PATIENT INFORMATION

Patient's Name:

____

(Last) (First) (MI) Nick Name

Date of Birth: __________________ Age: ________ Social Security No: __________________________

Marital Status: S M D W LS Tele #: Primary: ______________ Secondary: ____________________

Mailing Address: ____

Email Address: ____

If the patient is a minor: Parent/Guardian name: ____

Patient's Primary Care Physician: ____

Employment of Patient/Guardian:

Company Name: ____

Occupation: ____ Tele: ___________________

INSURANCE: Is the patient covered by insurance? Yes No Primary insurance: ___________________

Is the patient the subscriber? Yes No If No: Subscriber's Name: _________________________________

Date of Birth: ___________ Soc Sec #: ______________Tele No: _____________ Relationship:__________

Is there a secondary Insurance? Yes No If Yes, Please list secondary insurance: __________________

Is the patient the subscriber? Yes No If No: Subscriber's Name: __________________________________

Date of Birth: ___________Soc Sec #: ______________ Tele No: ___________ Relationship: __________

Referral Info: How did you find us? Referred by another physician ___ Physician name: ____________

OR did you choose our clinic because: __we are close to home/work __ a friend __ your insurance plan ____website ____ family

Have you been seen here before? Yes No If so, when?:___________________________

In Case of Emergency: Name of local friend or relative: _______________________________________

Relationship: ____________ Primary Tele No: _____________ 2ndary Tele No: _____________________

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 Emerald City Foot & Ankle Specialists or my insurance company to release any information required to process my claims.

Patient/Guardian Signature: ____Date: _______________

EMERALD CITY
FOOT & ANKLE SPECIALISTS

Patient Name: ____ Date: ________________________

Birthdate: ___________________ Age: __________________ Height: ______________Weight: ________

Please list all medications taken on a regular basis:

____
____
____

Please list anything to which you have an allergy or are sensitive to (i.e.: drugs, tapes, etc):

____
____

Have you had or do you have any of the following? Please check those that apply to you:

Foot Problems:		**Surgeries (Please List):**	**Broken Bones (Please List):**
Bunions	____		
Foot/Leg Injuries	____	______________________	__________________________
Foot/Leg surgeries	____		
Foot/Leg numbness	____	______________________	__________________________
Knee Pain	____		
Unequal Leg Length	____	______________________	__________________________
Weak Ankles	____		
Toenail Problems	____	______________________	__________________________

General Medical:

Alcohol/Drug Addiction	___	Heart Disease	___	Other: ______________________
Anemia	___	Hepatitis A ___ B ___ C ___		____________________________
Arthritis	___	High Blood Pressure	___	____________________________
Bleeding out of ordinary	___	HIV Positive	___	____________________________
Blood Disease	___	Kidney Disease	___	____________________________
Bursitis	___	Liver Disease	___	____________________________
Cancer	___	Low Back Pain	___	____________________________
Circulatory Problems	___	Polio	___	
Diabetes	___	Prone to Infection	___	
Epilepsy	___	Pregnant	___	
Fainting Spells	___	Rheumatic Fever	___	
Fibromyalgia	___	Stomach Ulcers	___	
Gout	___	Varicose Veins	___	
Hardening of Arteries	___	Do you smoke? Yes ____ No	___	If yes, how much? ___ PPD

Physician Signature: ____ Date: ______________

FINANCIAL & PRIVACY POLICIES

FINANCIAL:

Thank you for choosing us as your specialty podiatric care providers. We are committed to your treatment being successful. The following is a statement of our financial policy which we require you read, and sign, prior to any treatment. We accept cash, check (for returning patients), VISA, Mastercard, American Express, Discover, and debit cards.

Patients WITHOUT Medical Insurance: 100% of the fee is due at the time service is performed

Patients WITH Medical Insurance: Office visit co-pays are due at the time of service. Additional payment of the estimated amount not covered by your insurance policy, such as deductibles, may be required. We can make no guarantee of your benefits. There may be additional amounts due. Your insurance policy is a contract between you and your insurance company.

Regarding Usual and Customary Rates: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. Unless we are contracted with your insurance company, you are responsible for payment regardless of any insurance company's arbitrary determination of customary rates.

Minor patients (less than 18 years of age): The adult accompanying the minor is responsible for full payment regardless of insurance coverage.

PRIVACY POLICY:

There is a copy of the summary of our Notice of Privacy Practices for display at each of our office locations. You have the right to request a full copy. If you do not understand or have questions regarding the policy, one of our staff members will be happy to explain it to you.

I have read and understand the above Financial and Privacy Policy information listed above:

Patient name: ____

Parent or Authorized Representative (if applicable): ____

Signature & Date: ____

10305 19th Ave SE, Suite A, Everett, WA 98208 Phone: (425) 379-9999
13751 Lake City Way NE, Suite 301, Seattle, WA 98125 Phone: (206) 364-0330

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I give the physicians and staff of Emerald City Foot & Ankle Specialists permission to speak to the following people and/or organizations:

____

____

____

This authorization applies to:

_____ All health care information including drug, alchol, or mental health treatment

_____ Health care information related ONLY to the following treatment, condition and/or dates of service: ____

_____ Other: ____

In addition, I authorize the physicians and staff of Emerald City Foot & Ankle Specialists to leave messages at the telephone number(s) on file. This authorization applies to:

_____ All messages (may in clude but not limited to: appointment confirmations, insurance verfications, medication refill request)

_____ Only messages regarding: ____

OR

_____DO NOT LEAVE ANY MESSAGES FOR ME REGARDLESS OF THE CONTENT.

This authorization remains in effect for one (1) year unless withdrawn in writing.

Patient Printed Name: ____

Patient/Guardian Signature: _______________________________________ Date: _______________

10305 19th Ave SE, Suite A, Everett, WA 98208 Phone: (425) 379-9999
13751 Lake City Way NE, Suite 301, Seattle, WA 98125 Phone: (206) 364-0330

PRESCRIPTION POLICY

Controlled substance medications (i.e., narcotics, tranquilizers and barbiturates) have a high potential for misuse and are, therefore, closely controlled by local, state and federal governments. The DEA has implemented stronger rules governing narcotic dispensing. The State of Washington Health Care Authority policy states no more than a 3 day supply for patients age 20 or younger, and no more than a 7 day supply for patients age 21 and older, may be prescribed. Because my physician may prescribe controlled substance medications to help manage my pain, I agree to the following:

1) I am responsible for the controlled substance medications prescribed to me – if my prescription is lost, misplaced, stolen, or is consumed too quickly, I understand that it **WILL NOT BE REPLACED.**

2) The doctor is not to be paged for medication refills.

   Refills will only be made during regular office hours Monday through Friday and Saturday mornings when patients are being seen.

   Refills will not be granted as an emergency (ex: on a Friday afternoon because of sudden realization the medication will run out the following day). I will call **AT LEAST TWENTY FOUR (24) HOURS** ahead of time if I need assistance with a refill. Refills will not be granted for consuming medication too quickly, lost prescriptions, or misplacing the medication. I am responsible for taking the medication in the dosage prescribed and for keeping track of the amount remaining.

   YOU MAY GO TO THE EMERGENCY ROOM FOR EMERGENCY REFILLS

3) It may be deemed necessary by my doctor that I see a medication-use specialist at any time while I am receiving controlled substance medications. I understand that if I do not attend such an appointment my medications may be discontinued, may not be refilled beyond a tapering dose to completion, or I may be dismissed from the practice. I also understand that if this consulting specialist feels that I am at risk for psychological dependence/addiction, or if a recommendation for discontinuation of controlled substances is given, my medications will no longer be refilled.

4) I understand that if I violate any of the above conditions, my prescription for controlled substance medications may be terminated immediately and permanently. I may also be dismissed from the practice. If the violation involves obtaining a controlled substance medication from another individual, physician's office, or the concomitant use of non-prescribed illicit (illegal) drugs, I can also be reported to **ALL** of my other physician offices, medical facilities, the appropriate authorities, and/or dismissed from the practice.

The staff at Emerald City Foot & Ankle Specialists have adequately explained the risks of physical and psychological dependence (addiction) to controlled substances. I understand some individuals may develop a tolerance to the medications necessitating a dose increase to achieve the desired effect. I also acknowledge there is a risk of becoming physically dependent on the medication. This can occur if I am on the medication for an extended period of time. Therefore, when I need to stop taking the medication I must do so slowly and under medical supervision in order to avoid withdrawal symptoms.

I have both read this contract and had the above explained to me by my physician. In addition, I fully understand the consequences of violating this agreement.

Signature: ________________________________ Date: _______________________

Witness: _________________________________