

**NORTHWEST FOOT AND ANKLE CENTER, PS**

**MARK T LEWIS, DPM    PETRINA C LEWIS, DPM**

**PATIENT INFORMATION**

NAME: (LAST) \_\_\_\_\_ (FIRST) \_\_\_\_\_ (MI) \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX:  MALE  FEMALE SS# \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

MARITAL STATUS:  S  M  W  D EMAIL ADDRESS: \_\_\_\_\_

PHONE #: \_\_\_\_\_ CELL #: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK #: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PHONE #: \_\_\_\_\_

<b>RESPONSIBLE PARTY:</b> _____ <b>RELATIONSHIP TO PATIENT:</b> _____ <b>SS#:</b> _____ <b>DATE OF BIRTH:</b> _____
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**INSURANCE INFORMATION**

IB     WC     AA     SELF PAY

**PRIMARY:**

INSURANCE CO: \_\_\_\_\_ PHONE # \_\_\_\_\_

SUSCRIBER NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

ID # \_\_\_\_\_ GROUP # \_\_\_\_\_ SS# \_\_\_\_\_

**SECONDARY:**

INSURANCE CO: \_\_\_\_\_ PHONE# \_\_\_\_\_

SUSCRIBER NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

ID # \_\_\_\_\_ GROUP # \_\_\_\_\_ SS# \_\_\_\_\_

**WORKERS COMP/AA:**

INSURANCE CO: \_\_\_\_\_ PHONE # \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_ CLAIMS MNGR \_\_\_\_\_

CLAIM #: \_\_\_\_\_ CLAIM OPEN Y N IF CLOSED DATE \_\_\_\_\_

WORK RELATED INJURY:  YES  NO

DATE OF INJURY: \_\_\_\_\_

AUTO ACCIDENT:  YES  NO

BODY PART: R/L \_\_\_\_\_

3<sup>RD</sup> PARTY ACCIDENT:  YES  NO

CAUSE: \_\_\_\_\_

OTHER INJURY:  YES  NO

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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 PHYSICIANS 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 RESPONSIBLE 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

TODAY'S DATE: \_\_\_\_\_ NAME: \_\_\_\_\_  
AGE: \_\_\_\_\_ SEX: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ SHOE SIZE: \_\_\_\_\_  
FAMILY PHYSICIAN: \_\_\_\_\_ PHONE #: \_\_\_\_\_  
REFERRING PHYSICIAN: \_\_\_\_\_ PHONE #: \_\_\_\_\_

**REFERRAL SOURCE:** PLEASE TELL US HOW YOU CHOSE US TO PROVIDE YOUR CARE:

- |  |   |
|--|---|
| <input type="checkbox"/> FRIEND OR FAMILY        | <input type="checkbox"/> REFERRAL FROM ANOTHER DOCTOR                                       |
| <input type="checkbox"/> YELLOW PAGES            | <input type="checkbox"/> SIGN ON STREET OR BUILDING   |
| <input type="checkbox"/> INSURANCE PROVIDER LIST | <input type="checkbox"/> <a href="http://WWW.NWFOOTANDANKLE.COM">WWW.NWFOOTANDANKLE.COM</a> |
| <input type="checkbox"/> DEX ONLINE              | <input type="checkbox"/> OTHER: _____   |

**PODIATRIC MEDICAL INFORMATION:**

DESCRIBE YOUR FOOT/ANKLE PROBLEM: \_\_\_\_\_

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? \_\_\_\_\_

**ARE YOU DIABETIC:** \_\_\_\_\_

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

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> ACID REFLUX        | <input type="checkbox"/> JOINT PAIN          | <input type="checkbox"/> HEART PROBLEMS  |
| <input type="checkbox"/> BLEED EASILY       | <input type="checkbox"/> LOW BACK PAIN       | <input type="checkbox"/> HEART BURN      |
| <input type="checkbox"/> BRUISE EASILY      | <input type="checkbox"/> NAUSEA              | <input type="checkbox"/> URINARY PROBLEM |
| <input type="checkbox"/> CHILLS             | <input type="checkbox"/> NON HEALING SORES   | <input type="checkbox"/> VOMITING        |
| <input type="checkbox"/> COUGH              | <input type="checkbox"/> RASHES              | <input type="checkbox"/> OTHER: _____    |
| <input type="checkbox"/> DEPRESSION         | <input type="checkbox"/> SCARRING TENDENCY   | _____                                    |
| <input type="checkbox"/> EMOTIONAL PROBLEMS | <input type="checkbox"/> SEIZURES            | _____                                    |
| <input type="checkbox"/> FEVER              | <input type="checkbox"/> SHORTNESS OF BREATH | _____                                    |
| <input type="checkbox"/> GOUT               | <input type="checkbox"/> STOMACH ULCERS      | _____                                    |

**PLEASE ANSWER THE FOLLOWING QUESTIONS: (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: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

**DO YOU:**

CONSUME ALCOHOL?  YES  NO HOW MUCH: \_\_\_\_\_ HOW OFTEN: \_\_\_\_\_

USE TOBACCO?  YES  NO HOW MANY PACKS PER DAY: \_\_\_\_\_ HOW MANY YRS: \_\_\_\_\_

COMMENTS: \_\_\_\_\_

**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**

To whom it may concern:

**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. We require 24 hour notice for all medications so *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.

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\_\_\_\_\_  
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 within 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.

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Patient or Legal Guardian Signature

---

Witness (staff member)

---

Date

## REQUEST FOR CONFIDENTIAL COMMUNICATIONS

**PATIENT NAME:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_

I request that all communications to me (by telephone, mail, email, or otherwise) by Northwest Foot and Ankle, PS and/or its staff be handled in the following manner:

\* For written communications:      Address to:  Home     Other  
If other than home please provide alternative address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\* For email communications:      Email to: \_\_\_\_\_

\* For oral communications:      Call: \_\_\_\_\_  
(Telephone number)

Is it okay to leave a message on a machine or with a family member at this number regarding prescriptions, appointments or test results?

YES

NO

Is it okay to disclose your Patient Health Information to other physicians other than my immediate physician to include but not restricted to my Primary Care Physician and any Referral Physicians deemed to be instrumental in my care?

YES

NO (Except as necessary for insurance reimbursement.)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness (staff signature)

## NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

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