Date

Patient Signature

Parent or Authorized Representative (if applicable)
(please print)

Parent or Authorized Representative Signature

Ankle & Foot Clinic of Everett
3131 Nassau Street, Suite 101 * Everett Wa. 98201
Phone (425) 339-8888 Fax (425) 258-6933

Consent for Leaving Messages
Consent to Leave Messages /Share Information with Family/Friends

I understand that my healthcare information at the Ankle & Foot Clinic of Everett is protected and I have received a copy of their Notice of Privacy Practices.

In order for the Ankle & Foot Clinic of Everett to leave detailed messages on my voice mail or answering machine, I need to give permission to the Ankle & Foot Clinic of Everett.

Consent for Leaving Messages (please check box)

Yes No

I consent to information regarding myself (or my child's / under the age of 18) lab tests results or detailed appointment reminders/instructions be left on my voice mail or answering machine.

Consent for Shared Information with Family and Friends (please check box)

Yes No

I wish family members or friends to have access to my health care information. The name(s) listed below are family members or friends to whom I grant access to my health care information. I will rely on the professional judgment of my provider and his/her designee to share such information, as they deem necessary.

I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Information form.

NAME	RELATIONSHIP
1. _____	_____
2. _____	_____
3. _____	_____

(Print) _____

Patient Name

Date of Birth

Patient/Parent Signature

Date

This consent will be considered valid until such time that I cancel it. I reserve the right to cancel it at any time. It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time. I understand that any cancellation can only apply to future disclosures or actions regarding my protected health information and cannot cancel actions taken or disclosures made while the designation was in effect. (Rev:12/31/05)

AUTHORITY TO TREAT A MINOR

Patient Name

I hereby authorize Ankle & Foot Clinic of Everett to care for the above named patient, and, after discussion and approval by me, to administer whatever therapy the doctor deems necessary or advisable in the diagnosis and treatment of this patient. I further acknowledge that I am financially responsible for all charges incurred.

Date

Signature

Relationship

Witness

Jeffrey C. Christensen, DPM, FACFAS*, **

Mary E. Crawford, DPM, FACFAS*, **

Cherie H. Johnson, DPM, FACFAS*, **

Jarrold A. Smith, DPM*

Robert L. Stanton, DPM

Physicians and Surgeons* of the Ankle & Foot
Fellow, American College of Foot and Ankle Surgeons**

NATURE OF COMPLAINTS

PLEASE PRINT (Rev: 09/07/11)

PATIENT NAME: _____
REASON FOR VISIT (Please Complete): _____

IF INJURED, DATE: _____ PLACE: HOME SCHOOL WORK AUTO OTHER
IF WORK INJURY, IS THE CLAIM OPEN? YES NO CLAIM # _____
CLAIM MANAGER: _____ PHONE NUMBER: _____

**PERSONAL MEDICAL HISTORY - CHECK YES OR NO,
THEN CIRCLE CONDITION:**

- __yes __no **GENERAL:** weight gain or loss, change in energy level, appetite change activity, other: _____
- __yes __no **NEUROLOGICAL:** weakness, muscle spasms, numb feet, dizziness, chronic pain, epilepsy, seizures
other: _____
- __yes __no **PSYCHIATRIC:** increased nervousness, mood changes, depression, tension, other: _____
- __yes __no **EYES:** glasses, vision changes, dry eyes, double vision, other: _____
- __yes __no **EARS / NOSE / MOUTH / THROAT:** ringing of ears, hearing loss, bleeding gums, nose bleeds,
hoarseness, difficulty swallowing, sinus problems, sores in mouth, other: _____
- __yes __no **RESPIRATORY:** infections, difficulty breathing, cough, coughing blood, asthma, wheezing,
exposure to tuberculosis, emphysema, pneumonia, other: _____
- __yes __no **CARDIAC:** chest pain, heart flip-flops, fast heart beat, breathing difficulty when sleeping, shortness of
breath with activity, sleeping with multiple pillows to breath, heart attack, stroke, high blood
pressure, rheumatic fever, other: _____
- __yes __no **GASTROINTESTINAL:** ulcers, GERD, acid reflux, abdominal pain, nausea, vomiting, diarrhea,
bloody or black stool, enlarged liver, hepatitis, alcoholism, exposure to chemicals, other: _____
- __yes __no **URINARY SYSTEM:** flank pain, kidney disease, bladder problems, burning with urination,
other: _____
- __yes __no **MUSCULOSKELETAL:** muscle pain, joint stiffness or swelling, limited motion, back problems,
balance problems, arthritis, gout, osteoporosis, other: _____
- __yes __no **ENDOCRINE:** thyroid trouble, diabetes, excessive thirst or hunger, excessive urination, heat or
cold intolerance, prostate problems (if male), other: _____
- __yes __no **VASCULAR:** leg cramps, varicose veins, poor circulation, cold sensitivity, pulsations in legs/feet,
history of frostbite, other: _____
- __yes __no **BLOOD:** anemia, easy bruising, bleeding problems, enlarged lymph nodes, transfusions, drug abuse,
exposure to HIV, Aids, hepatitis: what type _____
- __yes __no **ALLERGIES:** hay fever, throat problems, latex sensitivity, metal sensitivity, history of anaphylaxis
other: _____
- __yes __no **SKIN / BODY:** rashes, non-healing lesions, sores, psoriasis, recent bug bites, tumor, abnormal growth,
cancer, other: _____
- __yes __no **OTHER CONDITIONS:** _____

ALLERGIES (PLEASE CHECK 'NONE' IF APPROPRIATE)

MEDICATION ALLERGIES-list below. <input type="checkbox"/> None	REACTION to that Medication:
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____

****For Office Use Only**** Reviewed with patient Date: _____ Signature: _____

PERSONAL INFORMATION (Rev: 09/07/11)

Do You Smoke? Yes No If Yes, How many packs per day? _____ For how long? _____
 Have you smoked previously? Yes No If Yes, When did you quit? _____
 Do you chew Tobacco? Yes No If Yes, For how long? _____
 Do you consume products with caffeine? Yes No If Yes, How many per day? _____
 Do you drink alcohol? Yes No If Yes, How many per week? _____
 Height _____ Weight _____ Shoe size _____

SURGICAL HISTORY

Please list all surgeries previously done	which side (if applicable)	Year	Physician
1.			
2.			
3.			
4.			
5.			

PRESCRIPTION MEDICATIONS (current and dosage)

Name of Medication	Dosage	How Taken (one/two times a day??)
1.		
2.		
3.		
4.		
5.		

Over the counter Medications / Vitamins: _____

****PLEASE INDICATE YOUR PHARMACY NAME/LOCATION/PHONE # as of (date) _____ :**

_____ **Pharmacy Name** _____ **Location** _____ **Phone Number**

FAMILY HISTORY (Please complete as best you can)

Adopted
Please state if your relatives listed below have or have had any of the following: Cancer, Heart trouble, Kidney Disease, Stroke, Arthritis, Diabetes, High Blood Pressure, Tuberculosis, Emphysema.

Health Problems	Age (if living)	Age (if deceased)	Cause of death
Mother			
Father			
Brothers			
Brothers			
Sisters			
Sisters			
Children			
Children			

The information provided by me is true to the best of my knowledge. I authorize release of any previous medical records, by fax, mail or phone either physician or hospital generated. Also, I hereby authorize the doctor or his assistants to initiate the diagnosis and treatment of my conditions with x-rays, examination, photographs or injections as necessary.

Patient Name (Please Print) _____

Patient Signature _____ Date _____

CANCELLATION POLICY

I am aware that Ankle & Foot Clinic of Everett has a policy requesting that I notify them *at least 24 hours* in advance if my appointment needs to be changed or cancelled.

I understand that I may be charged a fee for any appointment that I either miss, cancel or reschedule without giving the clinic **at least 24 hours** notice before the appointment time.

The fee for a missed or late cancelled/rescheduled appointment is a minimum of \$25.00, with a \$200.00 fee for surgeries.

I further understand that this charge **will not** be billed to my insurance and that I am financially responsible for payment. In addition, I may not be able to reschedule another appointment until such fee is paid.

To prevent this charge, please notify our office a minimum of 24 hours in advance if you cannot keep your appointment.

By my signature below, I agree to the terms and conditions as noted above and acknowledge that I understand the cancellation policy.

Print Name (Patient)

Date

Signature (Patient)

Date

Signature (Parent or Guardian)-if applicable)

Date

*Jeffrey Christensen, DPM, FACFAS

*Mary Crawford, DPM, FACFAS

*Cherie Johnson, DPM, FACFAS

Jarrold A. Smith, DPM

Robert Stanton, DPM

*Certified in Foot and Ankle Surgery