NORTHWEST FOOT AND ANKLE CENTER, PS
MARK T LEWIS, DPM PETRINA C LEWIS, DPM

PATIENT INFORMATION

NAME: (LAST)______________________________ (FIRST)_________________________ (MI)_____

DATE OF BIRTH:____________ AGE:_____ □ MALE □FEMALE SS#_____________________

ADDRESS:____

CITY, STATE, ZIP:____

MARITAL STATUS: □S □M □W □D EMAIL ADDRESS:____________________________

HOME #: ______________________________ CELL #: _______________________________________

EMPLOYER:_____________________________ WORK #:_______________________________________

EMERGENCY CONTACT:___________________________ PHONE # :_________________________

PHARMACY:____________________________________ PHONE #:__________________________

WHO IS THE SUBSCRIBER TO THE INSURANCE? _________________________D.O.B.__________

WORK RELATED INJURY: □ YES □ NO
AUTO ACCIDENT: □ YES □ NO
3RD PARTY ACCIDENT: □ YES □ NO
OTHER INJURY: □ YES □ NO

DATE OF INJURY:_________________
BODY PART: R/L_________________
HOW DID INJURY OCCUR:________________________
____

WORKERS COMP/AA:

INSURANCE CO: ________________________________ PHONE #_____________________________
ADDRESS:____
CITY, STATE,ZIP:______________________________ CLAIMS MNGR_________________________
CLAIM #:______________________________ CLAIM OPEN Y N IF CLOSED DATE______________

COMMUNICATIONS

May we leave a message on a machine or with a family member at phone numbers you have provided regarding prescriptions, appointments or test results?

◊ YES ◊ NO

May we disclose your Patient Health Information to your Primary Care Physician and any Referral Physicians deemed to be instrumental in your care (except as necessary for insurance reimbursement)?

◊ YES ◊ NO

May we use your cell phone number to text appointment reminders, orthotic recalls, Holiday and other closures, and general office service information?
(THERE IS NO ADVERTISING)

◊ YES ◊ NO

I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL. I AUTHORIZE NORTHWEST FOOT AND ANKLE CENTER TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE COMPANIES. I AUTHORIZE PAYMENT DIRECTLY TO NORTHWEST FOOT AND ANKLE CENTER. I AUTHORIZE THE RELEASE OF INFORMATION NECESSARY TO COLLECT ANY PAYMENTS TO ALL INSURANCE COMPANIES I FURTHER AUTHORIZE RELEASE OF MEDICAL INFORMATION TO ANY AND ALL PHYSCIANS INVOLVED IN MY CARE. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN THE PLACE OF ITS ORIGINAL. I AUTHORIZE THE USE OF SIGNATURE ON FILE TO BE USED ON ALL OF MY INSURANCE SUBMISSIONS. I UNDERSTAND THAT I AM RESPOSIBLE FOR NOTIFYING THE OFFICE OF ANY PRECERTIFICATION, REFERRALS, OR CHANGES NEEDED FOR MY INSURANCE.

SIGNATURE OF PATIENT/GUARDIAN:____________________________________ DATE:________

NORTHWEST FOOT AND ANKLE CENTER

MEDICAL HISTORY FORM

NAME:______________________________HEIGHT:________WEIGHT:______SHOE SIZE:_________
OCCUPATION: ____

FAMILY PHYSICIAN: ______________________________PHONE #:_________________________
REFERRING PHYSCIAN: ___________________________PHONE #:_________________________

PLEASE TELL US HOW YOU CHOSE US TO PROVIDE YOUR CARE:

□ FRIEND OR FAMILY	□ REFERRAL FROM ANOTHER DOCTOR
□ YELLOW PAGES	□ SIGN ON STREET OR BUILDING
□ INSURANCE PROVIDER LIST	□ WWW.NWFOOTANDANKLE.COM
□ DEX ONLINE	□ OTHER: ______________________________

PODIATRIC MEDICAL INFORMATION:
WHY ARE WE SEEING YOU TODAY? ____
____
WHICH **FOOT** HURTS? □ RIGHT □ LEFT □ BOTH
WHICH **ANKLE** HURTS? □ RIGHT □ LEFT □ BOTH
HOW LONG HAS IT BEEN A PROBLEM? ____
RATE YOUR PAIN ON A SCALE FROM 0-10 (0=NO PAIN; 10=MOST SEVERE PAIN)____________
DOES YOUR PROBLEM AFFECT YOUR ACTIVITIES OF DAILY LIVING? HOW?______________
____
HAVE YOU HAD PREVIOUS TREATMENT FOR THE PROBLEM(S)?__________________________
HAVE YOU HAD **PAST** PROBLEMS WITH YOUR FOOT AND/OR ANKLE?___________________

DO YOU HAVE A HISTORY OF VASCULAR DISEASE OR BLOOD CLOTS?: □ YES □ NO
ARE YOU DIABETIC: □ YES □ NO

GENERAL MEDICAL: *(CHECK IF YOU CURRENTLY HAVE OR HAVE HAD IN THE LAST YEAR)*

□ ACID REFLUX	□ JOINT PAIN	□ HEART PROBLEMS
□ BLEED EASILY	□ LOW BACK PAIN	□ HEART BURN
□ BRUISE EASILY	□ NAUSEA	□ URINARY PROBLEM
□ CHILLS	□ NON HEALING SORES	□ VOMITING
□ COUGH	□ RASHES	□ OTHER: ___________
□ DEPRESSION	□ SCARRING TENDENCY	____________________
□ EMOTIONAL PROBLEMS	□ SEIZURES	____________________
□ FEVER	□ SHORTNESS OF BREATH	____________________
□ GOUT		

PLEASE COMPLETE THE FOLLOWING: *(IF ANSWER IS NONE PLEASE INDICATE)*
LIST ANY ILLNESSES: ____
____
LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING: ______________________________
____
LIST ANY DRUG ALLERGIES ***(IF NONE PLEASE WRITE NONE)***:______________________________
LIST ANY PREVIOUS SURGERIES AND DATES: ____
LIST FAMILY ILLNESSES: ____

DO YOU: CONSUME ALCOHOL? □ YES □ NO HOW MUCH:___________HOW OFTEN:__________
USE TOBACCO? □ YES □ NO PACKS PER DAY?:______ # OF YRS:_____________

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOT HOLD MY PHYSICIAN OR ANY MEMBERS OF HIS/HER STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I HAVE MADE IN THE COMPLETION OF THIS FORM.

____ ___________________________
SIGNATURE **DATE**

____ ___________________________
REVIEWED BY **DATE**

NORTHWEST FOOT AND ANKLE CENTER, PS
MARK T LEWIS, DPM   PETRINA C LEWIS, DPM
4300 TALBOT ROAD SOUTH SUITE 102
RENTON, WA 98055

PATIENT RESPONSIBILITY

Billing: It is the policy of our office that all charges, regardless of insurance coverage, are ultimately the responsibility of the patient. Please understand that if for any reason, payment is denied by your listed insurance company, we will seek compensation from the individual patient.

Co-payments: Your co-payment is due at the time you check in for your appointment. If you do not have your co-payment, and it is a non-emergent appointment, your appointment will be rescheduled.

Appointments: Punctuality is an important aspect to our office. If you are more than fifteen minutes late to your appointment than it may be necessary to reschedule to another day. Also, if our doctor is running behind you have the right to reschedule your appointment. Please give our office a call as soon as possible if you are not going to be able to keep your scheduled appointment.

Medication Refills: Prescriptions ***will not*** be refilled after 4:00pm or on weekends or holidays, except for emergency cases. For all medication refills ***please call your pharmacy 24 hours*** in advance to have a refill request faxed to our office for approval.

Insurance: It is the responsibility of the patient to secure the appropriate referrals prior to your scheduled appointment as well as to understand the policy and possible restrictions of their individual plan. As a courtesy to our patients, we will check eligibility and benefits prior to your appointment for any major medical expenses.

____
Patient or Legal Guardian Signature

__________________________   __________________
Witness (staff member)   Date

FINANCIAL POLICY

Welcome to Northwest Foot & Ankle Center, PS. We look forward to providing you with the quality of care that you expect and deserve from a professional medical practice.

Insured Patients

We will bill your insurance company for all known covered services rendered. Once you receive your first statement you are responsible to pay the balance within 30 days. If you are disputing payment with your insurance, you must notify our bookkeeping office or set-up a financial agreement.

Non-Insured Patients

A $200.00+ deposit is required for an appointment.

Auto Insurance

A $200.00+ deposit is required for an appointment. We will bill the auto insurance one time and, after 30 days of non-payment, the balance will become your responsibility. We do not deal with attorneys or wait for payment from a settlement. If the PIP exhausts on the auto insurance, we will bill your private insurance.

Bad Debt Accounts

Collections balance must be paid, in full, and a $200.00+ deposit must be paid to further treatment.

Internal bad debt must be paid prior to more appointments.

Durable Medical Equipment

Orthotic balances must be paid in full at orthotic pick-up. The office will provide you an estimate of these costs, and this is the balance due at pickup.

For orthotics not covered by insurance (cash pay,) payment in full is due at time of casting.

Surgery

Our office will preauthorize the procedure codes with your insurance company. Our office will also provide the patient with an estimate of the surgical fees. The estimated patient balance is due in full at the time of the pre-operative History and Physical appointment. In the event that the patient has a credit after insurance payment, a refund will be issued with 30 days. If there is a balance owed, payment is due within 30 days of the procedure date.

Most procedures have a 90 day global period. This means that postoperative office visits are included within the surgical fee for 90 days. I understand this does not include services or items such as x-rays, imaging studies, post-op shoe, crutches, and/or pneumatic walking boot. It also does not include removal of hardware in the office or in outpatient surgery.

Terms of Financial Policy

Payments are due within 30 days of receiving your statement. Accounts become delinquent after 60 days of non-payment. A $15.00 rebilling charge will be added on accounts 60 days and older. Failure to communicate with our billing department once accounts are delinquent may result in turning the account over to a collection agency.

Payment Methods

We accept personal checks, Visa, MasterCard, cash and money orders. If a check is returned a $40.00 fee will be added to your account and no further checks will be accepted.

____

Patient or Legal Guardian Signature

__________________________ ____________________

Witness (staff member) Date

NOTICE OF PRIVACY PRACTICES – ACKNOWLEGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our office here at Northwest Foot and Ankle Center, PS. Our Notice of Privacy Practices describes in further detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

____ ______________________

Patient or legally authorized individual signature Date Time

____ ______________________

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, ect.)

____ ______________________

Witness (staff member) Date Time

This form will be retained in your medical record.

Updated : 2/21/06