INTEGRATIVE FOOT & ANKLE CENTERS OF WASHINGTON

PH: 425-822-7426 F: 425-827-1717

NAME (PRINT LEGAL NAME)**:** _____ ☐ **MALE** ☐ **FEMALE**
LAST NAME FIRST NAME M.I.

DOB: _____ / _____ / _____ **AGE:** _____ **SSN:** _____ **EMAIL:** _____

ADDRESS: _____ **APT #:** _____
STREET/PO BOX CITY STATE ZIPCODE

☐ **HIPPA PHONE AUTHORIZATION:** I AUTHORIZE INTEGRATIVE FOOT & ANKLE CENTERS OF WASHINGTON TO LEAVE MESSAGES ON MY VOICEMAILS IN REGARDS TO INFORMATION REGARDING APPOINTMENTS, TREATMENT RELATED ISSUES AND BILLING ISSUES.

HOME #: _____ **CELL #:** _____ **ATL #:** _____

HIPPA Phone Authorization Other than patient: This authorization will remain in effect until you choose to revoke it in writing. I authorize, IFAC of WA to leave a message for, or speak to the specified individual listed below in regards to information regarding appointments, treatment related issues and billing issues: (this person must provide us with your birth date)

☐ At my home number _____ with (name/relationship) _____
☐ At another number _____ with (name/relationship) _____

☐ **BY CHECKING THIS BOX I CONSENT TO RECEIVE TEXT/EMAIL APPOINMENT REMINDERS AND SPECIALS**. I UNDERSTAND THAT TEXT MESSAGES/EMAILS ARE NOT CONFIDENTIAL METHODS OF COMMUNICATION AND MAY BE INSECURE. I FURTHER UNDERSTAND THAT THER IS A RISK THE TEXT MESSAGING/EMAILS MIGHT BE INTERCEPTED AND READ BY A THIRD PARTY.

PRIMARY PHYSICIAN NAME: _____ **PHONE #:** _____

PHARMACY NAME: _____ **PHONE #:** _____

EMERGENCY CONTACT: _____

RELATIONSHIP: _____ PHONE #: _____ ALT. #: _____

INSURANCE INFORMATION: ☐ SELF PAY ☐ INSURANCE ☐ MEDICARE ☐ DSHS ☐ L&I ☐ AUTO ☐ OTHER

PRIMARY INSURANCE CO. _____ PHONE #: _____

ID #: _____ GROUP #: _____

INSURED'S NAME: _____ INSURED DOB: _____ RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE CO. _____ PHONE #: _____

ID #: _____ GROUP #: _____

INSURED'S NAME: _____ INSURED DOB: _____ RELATIONSHIP TO PATIENT: _____

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO THE PHYSICIAN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE. I ALSO AUTHORIZE INTEGRATIVE FOOT & ANKLE CENTERS OF WA OR INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIMS.

PATIENT SIGNATURE (OR PARENT/GUARDIAN)**:** _____ **DATE:** _____

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NAME: _____ WEIGHT: _____ HEIGHT: _____ SHOE SIZE: _____

REASON FOR TODAY'S VISIT: _____

HAVE YOU EVER BEEN TO A PODIATRIST BEFORE? IF SO, PLEASE LIST NAME AND LAST VISIT: _____

_____

IS THIS RELATED TO AN INJURY? _____ DATE OF INJURY: _____

DO YOU HAVE OR HAVE YOU EVER BEEN TREATED FOR THE FOLLOWING (CHECK ALL THAT APPLY):

☐ ACID REFLUX	☐ EMPHYSEMA	☐ HIV/AIDS	☐ RESPIRATORY DISEASE
☐ ANEMIA	☐ FAINTING SPELLS	☐ KIDNEY DISEASE	☐ RHEUMATIC FEVER
☐ ARTHRITIS	☐ FOOT/LEG CRAMPS	☐ LIVER DISEASE	☐ STROKE
☐ ASTHMA	☐ FREQUENT INFECTIONS	☐ LOWER BLOOD PRESSURE	☐ TUBERCULOSIS
☐ BACK PROBLEMS	☐ GOUT	☐ NERVE PROBLEMS	☐ ULCERS
☐ BLEEDING DISORDERS	☐ HEADACHES	☐ NUMBNESS	☐ VARICOSE VEINS
☐ CANCER _____	☐ HEART ATTACK	☐ OSTEOPOROSIS	☐ VASCULAR DISEASE
☐ CHEMICAL DEPENDENCY	☐ HEART DISEASE	☐ PACE MAKER	☐ WEIGHT LOSS/GAIN
☐ CIRCULATORY PROBLEMS	☐ HEPATITIS	☐ PARKINSONS DISEASE	☐ OTHER _____
☐ DIABETES _____	☐ HIGH BLOOD PRESSURE	☐ PHLEBITIS	☐ NONE OF THESE

☐ NEVER SMOKER ☐ SMOKER: _____ PACK/DAY YEARS SMOKED? _____ ☐ ALCOHOL: _____ PER WEEK
☐ FORMER SMOKER

FAMILY MEDICAL HISTORY

☐ DIABETES ☐ HIGH BLOOD PRESSURE ☐ OTHER _____

PRIOR SURGERIES

_____

_____

MEDICATIONS (PLEASE INCLUDE DOSAGE)

_____

_____

_____

ALLERGIES ☐ NO KNOWN DRUG ALLERGIES

☐ ASPIRIN ☐ CODEINE ☐ IODINE ☐ LOCAL ANESTHETICS ☐ NOVOCAIN ☐ PENICILLIN ☐ SULFA ☐ TAPES/ADHESIVES

☐ FOOD: _____ OTHER: _____

SIGNATURE (OR PARENT/GUARDIAN): _____ **DATE**: _____

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PRIVACY AND CONSENT INFORMATION

This consent form is required by the Health Insurance Portability and Accountability act of 1996 (HIPAA) which requires us by law to inform you of your rights for privacy with respect to the disclosure of your health care information.

I hereby give my consent to Integrative Foot and Ankle Centers of Washington to use and disclose my protected health information for the purpose of treatment, payment and operations of my health care and this practice.

Consent for treatment: I authorize Integrative Foot and Ankle Centers of Washington and any employee working under the direction of my physician to provide medical care for me or to the patient, which I am legally responsible for. This medical care may include services and supplies related to my health (or the identified person) and may include (but not be limited to) preventive, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical and mental status/function of the body and the sale or dispensing of drugs, devices, or other items required in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

Consent for the Release of Information for Payment and Operations: I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the Privacy Practice Notice.

Consent Related to the Privacy Notice: I have had an opportunity to review the Privacy Practice Notice as part of this registration process. I understand that the terms of the Privacy Practice Notice may change and I may obtain these revised notices at any time by contacting them by phone, fax, email, or in writing. I have the right to request information on how my protected health information has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to abide by my requested restrictions, then this practice is bound by that agreement. All requests for disclosure and/ or restriction must be made in writing for documentation purposes. I understand that this practice may refuse me services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at this time as well. If I revoke this consent, the revocation does not go into effect until this practice receives documented notification in writing.

Consent for Assignment of Benefits: I consent to assign all payment for these services to Integrative Foot and Ankle Centers of Washington. I understand that I am responsible for all co-payments, amounts applicable to deductibles and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulations. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. I am aware that I may be responsible for all the charges that are ensued.

PATIENT (or Parent/Guardian**)**: _____ Date:_____
(Please sign here)

Name Printed: _____ Relationship:_____

MEDICARE OR MEDICAID PATIENTS ONLY

Non-Covered Services Update: If I have DSHS and/or MEDICARE coverage I understand that some services may not be covered and if I agree to have the uncovered services, then I will be asked to sign an Agreement to Pay/ ABN form before services are provided.

PATIENT (or Parent/Guardian**)**: _____ Date:_____
(Please sign here)

Name Printed: _____ Relationship:_____

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Our goal is to provide and maintain a good physician-patient relationship and to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you and we want you to completely understand out financial policy.

PAYMENT is required at time of service. We accept cash, check or credit (Visa®, MasterCard®, Discover®, American Express® and Care Credit®)

1. On arrival, please sign in at the front desk and present your current insurance card at every visit. It is your responsibility to keep us updated with your correct insurance information.

   IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND TO SUBMIT THE CHARGES TO THE CORRECT PLAN.

2. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.

3. For patients with no insurance, full payment is required at the time of service.

4. While the filing of insurance claims is a courtesy that we extend to our patients, all charges not covered by your insurance company are your responsibility.

5. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered.

6. If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments, prior balances must be paid prior to the visit.

7. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within 30 business days of your receipt of your bill.

8. Bills unpaid for more than 90 days may be turned over to a collection agency unless other arrangements have been made. Accounts that are turned over to collections may result in dismissal from the practice.

9. A $45.00 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.

10. RELEASE OF INFORMATION: I hereby authorize and direct Integrative Foot and Ankle Centers of Washington to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

11. I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be occasionally amended by the practice.

_____ _____

Signature of Patient (or Guarantor, if applicable) Date

Please print the name of the patient _____

Relationship to patient: _____