West Campus Foot & Ankle Clinic

PATIENT REGISTRATION

(Please print and sign where indicated. Fax to 253-838-9474 or return at your first visit. If you have questions call 253-838-8377)

PATIENT INFORMATION

Patient Name: _____ [ ] Male [ ] Female

SSN# _____ DOB _____ Age: _____ [ ] Single [ ] Married [ ] Widowed

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Phone # _____ Cell # _____

Employer: _____ Work Phone: _____

Spouse Name: _____ DOB: _____ SSN: _____

Spouse Employer: _____ Work Phone: _____

Emergency Contact: _____ Emergency Contact Phone Number: _____

REFERRED TO CLINIC BY *(Please let us know how you found us)*

Referred by Doctor: _____ [ ] Internet search [ ] Friend/Family _____

[ ] Insurance Provider _____ [ ] Other _____

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Insurance:	Insurance:
Subscriber ID:	Subscriber ID:
Group Number:	Group Number:
Subscriber Name:	Subscriber Name:
Subscriber DOB:	Subscriber DOB:
Subscriber Employer:	Subscriber Employer:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the clinic. I understand I am financially responsible for all charges associated with medical services and agree to pay all bills within 30 days from the receipt of statement, unless other agreements/arrangements are made. I authorize the physician and clinic to release any protected health information required to gain authorization information and to process insurance claims.

Patient Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

West Campus Foot & Ankle Clinic

PATIENT REGISTRATION

(Please print and sign where indicated. Fax to 253-838-9474 or return at your first visit. If you have questions call 253-838-8377)

HEALTH INFORMATION

Patient Name: _____ Date: _____

What is the foot or ankle problem that brings you to the office today? Please be specific: _____

_____

_____

CURRENT MEDICAL INFORMATION:

Current Medical Conditions:
(please list all conditions even if no medication is needed)

Medications

1. _____ 1. _____ dose _____
2. _____ 2. _____ dose _____
3. _____ 3. _____ dose _____
4. _____ 4. _____ dose _____
5. _____ 5. _____ dose _____

PHYSICIAN INFORMATION

Family Physician: _____ Last Visit: _____

Address: _____ City: _____ Phone# _____

SURGERIES:

Previous surgeries (including same day surgery):

Reason: _____ Date: _____

Reason: _____ Date: _____

Reason: _____ Date: _____

Reason: _____ Date: _____

Reason: _____ Date: _____

Reason: _____ Date: _____

Reason: _____ Date: _____

West Campus Foot & Ankle Clinic

PATIENT REGISTRATION

(Please print and sign where indicated. Fax to 253-838-9474 or return at your first visit. If you have questions call 253-838-8377)

ALLERGIES

[ ] No Known Drug Allergies [ ] Adhesive/Tape [ ] Aspirin [ ] Codeine [ ] Demerol [ ] Sulfa [ ] Iodine [ ] Penicillin
[ ] Local Anesthetic [ ] Seafood [ ] Novocain [ ] Other _____

MEDICAL HISTORY (Please indicate past and present medical diagnosis)

Conditions:			Date Started:	Conditions:			Date Started:
Arthritis	[ ] Yes	[ ] No		Diabetes	[ ] Yes	[ ] No	
Asthma	[ ] Yes	[ ] No		Gout	[ ] Yes	[ ] No	
Shortness of Breath	[ ] Yes	[ ] No		Slow Healing	[ ] Yes	[ ] No	
Cancer	[ ] Yes	[ ] No		Liver Trouble	[ ] Yes	[ ] No	
Stroke	[ ] Yes	[ ] No		Kidney Trouble	[ ] Yes	[ ] No	
Heart Attack	[ ] Yes	[ ] No		Heart Trouble	[ ] Yes	[ ] No	
Thyroid Condition	[ ] Yes	[ ] No		High Blood Pressure	[ ] Yes	[ ] No	
Stomach Problems	[ ] Yes	[ ] No		Rheumatic fever	[ ] Yes	[ ] No	

Conditions:			Date started:	Conditions:			Date Started:
Anemia	[ ] Yes	[ ] No		Blood Clots/embolism	[ ] Yes	[ ] No	
Blood disease	[ ] Yes	[ ] No		Aids	[ ] Yes	[ ] No	
Hepatitis	[ ] Yes	[ ] No		HIV	[ ] Yes	[ ] No	
Bleeding problems	[ ] Yes	[ ] No		TB	[ ] Yes	[ ] No	

CHILDHOOD ILLNESSES:

Conditions:			Date started:	Conditions:			Date Started:
Measles	[ ] Yes	[ ] No		Mumps	[ ] Yes	[ ] No	
Chicken Pox	[ ] Yes	[ ] No		Rheumatic Fever	[ ] Yes	[ ] No	
Scarlet Fever	[ ] Yes	[ ] No					

PREVIOUS INJURIES:

(Fractures, dislocations, car accidents, etc) _____

West Campus Foot & Ankle Clinic

PATIENT REGISTRATION

(Please print and sign where indicated. Fax to 253-838-9474 or return at your first visit. If you have questions call 253-838-8377)

Family History of Medical Illnesses	Mother	Father	Grandparents	Siblings
Cancer				
Stroke				
High blood pressure				
Heart Problems				
Diabetes				

ALCOHOL/TOBACCO HISTORY

Coffee Usage: [ ] yes [ ] No Cups per day: _____

Alcohol Use: [ ] Never [ ] Occasional - # drinks per week _____

Tobacco use: [ ] None [ ] Quit On: [ ] Pipe [ ] Cigar [ ] Chewing Tobacco

[ ] Cigarettes Number of Years: _____ Packs per day: _____

I certify that the above information is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my conditions.

Patient Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

Relationship (if minor) _____

West Campus Foot & Ankle Clinic

33801 1st Way S. Suite 105, Federal Way, WA 98003 * Tel 253-838-8377 * Fax 253-838-9474

FINANCIAL POLICY

We are committed to providing you with the highest medical and surgical care. In return, we ask you to be equally committed to being fully responsible for paying our fees. This will help in reducing our billing and administrative burdens, leaving more time for helping you. This dual commitment is the foundation of our relationship. Our goal is to minimize misunderstanding regarding fees and payments. We accept many different insurance plans, however all health plans are not the same and do not cover the same services.

- **Managed Care Patients/Private Insurance**
  If you are in a managed care plan (HMO, PPO) with which we participate, we abide by our contract with them. In either managed care plans or private plans, we will bill your insurance company; however you are responsible for paying the copay and deductible required by your plan at the time of treatment. In 30-45 days your insurance company will send you a statement that will tell you what your balance, if any is due to our office. Your co-insurance balance must not exceed $100.00 or care may be suspended.
- **Medicare Patients**
  We accept assignment from Medicare; however, that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any co-payments.
- **Uninsured Patients**
  Payment is due at the time of service.
- **All Patients**
  For your convenience, we will accept Visa, MasterCard, cash or check.
  Any insurance balance over 90 days will become the entire responsibility of the patient.
  There is a service fee of $40.00 for all returned checks.

Please note: It is the responsibility of each patient to know his or her contract limitations. Specifically, if your policy requires a written referral prior to your visit, it is the patients responsibility to obtain that referral (or have it sent to our office) prior to making an appointment with our office. Denials from your insurance company based on lack of appropriate referral will be billed directly to the patient/responsible party.

I have read, understand and accept all responsibilities associate with this financial policy.

_____ Date _____

Patient / Guardian Signature

Durable Medical Equipment Policy

In the event that the patient leaves the office with an item recommended in the care and treatment of their foot condition (including, but not limited to custom made foot orthotics, ankle/foot orthotics, night splints, walking boots, pads, creams, solutions, etc.) it is understood such items are non-returnable and non-refundable.

It is the policy of this office to help obtain insurance benefits regarding a patient's individual coverage of these items, by contacting the insurance company. This is a courtesy service that we are happy to provide; however the doctor or agents of the Clinic are not held responsible for the accuracy of the information received. Information received by phone is not a guarantee of payment and if any doubt exists as to coverage of an item, it is highly recommended that you check your plan booklet for a detailed outline of your benefits or make a personal phone call to your insurance company. Please note, if these items are denied by insurance due to coverage limitations, the patient hereby accepts responsibility for the cost.

I have read, understand and accept all responsibilities associated with this Durable Medical Equipment Policy.

_____ Date _____

Patient / Guardian Signature

West Campus Foot & Ankle Clinic

33801 1st Way S. Suite 105, Federal Way, WA 98003 * Tel 253-838-8377 * Fax 253-838-9474

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 choose) and understand the notice.

Patient Name: _____
(Please Print)

_____ Date: _____
Signature of Patient

_____ Date: _____
Signature of Patient's parent / guardian / representative

_____
Relationship to Patient