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Vancouver, WA 98683
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www.ankleandfootphysicians.com

ANKLE AND FOOT
PHYSICIANS AND SURGEONS

Patient Information

First Name _____ Middle Initial ___ Last Name _____ Suffix ____

Date of Birth _____ Gender ☐ M ☐ F SSN# ____-____-____

Address _____ City _____ State _____ Zip Code _____

Phone Number (____) _____ Cell Number (____) _____

Preferred Language ☐ English ☐ Other _____ Race (Optional) _____ Hispanic/Latino? ☐ Yes ☐ No

Insurance and Other Coverage Information

Primary Insurer _____

ID/Policy Number _____

Group Number _____

Name of Policy Holder _____

Date of Birth of Policy Holder _____

Relationship to Patient _____

Secondary Insurer _____

ID/Policy Number _____

Group Number _____

Name of Policy Holder _____

Date of Birth of Policy Holder _____

Relationship to Patient _____

Is this an injury related to: ☐ Work ☐ Auto ☐ Other _____ If Yes, Date/Time of Injury _____

Claim Manager/Legal Representative Contact Information _____

Pediatrician/Primary Care and Referral Information

Primary Care Provider _____ Whom may we thank for your Referral? ☐ PCP ☐ Other _____

Preferred Pharmacy

Pharmacy Name _____ Address or Cross Streets _____ ☐ None

Parental Employment Information

Employer _____ Job Title _____

Address _____ City _____ State _____ Zip Code _____

Phone Number (____) _____ ☐ Employed ☐ Student ☐ Retired ☐ Unemployed ☐ Other _____

Emergency Contact

Name _____ Relationship to Patient _____ Phone Number (____) _____

_____ _____

Signature of Parent/Patient Representative Date

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SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding the attached Notice of Privacy Practices

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information

We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization

Except as stated in more detail in the ***Notice of Privacy Practices***, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization

In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights

As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

In addition, I request the following restrictions regarding my child's Protected Health Information be placed on this account:

_____

_____ _____

Signature Date

_____ _____

Patient Name OR Other Authorized Representative Relationship to Patient

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Patient Financial Policy and Assignment of Benefits

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- Unless other arrangements are made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We accept Visa, MasterCard, Discover, American Express, cash, or check.
- As our patient, you are responsible for authorizations/referrals necessary for treatment. You must inform the office of insurance changes and authorization/referral requirements and, if necessary, present authorization at the time of visit; if the practice is not informed, you will be responsible for any charges denied.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim if you assign the benefits (in other words, the direct payment) to Ankle and Foot Physicians and Surgeons, PLLC or the physician individually, for services rendered to yourself or your dependent(s) by the physician or under his/her direction. If your insurance company does not pay in a reasonable time frame, we will have to look to you for payment.
- We have contracts with many insurers/health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible.
- If we are not contracted with your insurance plan, we will prepare and send the claim for you on an unassigned basis; your insurer may send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- Some services, imaging, procedures, and/or durable medical goods may have a co-pay/co-insurance/deductible separate from office visits or in some instances may not be covered by your particular medical plan. In either instance, these are separately billable and payable by you, the insured.
- It is necessary in the submission of health insurance claims to send certain personal information and/or parts of the non-public patient record. You consent to the release of your or your dependent(s) record(s) for this purpose.
- Worker's Compensation/Labor and Industries claims must be brought to the attention of the staff at the time of scheduling. If you have not yet filed your claim, you may file in office. You must provide a secondary form of payment in the event your claim is denied; if claim is denied, the balance of all professional services rendered is payable in full, by you. Worker's compensation claims cannot be billed to a private insurer unless the claim has been denied, does not exists, or has been closed.
- If you are being treated for injuries resulting from a Motor Vehicle Accidents (MVA), the claim must be submitted to your Motor Vehicle (PIP) Carrier and cannot be billed to a private insurance plan unless the PIP claim has been denied, coverage does not exist, or private insurance was selected as primary carrier. You are responsible for any deductibles and/or co-payments under your PIP coverage. You also agree, to have a lien placed against any settlement that you may receive due to an MVA clAIM for which you are treated by PIP coverage, to pay any open/unpaid balances due to Ankle and Foot Physicians and Surgeons, PLLC or her physicians.
- All health plans are not the same and do not cover the same or all services. If your insurer determines a service or item to be "non-covered," for any reason, you are responsible for the charges and may be requested to pay in full at time of service. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges for any service rendered. Patients are encouraged to contact their plans for clarification of benefits.
- Hospital and outpatient surgery services are billed to the insurer. Any balance due is your responsibility.
- Certain elective surgical procedures may require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Accounts more than 90 days past due will be considered for transfer to collections. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due.
- There is a service fee of $50.00 for all returned checks. Your insurance company does not cover this fee.
- We understand emergencies occur, however, repeated no-shows or cancellations with less than 24 hour notice are subject to a $50 no-show/late cancellation fee; this is not covered by your insurer. Patients who arrive more than 10 minutes late for their appointment may be asked to reschedule.

_____	_____	_____	_____
Signature	**Printed Name**	**Relationship (if not Patient)**	**Date**

Updated 2017.01.21

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Consents and Acknowledgements

Consent to Release of Information

In order to facilitate and coordinate treatment and to conduct business including insurance benefit payment, we must release certain health information to other providers and insurers.

- As our patient, you hereby authorize Ankle and Foot Physicians and Surgeons, PLLC, and her physicians individually, to release your, or your dependent(s) medical and incidental non-public personal information that may be necessary for medical treatment, evaluation, consultation, or the processing of insurance benefits.

Consent to Communication

Ankle and Foot Physicians and Surgeons, PLLC will routinely use mail, telephone calls and/or messages in the delivery of care to relay appointment and/or healthcare reminders, updates on referral arrangements, and the receipt of laboratory results, unless otherwise requested.

- You have the right to limit the methods of communication that originate from our office. If you have restrictions that you would like to place on your account, we will be more than happy to place those. If at any time you wish to rescind this authorization, you may do so by notifying Ankle and Foot Physicians and Surgeons, PLLC in writing of the changes that you wish to make.
- If you elect to use email as a method of communication with the office, you certify that you understand the risks and we will require a separate authorization. Email should never be used for time sensitive matters.

Consent to Treatment

- You hereby consent to the evaluation, testing, and treatment(s) as directed by Ankle and Foot Physicians and Surgeons, PLLC and her physician(s) and/or designee(s).

Consent to Photography

- As our patient, photographs, video, or other images (digital or analog) may be employed to document your care, and your signature below indicates your consent to this. Your signature indicates that you understand that Ankle and Foot Physicians and Surgeons, PLLC will retain ownership rights to these photographs, videotapes, digital, or other images, but that that you will be allowed access to view them or obtain copies. You understand that these images will be stored in a secure manner that will protect your privacy and that they will be kept for the time period required by law or per policy of Ankle and Foot Physicians and Surgeons, PLLC.

Fees for Additional Reports, Forms, Records, Etc.

- Requests for completion of disability forms, reports, or other paperwork may require a fee, payable in advance, related to the amount of preparation involved. Please allow 5-7 business days for completion of any disability forms.
  If the necessary disability forms are related to either a non-elective or elective surgery, your surgeon may elect to complete these forms at no fee, but they will not be completed prior to the preoperative examination date. Forms will be completed and available prior to your scheduled surgery day.
- Radiographs performed in our office are an integral part of your medical record. Fees for digital copies of your films, advanced imaging, or copies of outside studies (i.e. on CD-ROM) will be charged based on guidelines as set forth by the Washington State Department of Health. For the current price list, contact the front office staff.
- Medical records requests will be processed within 5-7 business days of the request and fees for records processing are based on guidelines as set forth by the Washington State Department of Health. For the current price list, contact the front office staff.

Notice of Privacy Practices

- I certify that I have been given or have been offered and/or read (and understood) the HIPAA Notice of Privacy Practices that is available from Ankle and Foot Physicians and Surgeons.

_____	_____	_____	_____
Signature	**Printed Name**	**Relationship (if not Patient)**	**Date**

FOR OFFICE USE ONLY

PATIENT ID	DME ALERT ☐
PCP	REFERRING

Patient Name _____

Date of Birth _____

Visit Information

Why is the child seeing the doctor today? _____

When did this problem begin? _____

Is this an injury due to an accident? ☐ Yes ☐ No **If yes:** Date and Time of Injury _____ ☐ School ☐ Auto ☐ Other _____

Does the child have pain? ☐ Yes ☐ No **If yes:** does it vary? ☐ Yes ☐ No Does it radiate? ☐ Yes ☐ No Where? _____

What causes or aggravates the pain? _____ What have you tried for pain relief? _____

What works best to relieve the pain? _____ Additional Factors _____

Birth and Post Natal History

Biological Status ☐ Birth ☐ Adoption ☐ Stepchild ☐ Other _____

Were there any pregnancy complications? ☐ Yes ☐ No If yes, describe _____

Was the child born term? ☐ Yes ☐ No If no, why and at what week of gestation was birth? _____

How was the child born? ☐ Vaginal ☐ C-Section If C-section, why? _____

Presentation: ☐ Normal/Fetal ☐ Breech Birth Weight/Length _____ APGAR Score _____

Birth complications? ☐ Yes ☐ No If yes, describe _____

Is the child a multiple? (i.e. twins, triplets, etc)? ☐ Yes ☐ No If Yes, Type _____

How many siblings does the child have? _____ What order is the child in sibship (i.e. oldest, youngest, 3/5)? _____

Did any sibling(s) have birth issues (i.e. abnormal presentation, prematurity, etc)? _____

When did the child reach the following milestones (approximate age)?

Head Control _____ Rolling Over _____ Sitting _____ Crawling _____ Standing _____ Walking _____

Past Medical History

Does the child have OR has the child ever had any of the following:

Constitutional/General
- ☐ Cancer
  - Type _____
- ☐ Unexplained
  - ☐ Fever ☐ Chills
  - ☐ Night sweats
  - ☐ Weight Loss
- ☐ Chronic Illness
- ☐ Tires Easily

Cardiovascular
- ☐ Blood clots/DVT
- ☐ Edema
- ☐ High Blood Pressure/HTN
- ☐ High Cholesterol
- ☐ Irregular heart beat
- ☐ Rheumatic fever
- ☐ Valve problems of heart

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Chronic Cough
- ☐ COPD

Gastrointestinal
- ☐ Eating Disorders
- ☐ Cholecystitis
- ☐ Hernia
- ☐ IBS

Genito-Urinary
- ☐ Bladder or kidney stones
- ☐ Infection/UTIs
- ☐ Kidney disease
- ☐ History of Pregnancy

Endocrine
- ☐ Cushing's OR Addison's
- ☐ Diabetes
- ☐ Hyperthyroidism
- ☐ Hypothyroidism

Hematologic Disease
- ☐ Anemia
  - Type _____
- ☐ Easy bruising/bleeding
- ☐ Leukemia
  - Type _____
- ☐ Sickle Cell Disease or Trait

Infectious Diseases
- ☐ Hepatitis
  - Type _____
- ☐ HIV/AIDS
- ☐ Tuberculosis/TB

Liver
- ☐ Jaundice

Musculoskeletal
- ☐ Arthritis
  - Type _____
- ☐ Fracture(s)
  - Location(s) _____
- ☐ Limb or Joint Deformity
  - Describe _____
- ☐ Limb or Joint Pain
  - Describe _____
- ☐ Muscular dystrophy
  - Type _____
- ☐ Muscular sclerosis
- ☐ Paralysis

Special Senses
- ☐ Double/blurred vision
- ☐ Contacts ☐ Glasses
- ☐ Ear Infections
- ☐ Hearing deficit/loss
  - ☐ Hearing aids
- ☐ Speech Problems
- ☐ Strabismus/Lazy Eye

Nervous system
- ☐ Anxiety
- ☐ Autism
- ☐ Charcot Marie Tooth
- ☐ Convulsions/epilepsy
- ☐ Depression
- ☐ Fainting
- ☐ Inherited Neural Disorder
  - Type _____
- ☐ Migraines

Skin
- ☐ Birth Marks
- ☐ Rashes

☐ **Other** _____

Medications

Please note: Include prescription, over the counter, vitamins and supplements. You may also submit a current medication list.

Medication	Dosage	Frequency	Medication	Dosage	Frequency

Allergies

Please indicate **all** allergies, including those to medication and food.

☐ **No Known Drug Allergies**

Medication	Reaction	Medication	Reaction

Food allergies	☐ **NONE**	**Environmental/Other allergies**	☐ **NONE**
☐ Eggs	☐ Nuts	☐ Adhesives	☐ Band Aids/Tape
☐ Guava	☐ Seafood/Shellfish	☐ Anesthetics	☐ Gloves
☐ Kiwi	☐ Other _____	Type _____	☐ Other _____
☐ Peaches	_____	☐ Latex	_____

Surgical and Hospitalization History

Surgeries (please include type AND year) _____

Any complications due to anesthesia? ☐ Yes ☐ No Describe _____

Hospitalizations (please include reason AND year) _____

Social and Immunization History

School Child is enrolled at _____ ☐ Home Schooled Grade Level _____

Does the child have issues related to: ☐ Learning ☐ School ☐ Behavioral ☐ Social issues ☐ Other _____

Child's Interests (hobbies, sports, etc) _____

Do any of the child's care-takers smoke or use tobacco? ☐ Yes ☐ No Whom? _____

Child's parents are: ☐ Married ☐ Separated ☐ Divorced ☐ Deceased ☐ Other _____

Are child's immunizations (tetanus, diphtheria, pertussis, etc) current? ☐ Yes ☐ No

If yes: When was child's last Tdap booster? _____ When was child's last MMR booster? _____

Has child received the:
Most recent flu shot? ☐ Yes ☐ No
Pneumonia vaccine? ☐ Yes ☐ No
Hepatitis B vaccine? ☐ Yes ☐ No
Other elective vaccines? ☐ Yes ☐ No

Family History

Please indicate known medical history of first degree relatives (e.g. diabetes, heart disease, glaucoma, amputation, kidney dx, etc).

	Age (or Age at Death)	Diseases
Mother		
Father		
Siblings		
Maternal Grandparents		
Paternal Grandparents		
Aunts		
Uncles		

_____ _____

Signature of Parent/Patient Representative Date

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Non-Parental Authorization for Consent to Medical/Surgical Care and Treatment

I, _____, parent/legal guardian of the child(ren) listed below do hereby give my authorization and consent for the below named authorized person(s) to consent to the medical/surgical care and treatment of my child(ren). I hereby authorize and grant that the below named person(s) has/have permission from the natural parents to sign for any medical/surgical procedures or treatments deemed necessary for the well-being of my child(ren). I am, by this document, representing that I have the authority to consent for all medical/surgical care and treatment of said child(ren):

Child(ren):

Name	Age	Name	Age
Name	Age	Name	Age

Person(s) who are authorized to consent for medical care/procedures for the child(ren) listed above:

Name	Relationship to Child(ren)	Name	Relationship to Child(ren)
Name	Relationship to Child(ren)	Name	Relationship to Child(ren)

Signature of Parent/Guardian _____ Relationship to the child(ren) _____ Date _____

Printed Name _____