Welcome to the Plateau Foot & Ankle Clinic

Tel: 425-868-3338
Fax: 425-836-9211

Our goal is to provide patients with the best quality medical and surgical care possible.
Please take a few minutes to fill out the following information.

PATIENT INFORMATION — *PLEASE PRINT LEGIBLY*

TODAY'S DATE_____

PATIENT'S LAST NAME_____FIRST_____MIDDLE INITIAL_____

MAILING ADDRESS_____

CITY_____STATE_____ZIP _____

HOME PHONE # (_____CELL PHONE # (_____)_____

PATIENT EMAIL ADDRESS **(PLEASE PRINT CLEARLY)** _____@_____

DATE OF BIRTH_____ AGE_____ ❑MALE ❑FEMALE

HEIGHT_____ WEIGHT_____ SHOE SIZE _____

OCCUPATION_____EMPLOYER_____

WORK # (_____)_____ FAX# (_____)_____

MARITAL STATUS: ❑SINGLE ❑MARRIED ❑DOMESTIC PARTNER ❑WIDOWED ❑DIVORCED ❑SEPARATED

SPOUSE NAME_____ # OF CHILDREN_____

PHARMACY: _____

NAME AND NUMBER OF PERSON (OTHER THAN AT YOUR ADDRESS) THAT WE MAY CONTACT IN CASE OF EMERGENCY

_____RELATIONSHIP_____

PLEASE CHECK YOUR CONTACT PREFERENCE FOR APPOINTMENT REMINDERS:

❑ HOME TELEPHONE ❑ CELL PHONE ❑ E-MAIL ❑TEXT

NAME OF PARENTS OR GUARDIAN (IF PATIENT IS A MINOR) _____

EMPLOYER_____ WORK# (_____) _____

PARENT/GUARDIAN DATE OF BIRTH_____

REFERRAL SOURCE — *HOW DID YOU FIND OUT ABOUT US? WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?*

❑ FRIEND _____ ❑FAMILY _____

❑ DR. _____ (CITY) _____

❑ INTERNET/WEBSITE_____ ❑NEIGHBORHOOD DIRECTORY ❑I SAW YOUR SIGN

❑ TELEPHONE BOOK (❑QWEST ❑VERIZON) ❑OTHER:_____

INSURANCE INFORMATION — *PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST*

PRIMARY INSURANCE _____ POLICY #_____ GROUP #_____

SECONDARY INSURANCE _____ POLICY #_____ GROUP #_____

ARE YOU THE SUBSCRIBER? PRIMARY ❑ NO ❑ YES SECONDARY ❑ NO ❑ YES

IF YOU ARE **NOT** THE SUBSCRIBER FOR EITHER INSURANCE, PLEASE COMPLETE:

LAST NAME OF SUBSCRIBER_____FIRST_____MIDDLE INITIAL _____

RELATIONSHIP TO PATIENT_____ PHONE #_____DATE OF BIRTH_____

ADDRESS (IF DIFFERENT THAN PATIENT)_____

DOES YOUR INSURANCE PLAN REQUIRE A COPAY? ❑NO ❑YES COPAY AMOUNT $ _____

DOES YOUR INSURANCE PLAN REQUIRE A REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN? ❑NO ❑YES

PLEASE TURN OVER

PODIATRIC HISTORY

WHAT IS THE CHIEF COMPLAINT FOR WHICH YOU CAME TO BE TREATED?

_____

_____

_____ **DURATION OF PROBLEM** _____

HAVE YOU HAD PREVIOUS TREATMENT FOR THIS CONDITION? ❑NO ❑ YES

IF YES, BY WHOM? _____ WHEN? _____

MEDICAL HISTORY

DO YOU CURRENTLY OR HAVE YOU EVER HAD THE FOLLOWING MEDICAL CONDITIONS?

			PLEASE LIST ALL SURGERIES YOU'VE HAD	DATES
DIABETES	❑NO	❑YES		
HIGH BLOOD PRESSURE	❑NO	❑YES		
HEART DISEASE	❑NO	❑YES		
STOMACH DISORDER	❑NO	❑YES		
LIVER DISEASE	❑NO	❑YES		
KIDNEY DISEASE	❑NO	❑YES		
POOR CIRCULATION	❑NO	❑YES		
AIDS/HIV/HEPATITIS (CIRCLE ONE)	❑NO	❑YES		

OTHER _____

OTHER MEDICAL PROBLEMS THAT RUN IN THE FAMILY: _____

- **DO YOU SUFFER WITH CHRONIC ❑ BACK ❑ HIP or ❑ KNEE PAIN? (CHECK ALL THAT APPLY)**
- **DO YOU HAVE FIBROMYA LGIA OR A CHRONIC PAIN CONDITION?** ❑NO ❑YES
- **DO YOU CURRENTLY OR HAVE YOU EVER BEEN TREATED FOR DEPRESSION?** ❑NO ❑YES
- **ARE YOU CURRENTLY OR HAVE YOU EVER BEEN TREATED FOR ANY PSYCHIATRIC DISORDERS?** ❑NO ❑YES

IF YES TO ANY OF THE ABOVE, PLEASE EXPLAIN: _____

➔DO YOU SMOKE? ❑ NO ❑YES - IF YES, FOR HOW LONG? _____ PACKS PER DAY_____ ❑QUIT WHEN?_____

➔DO YOU DRINK ALCOHOL? ❑NO ❑YES - IF YES, HOW MANY DRINKS PER WEEK? _____ ❑QUIT WHEN?_____

FAMILY PHYSICIAN _____ CITY_____ LAST VISIT_____

If your physician referred you to our office, we will provide him/her with a medical report. If you would like a copy of your report to go to a different physician as well, please indicate the doctor's name (and address, if known) _____

PRESENT MEDICATIONS AND DOSAGE: *(you may provide us with a list to copy)*

_____ _____

_____ _____

_____ _____

HAVE YOU EVER HAD ANY ADVERSE SIDE EFFECTS OR ALLERGIES TO:

PENICILLIN	❑NO	❑YES	ADHESIVE TAPE	❑NO	❑YES
ASPIRIN	❑NO	❑YES	ANTI-INFLAMMATORY MEDS	❑NO	❑YES
NOVACAINE	❑NO	❑YES	METAL/JEWELRY	❑NO	❑YES
CORTISONE	❑NO	❑YES	IODINE	❑NO	❑YES
CODEINE	❑NO	❑YES	OTHER ANTIBIOTICS_____		
LATEX	❑NO	❑YES	OTHER PAIN MEDICATION_____		

OTHER ALLERGIES: _____

SIGNATURE ON FILE AND PERMISSION TO TREAT

I request that payments of authorized benefits be made on my behalf for any services furnished me by **PLATEAU FOOT & ANKLE CLINIC.** I authorize any holder of information about me to release any information needed to determine these benefits or the benefits payable to related services to the insurance agent. I recognize my financial obligation of any co-insurance, co-pays or deductibles and non-covered services that may be required. I also hereby give permission to Dr. Howard Schaengold and his staff to evaluate via appropriate diagnostic testing and administer treatment of my foot/ankle condition.

Signed ✓ _____ Date_____

PLATEAU FOOT AND ANKLE FINANCIAL POLICY

We are committed to providing you with the highest quality 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 maximize the quality of your care and minimize misunderstandings regarding fees and payments. **To ensure quality communication, it is the patient's (and/or guardian's) responsibility to inquire about fees/insurance coverage prior to any service being performed.**

We accept many different insurance plans, however all health plans are not the same and do not cover the same services.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. It is the responsibility of each patient to know their contract limitations. Please contact your insurance company with any questions you may have regarding your coverage.

2. Referrals. 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 at the Plateau Foot and Ankle Clinic. Denials from your insurance company based on lack of appropriate referral will be billed directly to the patient/responsible party.

3. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

4. Non-covered services. Please be aware that some - and perhaps all - of the services you receive may be uncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

7. Nonpayment. Invoices are sent out every 30 days. Your prompt payment will assist us in keeping the cost of healthcare down. If your account is over 60 days past due, you will receive a letter requesting immediate payment. Partial payments will not be accepted unless otherwise approved by our Billing Department.

8. AFTER 120 DAYS, ALL ACCOUNT BALANCE WILL BE THE PATIENT'S IMMEDIATE RESPONSIBILITY.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read, understand and accept all responsibilities associated with this financial policy:

_____ _____

Signature of patient or responsible party Date

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 (inclusive of but not limited to custom made foot orthoses, Ankle/Foot Orthoses, night splints, walking boots, pads, creams, solutions, etc.), it is understood that 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 which we are happy to provide; however, the Plateau Foot & Ankle Clinic is ***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 eligibility, 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.***

My initials below represent that I have read, understand and accept this policy

√_____ _____

Patient or Authorized Representative's Initials Date

THE PLATEAU FOOT AND ANKLE CLINIC

PRIVACY STATEMENT

The Plateau Foot and Ankle Clinic will use and disclose your health information for the following purposes: to treat you, to assist other health care provides in treating you, to allow insurance companies to process insurance claims for services rendered to you, to obtain payment for services rendered to you and for certain limited operational activities, such as quality assessment, licensing, accreditation and training of students. 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. If you have any questions, concerns or complaints regarding our privacy practices, please refer to the actual Notice of Privacy Practices provided to you for the person(s) whom you may contact.

Additional Disclosure Authority:

In addition to the allowable disclosures described in the State of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY		YES		NO
SPOUSE ONLY		YES		NO
OTHER (PLEASE SPECIFY)		YES		NO

Acknowledgement of Receipt of Notice of Privacy Practices:

(Signature represents that I have been offered a copy of the policy)

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

√_____ _____

Signature Date

_____

Patient Name or Authorized Representative (Print)