PATIENT REGISTRATION Today's Date_____

Patient Information

First Name_____ Middle Initial_____ Last Name_____

Date of Birth_____

Street Address_____ City, State, Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Marital Status_____ Student? (Please Circle) Yes / No Employed? (Please Circle) Yes / No)

How did you hear about us (phone book, doctor, friend, etc.)?_____

Physician Information

Primary Care Physician Name_____ Date Last Seen_____

Physician Address_____ City, State, Zip_____

Phone Number_____

Referring Physician Name_____

Physician Address_____ City, State, Zip_____

Phone Number_____

Insurance Information

Primary Insurance Name_____ Subscriber Number_____ Group#_____

Primary Card Holder's Name_____ Relationship to Patient_____

Street Address_____ City, State, Zip_____

Date of Birth_____

Employer Name_____ Occupation_____

Employer Address_____ City, State, Zip_____

Secondary Insurance Name_____ Subscriber Number_____ Group#_____

Please Submit Copy of Insurance

Past Medical History

Family History **Personal History**

(mark all that apply)

- □ Anemia
- □ Anesthesia problems
- □ □ Arthritis
- □ □ Bleeding problems
- □ □ Chemical Dependency
- □ □ Chest pain
- □ □ Cancer

  Type:_____
- □ Artifical Heart Valve Or Joint
- □ □ Asthma
- □ Back Problems
- □ □ Circulatory problems
- □ □ Diabetes
- □ Difficulty Healing
- □ Epilepsy
- □ Fibromyalgia
- □ □ Gout
- □ □ Heart disease/Murmur
- □ Hepatitis
- □ □ High Blood Pressure
- □ High Cholestrol
- □ HIV Positive
- □ □ Kidney Problems
- □ Leg Cramps
- □ □ Liver disease
- □ □ Lung/Respiratory Problems
- □ Menopause
- □ □ Mental Illness
- □ □ Phlebitis/Blood clots
- □ □ Psoraisis
- □ Rheumatic Fever
- □ □ Sickle trait/Disease
- □ □ Stroke
- □ Thyroid problems
- □ Tuberculosis
- □ □ Stomach Ulcers
- □ Venereal Disease
- □ Weight Change

  +/-_____lbs
- □ Pregnant?

  □ yes □ no

Past Surgical History

List any surgeries:

_____Year:___

_____Year:___

_____Year:___

_____Year____

Social History

Occupation:

_____

_

□Married □ Single

□Divorce □Widow(er)

# of _____ children

□Smoker

□ yes □ no

Packs per week_____

Number of years____

□Alcohol beverages

□ yes □ no

Amount per week_____

□ Recreational Drugs

□ yes □ no

What?_____

General

Height:_____

Weight:_____

Shoe size:_____

Medications

include doses and how many times per day

1._____

2._____

3._____

4. _____

5. _____

6. _____

7._____

Allergies

- □ No known drug allergies
- □ Adhesive Tape
- □ Sulfa
- □Codeine/Demerol/Morphine
- □ Aspirin
- □ Anticoagulation Therapy
- □ Iodine
- □ Local Anesthetics (ex: Novacaine)
- □ Latex
- □ Seafood
- □ Penicillin
- □ Food:(types)_____
- □ Bee Stings
- □ Other_____

Anything you would like to add?

_____

_____

_____

_____

____

Lower Extremity Medical History:

What is your chief concern that brings you to the office?

_____

_____

Former foot and ankle physician?: Yes No Name:_____

Last Visit date:_____

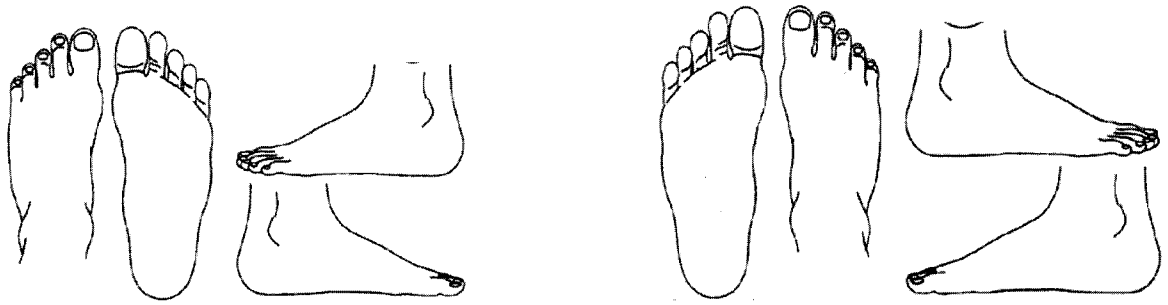
Symptoms: ***(circle all that apply)***

Which side: Right Left Both

Type of discomfort: Dull Achy Throbbing Burning Sharp Shooting

Area of discomfort :

(place a mark where you have symptoms)



LEFT **RIGHT**

(circle all that apply)

Onset of symptoms? Slow Sudden Traumatic

Durations? ___ Days Weeks Months Years

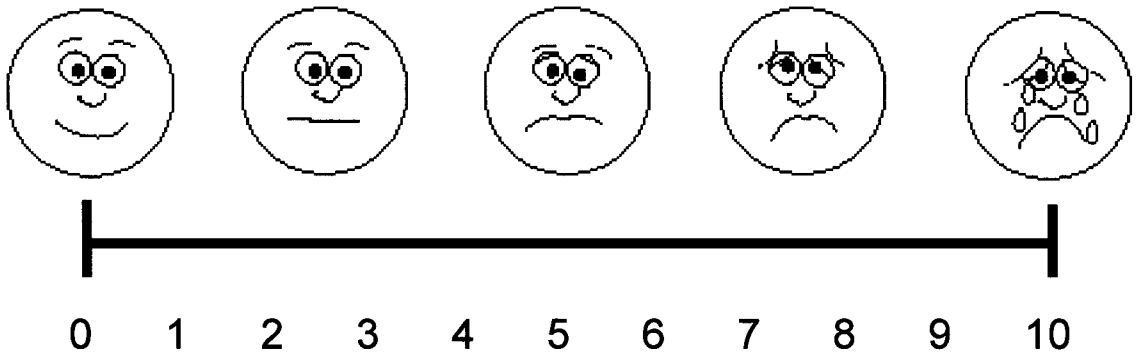
Have symptoms gotten? Better Worse Stayed the Same

What aggravates the symptoms? Walking Running Standing Shoes

What decreases the symptoms? Medication Decrease activity Other_____

Pain Scale

(Indicate on the line where you would rate your worst discomfort)



AUTHORIZATION FOR RELEASE OF INFORMATION AND INSURANCE ASSIGNMENT

I authorize payment directly to Premier Ankle & Foot Specialists PC of any or all insurance benefits otherwise payable to me up to the amount of my bill. I assign the benefits payable for physician services to the physician or organization providing physician services,

I authorize and holder of medical or other information about me to release to my insurer or its intermediaries any information needed for this or a related insurance company.

PATIENT'S SIGNATURE _____DATE_____

MEDICARE AUTHORIZATION

I certify that the information given by me in applying for payment under title XVII of the Social Security Act is correct.

I request that payment of authorized benefits be made on my behalf for any services furnished to me by for physician services. I assign the benefits payable for physician services to the physician or organization furnishing the services such physicians or organization to submit a claim to Medicare for payment for me.

I authorize any holder of medical or other information about me to release to the Health Care Financial. Administration or its intermediaries or carriers any information needed or this or a related Medicare Claim.

PATIENT'S SIGNATURE_____ DATE_____

MEDICAID AUTHORIZATION

1certify that the information given by me is true, correct, and accurate. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment or material facts may be prosecuted under applicable Federal and State Laws.

PATIENT'S SIGNATURE _____DATE_____

WITNESS _____DATE _____

Receipt of Notice of Privacy Practices Written Acknowledgement.

Premier Ankle & Foot Specialists PC is required to provide a notice that describes how medical information about you may be used and disclosed and how to get access to this information. Patient consents to possible audio recording office visit.

Please sign below to indicate you have received or declined to receive this Notice of Privacy Practices.

☐ I have received a copy of Premier Ankle & Foot Specialists PC, Notice of Privacy

☐ I declined a copy of Premier Ankle & Foot Specialists PC, Notice of Privacy

Patient's or Legal Guardian Signature_____

FINANCIAL POLICY

Welcome To Our Office

Thank you for choosing us as your podiatric physicians. We are committed to your treatment being successful, as you, the patient, are our first and foremost concern. As part of our service, we try to contain the cost of health care. In an effort to do this, we have implemented a Financial Policy. The following is a statement of our **FINANCIAL POLICY** which we request you read and sign prior to any treatment. To avoid any misunderstandings, please contact us should you have any questions about our policies.

INSURANCE: If your doctor is a participating provider with your insurance plan, we will submit the claim to your insurance company. To do this we must have *complete and accurate* insurance information and a copy of your identification card or claim form. Your insurance policy is a contract between you and your insurance company; therefore you are responsible for payment whether or not your insurance company pays. **It is your responsibility to contact your insurance company regarding *preauthorizations, obtaining required referrals, second opinions, etc.*** Failure to do so may reduce the amount of benefits paid by your insurance, and the balance will then become your responsibility to pay. All co-payments must be paid at the time of service.

NO INSURANCE: If you do not have insurance or the doctor is not a participating provider with your insurance plan, please be prepared to fully cover the fees for each visit at the time of treatment.

PAYMENT: Payments for the balance due, co-payments, deductibles, etc., are due at the time of service and may be made by *cash, or check* There will be a $25.00 charge for *returned checks.*
Delinquent accounts will be referred for collection at the discretion of the office manager.

CO-PAYMENTS: Please be prepared to pay all co-payments at the time of service. We do not send bills out for co-payments, so your visit will have to be re-scheduled if you are not prepared to pay the co-payment.

DEDUCTIBLES: If you have an annual deductible which has not yet been paid in full then any charges incurred up to that amount are due at the time of your visit.

MINOR PATIENTS: The adult or the parent (custodial guardian) accompanying a minor is responsible for payment of services. For unaccompanied minors, non-emergency treatment will be denied unless prior authorization from the parent or guardian has been made for the charges and treatment. Young adults (age 18 & over) are legally responsible for their accounts unless a parent accompanies them to the initial appointment and signs this financial agreement, regardless of insurance coverage.

MISSED APPOINTMENTS: Please help us serve you better by keeping scheduled appointments. If it is necessary to cancel, please call our office 24 hours in advance. This allows us to accommodate our other patients. We reserve the right to charge for missed appointments.

ORTHOTICS: Orthotics are a non-covered service by some insurance plans. Please check with your insurance company *prior* to the examination and casting for orthotics to determine your orthotic benefits. A deposit of $150.00 is requested at the time of the examination and casting and full payment is due when the orthotics are dispensed.

SUPPLIES: For your convenience we make some supplies available for purchase in the office. If you choose to purchase these items, payment is due at time of purchase. We cannot bill for these items. In addition, we contract with outside suppliers to provide some supplies through our office. If any of these supplies are used for your treatment you or your insurance will be billed for these supplies by the outside provider. The Foot and Ankle Center of Washington has no part in billing for these supplies.

Please complete the following items:

What is your co-payment per visit? $_____

What is your insurance annual deductible? $ _____

How much of the deductible is currently not yet paid?: $_____
(if you are not sure what your current (not yet paid) deductible is, please call your insurance company prior to your visit.)
Please be prepared to pay your co-payment and any charges within your current deductible at the time of your visit

I have read and agree to the terms set forth in the above financial policy. I am financially responsible for any balance due.
SIGNED_____ DATE_____