Ankle & Foot Clinics NORTHWEST

☐ Everett Location
3131 Nassau Ste 101
Everett, WA 98201
Ph: 425-339-8888
Fax: 425-258-6933

☐ Smokey Point Location
17432 Smokey Pt. BLVD. Ste 103
Arlington, WA 98223
Ph: 360-653-2326
Fax: 360-658-8944

Dear Patient,

Welcome to Ankle & Foot Clinics Northwest, ***Everett and Smokey Point Locations.*** To make your upcoming visit go smoothly, please review the following:

Please complete and sign all of the enclosed 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 to Include Vitamins and Supplements (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.

New Patients: Please plan on arriving at the clinic at least 30 minutes before 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.

We have included both a copy of 'Summary of Notice of Privacy Practices' and the detailed version of the HIPAA Notice of Privacy Practices for your reading pleasure.

Managed Care Plans

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. Should you have any questions or concerns about our office policy on this matter, please ask to speak with our office manager.

We look forward to welcoming you as a patient to the offices of Ankle & Foot Clinics Northwest.

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
- □ Cancellation Policy
- □ Insurance Card
- □ Drivers License
- □ Medication List

See MAP
(on reverse side)

PATIENT INFORMATION (PLEASE PRINT) ANKLE & FOOT CLINIC'S NORTH WEST

Patient Name: (Last) _____(First) _____ (Middle Initial) _____

Address: (Street) _____ (City) _____ (State) _____(Zip) _____

Email_____

DOB: _____ (Age) _____ Sex: M___ F___ Preferred Language: _____

Single___ Married___ Widowed__ Divorced__ Legally Separated___ Significant Other__

Race: _____ **DECLINED**____ Ethnicity: _____ **DECLINED**____

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

Employed: Yes___ No___ Retired___ Full or Part Time: _____ Occupation: _____ Employer: _____

Student: Yes___ No__ Full or Part Time: _____ Primary Care Doctor: _____
Phone: _____
Clinic Name: _____
Referred by:_____

IF WORKERS COMP OR OTHER INSURANCE (PLEASE PRINT)

Treatment Authorized by: Claims Mgr.:___***NEW CLAIM***___ **Re-Open** Claim__ Other__ CLAIM NUMBER_____

Date of Injury: _____ PLACE: Home__ Work__ School__ Auto__ Other__ State Insured: ___ or Self Insured: ___ Motor Vehicle: Yes__ No__

Claims Manager Name: _____ Phone: _____

PRIMARY INSURANCE INFORMATION (PLEASE PRINT)

Insurance Company: _____ Is this PLAN: Group____ Individual___ Self Insured__ or Other___?

Subscribers Name: Last_____ First_____ M. I. ___

DOB: _____ Relation to Patient: Self____ Spouse___ Parent___ Other___ Employer _____

ID/ Policy Number: _____ Grp Number: _____

SECONDARY INSURANCE INFORMATION (PLEASE PRINT)

Insurance Company: _____, Is this PLAN: Group____ Individual___ Self Insured__ or Other___?

Subscribers Name: Last_____ First_____ M. I. ___

DOB:_____ Relation to Patient Self__Spouse__Parent__Other_____Employer:_____

ID/ Policy Number: _____ Grp Number: _____

EMERGENCY CONTACT: Name_____ Relation_____

Phone_____

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 Ankle & Foot Clinic's Northwest for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my Insurance. 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's Northwest to act as my representative in obtaining benefit information.

Patient Signature_____ **Date**: _____

PARENT OR GUARDIAN IF UNDER 18

HISTORY AND PHYSICAL (PLEASE PRINT)

PATIENT NAME:_____

REASON FOR VISIT:_____

HAVE YOU HAD A FLU SHOT THIS YEAR? YES__ NO__HAVE YOU HAD A PNEUMONIA SHOT THIS YEAR? YES__NO__

********** **IF WORKERS COMP, PLEASE CHECK THIS BOX:** ☐ **********

PERSONAL MEDICAL HISTORY- CHECK YES OR NO, THEN CIRCLE CONDITION THAT APPLY'S

__**yes** __ **no** ***GENERAL***: weight gain or loss, change in energy level, appetite change, 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 heartbeat, 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 issues, arthritis, gout, osteoporosis, other_____
__**yes** __ **no** ***ENDOCRINE***: thyroid issues, diabetes, excessive thirst or hunger, excessive urination, heat or cold Intolerance, prostate issues (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 NO KNOWN ALLERGIES

MEDICATION ALLERGIES- List Below-- **NONE_____**
1._____----Reaction_____
2._____----Reaction_____
3._____----Reaction_____
4._____----Reaction_____

***FOR OFFICE USE ONLY**Reviewed with Patient Date:_____ Signature:_____

PERSONAL INFORMATION

Do you Smoke? Yes___ No___ Packs per day? _____ How Long?_____
Did you smoke previously? Yes___ No ___ If Yes, when did you quit?_____
Do you chew Tobacco? Yes___ No ___ If Yes, how long? _____
Do you consume products with caffeine? Yes___ No ___ If Yes, How many per day?_____
Alcohol? Yes___ No ___ If Yes, How many drinks per week?_____
Height_____ Weight_____ Shoe Size _____

SURGICAL HISTORY

PREVIOUS SURGERIES	LEFT OR RIGHT (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/ Vitamin: _____

PHARMACY INFORMATION

_____ _____ _____
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 Problem	Age (if living)	Age (if deceased)	Cause of Death
Mother			
Father			
Brother			
Brother			
Sister			
Sister			
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

REVISED 9/2/14

STATEMENT OF BILLING/CREDIT/NOTICE OF INFORMATION

POLICIES FOR THE BENEFIT OF OUR PATIENTS (Rev: 5/08/2018)

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: contract between YOU and your carrier, so payment for our
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 responsibility for collecting an insurance claim or negotiating a disputed claim, however, we will assist you in the 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 and ALL major Credit **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 or we will request you apply for a 3rd party credit service such as Care Credit. However, this plan **must be** agreed to prior to treatment being rendered.

Monthly statements will include re-billing charges beginning with the second statement.

7. FAILED AND CANCELLED APPOINTMENTS:
Patients who fail to show or cancel their appointments without giving our office at least 24 hours' notice may be charged **$50.00 fee for appointments** and a **$200 fee for surgeries**, requiring payment prior to rescheduling.

8. INSURANCE / DISABILITY / MISC FORMS: There will be a minimum ***$15.00*** 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. HIGH DEDUCTIBLE PLANS: If you have a high deductible ($1000 & over) and have not met that deductible at the time of your visit with us, we will request payment at time of service. We will bill your insurance so they can apply the charges to your deductible.

11. 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.

12. 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.

***Please request a copy of our Notice of Privacy Practice for all details regarding the use and disclosure of your private health information ***

I ACKNOWLEGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND HAVE READ (OR HAD THE OPPORTUNITY TO READ) AND UNDERSTAND THE NOTICE.

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/Alpine Foot & Ankle or my provider on my behalf for any services or supplies furnished by my doctor or Ankle & Foot Clinic of Everett/Alpine Foot & Ankle 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.

Patient Name (Please Print) _____ Signature of Person Financially Responsible _____ Date _____

Patient Date of Birth:_____

Patients With High Deductibles

The insurance landscape has changed over the last several years-premiums and co-pays have increased significantly and high deductibles have become more prevalent.

Although we have tried to maintain our current policy of billing insurance first and then billing the patient once we have obtained the explanation of benefits (EOB), the number of patients who have high deductible plans have increased to the point where we can no longer continue in this manner.

We will continue to bill your insurance so our charges will contribute towards your deductible, but we will now request **PAYMENT AT TIME OF SERVICE** if the majority of your deductible has not been met at the time of your appointment with us. We will require a debit/ credit card be on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. If we collect more than what your insurance allows, and, you are no longer in active treatment, we will refund any credits on your account after all balances have been satisfied.

Your credit card information is kept confidential and secure and payments to your card are processed **ONLY** if you do not pay at the time of service or your portion is greater than estimated at the time of service.

☐ ***I authorize Ankle & Foot Clinics Northwest to charge the portion of my bill that is my financial responsibility to the following credit/ debit card:***

☐Amex ☐Visa ☐Mastercard ☐Discover

Credit Card Number _____

Expiration Date _____ / _____ Security Code On Back_____

Cardholder Name _____

Signature _____

Billing Address _____

City _____ State_____ Zip _____

☐ ***I request to receive 1 statement prior to my card being charged.***

I (we), the undersigned, authorize and request Ankle & Foot Clinics Northwest to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by Ankle & Foot Clinics Northwest. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to Ankle & Foot Clinics Northwest in writing and the account must be in good standing.

Patient Name (Print): _____ Date of Birth:_____

Patient Signature: _____Date:_____/_____/ _____

Ankle & Foot Clinic's Northwest
Everett Location*425-339-8888*** Alpine Location*360-653-2326**

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, answering machine, EMAIL or TEXT. I need to give permission to the Ankle & Foot Clinic of Everett.

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 Leaving Messages (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.

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

❑ Yes ❑ No

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.	

_____ _____

Patient Name (Please Print) **Signature (Parent / Guardian if under 18)**

_____

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: 9/2/14)

Summary Statement of Privacy Practices

Ankle & Foot Clinics Northwest

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. It is a requirement of this practice that every employee receive appropriate training and is dedicated to the principal concept that your health information shall never be compromised. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your our obligations and your rights.

PROTECTING YOUR HEALTHCARE INFORMATION

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given or disclosed to anyone – even family members – without your consent or written authorization. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.
Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality, integrity, and access to your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Healthcare Information (PHI)

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of your Protected Healthcare Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing or fund-raising purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards unless you direct us otherwise. We will never use, disclose, sell, or otherwise allow access to your personal, protected information in exchange for or receipt of financial remuneration.

Any breach in the protection of your personal health information, including unauthorized acquisition, access, use, or disclosure, will be fully investigated, addressed, and mitigated as established by the HIPAA Privacy Breach Notification Rule. You have a right to and will be provided all information relating to any breach involving your personal PHI

Your Rights as our Patient

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

An expanded, and complete copy of our Statement of Privacy Practices, is available for your review on our website www.ankleandfootnorthwest.com as well as in our office.

Ankle & Foot Clinics Northwest
Everett location* 425-339-8888 *******Smokey Point location* 360-653-2326