



12911 120th Ave. NE, Suite C 50, Kirkland, WA 98034
T 425-899-3234 F 425-899-3235 www.rundoctor.com

Welcome to the Washington Foot & Ankle Sports Medicine clinic!

Thank you for selecting our office for your foot and ankle health care needs. We have prepared this packet of information and patient forms in order to help make your visit a convenient and pleasant experience.

Prior to your appointment, please contact your insurance company to clarify your coverage requirements.

URGENT INFORMATION ABOUT REFERRALS:

You cannot assume that your referral has been approved unless you have received written confirmation from your insurance company. If you are not sure that your referral has been approved, please contact your insurance company prior to your appointment. If we do not have a paper copy of the referral in the office, you may be financially responsible for the appointment, unless other arrangements are made at the time of service.

When you come for your appointment, please bring the following:

(Do not send prior to your appointment)

- Written referral (If required by your insurance company)
- Completed *Registration Form*
- Completed *History Form*
- Completed and signed *Financial Policy Form*
- Completed and signed *Privacy Statement Form*
- Medical insurance card
- Previous X-rays and medical records, if applicable
- Shoes (bring a sample of the more common shoes that you wear –including athletic and walking shoes)
- Toenail procedures- bring flip flops or sandals for each appointment

Note: As you will be receiving advice on the proper shoes for your feet, we recommend that you not purchase any new shoes before your visit.

Please be prepared to pay for the following at the time of your visit:

- Co-Payment (If applicable)
- **Deductible** (If not fully paid for this year)
- If no insurance, the full cost of the visit

- **Upon Check-in, please allow 15 minutes for patient registration processing.**
- **A Medical Review questionnaire will be administered by our Medical Assistant staff prior to your appointment with our physician. This may take 5-15 minutes.**

Our entire staff is here to help you in whatever manner we can. We look forward to serving you in the near future.

A courtesy email will be sent for appointments scheduled out 3 business days or more in advance. As a courtesy to other patients who are waiting to get in, please call at least 24 hours in advance if you must cancel your appointment. We reserve the right to charge for missed appointments.



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Patient Registration
(Please Print)

LAST NAME: _____ FIRST: _____ MIDDLE INITIAL _____ MF

BY WHAT NAME DO YOU PREFER TO BE ADDRESSED? _____ DOB: _____ AGE: _____

BILLING ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PRIMARY PHONE: (_____) _____ (CIRCLE) CELL OR HOME WORK # (_____) _____

SECONDARY PHONE: (_____) _____ (CIRCLE) CELL OR HOME

EMAIL: _____

MARITAL STATUS: SINGLE MARRIED OTHER SS# _____

OCCUPATION: _____ EMPLOYER OR SCHOOL NAME: _____

PARENT/GUARDIAN: _____ PHONE: (_____) _____

EMERGENCY CONTACT & RELATIONSHIP TO PATIENT _____

PHONE: (_____) _____ PHONE: (_____) _____

HOW DID YOU HEAR ABOUT WFASM? (CHECK ALL THAT APPLY)

- FAMILY MEMBER(NAME) _____ FRIEND/PATIENT INTERNET SEARCH
- MEDICAL PROVIDER (NAME/LOCATION) _____ SPORTS GROUPS/SOCIAL MEDIA GROUPS

PRIMARY CARE PROVIDER: _____ CLINIC NAME/LOCATION: _____

PRIMARY INSURANCE CARRIER: _____

LAST NAME OF SUBSCRIBER: _____ FIRST: _____ MIDDLE INITIAL: _____

RELATIONSHIP TO PATIENT: _____ SUBSCRIBER DOB: _____ SS # _____

SECONDARY INSURANCE CARRIER: _____

LAST NAME OF SUBSCRIBER: _____ FIRST: _____ MIDDLE INITIAL: _____

RELATIONSHIP TO PATIENT: _____ SUBSCRIBER DOB: _____ SS # _____

ACCIDENT/INJURY DATE: _____ TYPE: LABOR & INDUSTRY SELF-INSURED AUTO
 OTHER: _____

HAS A CLAIM BEEN FILED? YES NO CLAIM # _____ WHERE: _____

NAME OF ADJUSTER/AGENT: _____ PHONE # (_____) _____

ADDRESS: _____ CITY: _____ ZIP: _____

CAUSE OF INJURY: _____

RELEASE OF BENEFITS INFORMATION

I authorized my insurance benefits to be paid directly to the doctor. I understand that the doctor's office will bill my insurance as a courtesy and that I am responsible for all co-pays, deductibles, and non-covered services. I authorize the release of any information required to process my claims.

Signed: _____ Date: _____



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Financial Policy

This is an agreement between Washington Foot & Ankle Sports Medicine, as creditor, and the Patient/Debtor named on this form.

In this agreement the words, “you”, “your”, and “yours” mean the Patient/Debtor. The word “account” means the account that has been established in your name to which charges are made and payments credited. The words “we”, “us”, and “our” refer to Washington Foot & Ankle Sports Medicine Clinic.

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the due date on your statement.

Co-Payments, Deductibles and Balances are required as services are rendered.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Required payments: Any co-payments and/or deductibles required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

Initial: _____

Missed Appointment Fee: Any patient who does not show up for an appointment, or cancels with less than 24 hours notice, a \$50 fee will be charged. We reserve the right to increase this fee without notice. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments will be asked to transfer their records to another doctor.

Initial: _____

The Financial Policy continues on the back side of this page.

Patient's Name: _____

Responsible Party:
(If not Patient) _____

Signature: _____ Date: _____

By signing this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

Contracted Insurance: If we are contracted with your insurance we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we must ask for payment in full at the time of service. Should your insurance company return payment a refund will be issued to you less any remaining balance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of one percent (1.5%) per month or an **ANNUAL PERCENTAGE RATE** of twelve (12%) percent. The finance charge on your account is computed by applying the periodic rate (1.5%) to the "overdue balance" of your account. The "overdue balance" of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during the time, but not to exceed the maximum rate permitted by law."

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees which we incur plus all court costs. In case of suit, you agree the venue shall be King County, Washington.

Returned Checks: There is a fee (currently \$25.00) for any checks returned by the bank.

Credit History: You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee if you want to have copies of your records sent to another doctor or organization. The amount of the fee is dependent on the number of pages we need to copy. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record and you consent to such disclosure.

Worker Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility.



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We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Home Telephone _____ | <input type="checkbox"/> Cell Telephone _____ |
| <input type="checkbox"/> O.K. to leave message with detailed information | <input type="checkbox"/> O.K. to leave message with detailed information |
| <input type="checkbox"/> Leave message with call-back number | <input type="checkbox"/> Leave message with call-back number |
| <input type="checkbox"/> Work Telephone _____ | <input type="checkbox"/> Written Communication |
| <input type="checkbox"/> O.K. to leave message with detailed information | <input type="checkbox"/> OK to mail to home address |
| <input type="checkbox"/> Leave message with call-back number | <input type="checkbox"/> OK to fax to this number _____ |

I consent to the use or disclosure of my protected health information by Lawrence M. Maurer, D.P.M. and Peter M. Vincent, D.P.M. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Lawrence M. Maurer, D.P.M. and Peter M. Vincent, D.P.M.,

I understand that diagnosis or treatment of me by Dr. Maurer, Dr. Vincent and Associates may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Dr. Maurer, Dr. Vincent, and Associates are not required to agree to the restriction that I request. However, If Lawrence M. Maurer, D.P.M., Peter M. Vincent, D.P.M., agrees to a restriction that I request, the restriction is binding on Lawrence M. Maurer, D.P.M., Peter M. Vincent and Associates.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Maurer, Dr. Vincent and their Associates or Lawrence M. Maurer, D.P.M., Peter M. Vincent, D.P.M. has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

_____	_____	_____
Patient or legally authorized individual signature	Date	Time

_____	_____
Printed name if signed on behalf of the patient representative)	Relationship (Parent, legal guardian, personal representative)

This form will be retained in your medical record.



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This history form provides us with information to help us meet your healthcare needs. Please complete this form answering each question. **This is a confidential part of your medical record and will be kept in this office.**

Patient Name: _____ **Date:** _____

What condition/body part(s) are you being seen for today? _____

Onset date: _____ Previous treatment for this condition Yes No

Treatment by: _____ Date treated: _____

Where treated: _____

Check all treatment(s) received for this condition:

Anti-inflammatories _____ X-rays _____ Hospitalization _____
 Pain medication _____ MRI _____ Physical Therapy _____
 Injection _____ Bone scan _____ Fracture to put _____
 Surgery _____ EMG _____ back in place _____

Past Medical History

Have you ever had:	No	Yes	Year
Anemia			
Angina			
Arthritis			
Asthma			
Bad teeth			
Bladder infection			
Bladder problems			
Blood clots			
Cancer			
Depression			
Diabetes			
Emphysema			
Epilepsy			

Have you ever had:	No	Yes	Year
Glaucoma			
Gout			
Heart attack			
Heart arrhythmia			
High blood pressure			
Kidney stones			
Liver disease/hepatitis			
Psychiatric treatment			
Stomach ulcers			
Stroke			
Thyroid disorders			
Tuberculosis			
Other			

Previous Surgeries

None List procedure and date performed:

Family History

Is there a family history of arthritis, heart disease, stroke, or cancer? No Unknown Yes

Condition and relative: _____

Patient: Weight: _____ Height: _____ Shoe Size: _____

Continued on Reverse



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Patient Name: _____

Social History

Please answer each of the following:

Occupation: _____ How many years? _____

	No	Yes	How much
Caffeine:			
Drugs:			

	No	Yes	How much
Tobacco:			
Alcohol:			

Allergies None

List all known allergies:

Current Medications None See attached list

List all known medications and dosage:

Review of Systems:

Check all condition and symptoms that you currently have:

- | | | | | |
|-------------------------|---------------------|--------------------------|--------------------------|-----------------|
| <i>General</i> | ___ Fever | ___ Chills | ___ Weight loss | ___ Weight gain |
| <i>Eyes</i> | ___ Blurred Vision | ___ Double vision | ___ Poor vision | ___ Glasses |
| <i>Ears/nose/throat</i> | ___ Ringing in Ears | ___ Sinus congestion | ___ Hearing loss | ___ Sore throat |
| <i>Heart</i> | ___ Chest Pain | ___ Irregular heart beat | ___ Palpitations | ___ Other |
| <i>Lungs</i> | ___ Cough | ___ Shortness of breath | ___ Difficulty breathing | ___ Other |
| <i>Intestinal</i> | ___ Upset Stomach | ___ Bloody stools | ___ Constipation | ___ Diarrhea |
| <i>Urinary</i> | ___ Burning | ___ Frequent urination | ___ Incontinence | ___ Other |
| <i>Musculoskeletal</i> | ___ Joint pain | ___ Muscle weakness | ___ Joint stiffness | ___ Other |
| <i>Skin</i> | ___ Rashes | ___ Sores | ___ Masses | ___ Scars |
| <i>Neurological</i> | ___ Tremors | ___ Numbness | ___ Poor balance | ___ Dizziness |
| <i>Psychiatric</i> | ___ Depression | ___ Mood swings | ___ Anxiety | ___ Other |
| <i>Endocrine</i> | ___ Hair loss | ___ Excessive thirst | ___ Fatigue | ___ Other |
| <i>Blood/Lymphatic</i> | ___ Leg swelling | ___ Bleeding tendency | ___ Bruise easily | ___ Other |
| <i>OB/GYN</i> | ___ Pregnant | ___ Birth control pills | ___ Hormone therapy | ___ Menopausal |

Provider Comments _____

All other systems negative

 Patient Signature

 Legal Guardian Signature (if patient a minor)

 Relationship to patient

Permission to Discuss Protected Health Information

I give permission for Washington Foot & Ankle Sports Medicine to share the information I have checked with the authorized representative that I have identified below as being involved in my health care, care coordination or payment related to my health care. This form does not authorize releasing copies of my medical records. This form is in addition to those parties permitted by law to receive your PHI in relation to HIPAA and is optional.

Please check any applicable categories below that you are granting permission for:

- Billing and other payment info, receipts
- Scheduling/Appointment info
- Medical information
- Other

Washington Foot and Ankle has my permission to discuss the above information with the following parties:

Name(s): _____

Relationship to the patient: _____

Primary Contact Number: _____

I understand I have the right to revoke this consent, in writing, at any time except to the extent that Dr. Maurer, Dr. Vincent and associate staff of Washington Foot & Ankle Sports Medicine has taken action in reliance on this consent.

Signature of Patient: _____

Date: _____



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**Automatic Payment Authorization Agreement
For Health Savings Accounts & Patient Elected Accounts
(REQUIRED FOR HSA ACCOUNTS)**

I authorize Washington Foot & Ankle Sports Medicine (WFASM) to automatically withdraw from my account identified below the payment for the WFASM account number listed below. I authorize the Financial Institution listed below to accept such withdrawals initiated by WFASM. **The withdrawals shall be made from my account subsequent to claims processing by insurance.**

This authorization is to remain in effect until WFASM and the Financial Institution have received written notification from me of termination in such time as to afford WFASM reasonable opportunity to act upon it (30 days). I am aware of my right to stop payment of a withdrawal by notifying WFASM at any time up to 3 business days before the withdrawal date.

If an erroneous withdrawal occurs and I notify WFASM of the error within 60 days of the issuance of my WFASM statement, WFASM must investigate and resolve the error within 45 days of notification. If the error is not resolved within the first 10 days following receipt of my notification, my account shall be re-credited for the amount in question until the investigation is complete.

Credit Card Type: Visa MasterCard Discover AMEX

WFASM Acct. Number(s): _____

Name As it Appears on Card: _____

Card Number: _____ Exp: _____

Address: _____

City: _____ State: _____ Zip: _____

Authorizing Signature: _____

Date: _____

Email Address: (To send payment receipt) _____