NORTHWEST FOOT AND ANKLE CENTER, PS

MARK T LEWIS, DPM PETRINA C LEWIS, DPM
JEREMY D CROSS, DPM ALI L CROSS, 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	DATE OF INJURY:_____
AUTO ACCIDENT:	□ YES	□ NO	BODY PART: R/L_____
3RD PARTY ACCIDENT:	□ YES	□ NO	HOW DID INJURY OCCUR:_____
OTHER INJURY:	□ YES	□ NO	_____

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?

◊ YES ◊ NO

May we use your cell phone number to text appointment reminders, orthotic recalls, Holiday and other closures, and general office service information?

◊ 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:_____

Medical History

NAME:_____HEIGHT:_____WEIGHT:_____SHOE SIZE:_____
OCCUPATION: _____

FAMILY PHYSICIAN: _____PHONE# :_____
REFERRING PHYSICIAN: _____PHONE# :_____

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

- □ FRIEND OR FAMILY
- □ YELLOW PAGES
- □ INSURANCE PROVIDER LIST
- □ DEX ONLINE
- □ REFERRAL FROM ANOTHER DOCTOR
- □ SIGN ON STREET OR BUILDING
- □ WWW.NWFOOTANDANKLE.COM
- □ 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
- □ BLEED EASILY
- □ BRUISE EASILY
- □ CHILLS
- □ COUGH
- □ DEPRESSION
- □ EMOTIONAL PROBLEMS
- □ FEVER
- □ GOUT
- □ JOINT PAIN
- □ LOW BACK PAIN
- □ NAUSEA
- □ NON HEALING SORES
- □ RASHES
- □ SCARRING TENDENCY
- □ SEIZURES
- □ SHORTNESS OF BREATH
- □ HEART PROBLEMS
- □ HEART BURN
- □ URINARY PROBLEM
- □ VOMITING
- □ OTHER: _____
- _____
- _____
- _____

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 ANY MAJOR 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**

Patient Responsibility

Thank you for choosing Northwest Foot and Ankle Center, PS as your health care provider. We are committed to the successful treatment of your condition. Please understand that payment of your bill is considered part of your treatment. Should you have any questions regarding any aspect of your financial status with our office, please feel free to contact our Billing Supervisor Matt at (425) 277-3668.

PUNCTUALITY IS APPRECIATED BY OUR OFFICE. IF YOU ARE MORE THEN FIFTEEN MINUTES LATE TO YOUR APPOINTMENT THEN IT MAY BE NECESSARY TO RESCHEDULE TO ANOTHER DAY.

PRESCRIPTIONS WILL NOT BE REILLED AFTER 4:00PM OR ON WEEKENDS, EXCEPT FOR EMERGENCY CASES. FOR MEDICATION REFILLS, PLEASE CALL YOUR PHARMACY 48 HOURS IN ADVANCE TO HAVE THE REFILL REQUEST FAXED TO OUR OFFICE FOR APPROVAL. IF YOUR MEDICATION IS IN THE NARCOTIC FAMILY, IT WILL REQUIRE A PHYSICAL PRESCRIPTION AND MUST BE REQUESTED 48 HOURS IN ADVANCE.

5 BUSINESS DAYS NOTICE IS REQUIRED FOR COPIES OF MEDICAL RECORDS OR X-RAYS AND THERE MAY BE A NOMINAL FEE.

Self Pay: We expect payment at the time of service unless prior arrangements have been made.

Patients with Insurance – We will file your insurance claim for you. However, in order to work with your insurance company, we must have complete and current information as well as a copy of your insurance card and your signature on file.

Denied Claims – You will be responsible for any charges that are denied by your insurance company which result from your failure to provide our office with complete and current information in a timely manner. It is your responsibility to inform us of any changes in insurance benefits.

Referrals– If your insurance requires that you obtain a referral from your Primary Care Physician; it is your responsibility to ensure that our office receives the referral prior to your visit. If a referral is not in place, you will be responsible to pay in full at the time of service. Although we do our best to check for you, it is ultimately the responsibility of the patient.

Workers' Compensation: If you are here because of a work related injury, we will require information regarding both health insurance and your employer's Workers' Compensation insurance. If payment is not received from these third parties within 90 days, we have the right to bill you directly.

_____

Patient or Legal Guardian Signature

_____ _____

Witness (staff member) Date

Financial Agreement

Payment due at time of service

Self-pay patients – Payment in full is due at the time of service.

Durable Medical Equipment– Our office will assist in determining coverage for Durable Medical Equipment (braces, splints, boots, walkers, and/or orthotics as needed. This means any and all procedures, treatments and care will be billed to you and your insurance. This does not guarantee payment by your insurance company. Any item not covered by insurance is deemed "patient responsibility."

Insurance benefits – It is your responsibility to know your insurance benefits. Please contact your insurance company with any questions that you may have regarding coverage of podiatric services.

Copayments, Co-Insurances and Deductibles – All patient balances are due at the time of service. Patients with private insurance plans (non-Medicare/Medicaid) that include deductibles will need to pay at the time of service. If copays are required by your plan, payment at time of service will also be due. Northwest Foot and Ankle Center, PS reserves the right to refuse treatment if required payments are not made at the time of service. For your convenience, all major credit cards are accepted.

Non-Covered Charges – Please understand there may be some charges for our services which your insurance company considers non-covered and may be excluded from your policy. Accordingly, you will be responsible for these charges.

Returned checks – Any returned check is subject up to a $45.00 bank fee.

Past due accounts – We will send a statement to the mailing address you provide notifying you of any outstanding balances. If you do not respond to the first statement within 30 days of receipt and additional statements are mailed, a $10 re-billing fee will be added each month. If you are not able to pay your balance in full, you must contact out billing office to discuss a possible payment plan. If you then fail to make payments, your account may be referred to a professional collection agency and/or attorney and will be subject to a 35% fee.

Payment Methods – We accept personal checks, Visa, MasterCard, American Express, Discover, ApplePay, cash, and money orders.

_____

Patient or Legal Guardian Signature

_____ _____

Witness (staff member) Date

HIPAA Privacy 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 : 06/26/2019