Valley Foot and Ankle
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PATIENT INFORMATION FORM

Patient's Name (please print) _____ **Nickname** _____
DOB _____ **Age** _____ ☐Male ☐Female **SSN** _____ **Marital Status** ☐Single ☐Married ☐Divorced ☐Widowed ☐Other
Address _____ **City** _____ **State** _____ **ZIP** _____
Email (required) _____
Home Phone _____ **Mobile Phone** _____ **Work Phone** _____
Emergency Contact _____ **Phone** _____ **Relationship** _____

MEDICAL INSURANCE INFORMATION ☐Check if Uninsured

Primary Insurance Co. _____ Name of Insured (if other than self) _____
ID Number _____ Birthdate: _____ Relationship to Patient _____
Group Number _____ Patient Is: ☐Subscriber ☐Spouse ☐Dependent

Secondary Insurance Co. _____ Name of Insured (if other than self) _____
ID Number _____ Birthdate: _____ Relationship to Patient _____
Group Number _____ Patient Is: ☐Subscriber ☐Spouse ☐Dependent

☐ Work Injury (please check) Claim (L&I) #_____ Date of Injury _____
Claim filed? ☐Yes ☐No Where was claim filed? _____ Cause of Injury _____

SOCIAL HISTORY

Occupation _____ Employer _____
Height _____ Weight _____ Shoe Size _____
Alcohol Use: ☐ None ☐ Occasional ☐ Mild/ Moderate ☐ Heavy
Do you smoke? ☐ No ☐ Yes _____ Packs/day
Recreational Drugs ☐ No ☐ Yes Type _____
Pregnant or possibly pregnant? ☐ No ☐ Yes
Exercise: ☐ None ☐ Occasional ☐ Regular Light ☐ Regular Moderate ☐ Regular Heavy

CURRENT COMPLAINT

Reason for seeing doctor today _____
Which Foot? ☐ Left ☐ Right ☐ Both Choose all that apply: ☐ Ankle ☐ Foot ☐ Toes
Duration of current condition _____ Have you had any treatments for your current condition? ☐ No ☐ Yes
If yes, explain _____

Do you wear store-bought arch supports? ☐ No ☐ Yes
Do you wear custom orthotics? ☐ No ☐ Yes If yes, who made them? _____ How old are they? _____

MEDICAL HISTORY | MENTAL/ EMOTIONAL

Have you ever had or been treated for the following?

☐ AIDS/ HIV	☐ Cancer	☐ Hepatitis/ Liver	☐ Neuropathy	☐ Seizures
☐ Arthritis - Type _____	☐ Diabetes	☐ High Blood Pressure	☐ Osteoporosis	☐ Stomach Ulcers
☐ Asthma	☐ Falling	☐ Kidney Problems	☐ Poor Circulation	☐ Stroke
☐ Back Problems	☐ Fibromyalgia	☐ Leg Cramps	☐ Problems w/ Anesthesia	☐ Thyroid Problems
☐ Bleeding Tendencies	☐ Gout	☐ Lung/ Respiratory	☐ Psoriasis	☐ Tuberculosis
☐ Blood Clots/ DVT	☐ Heart Problems	☐ Melanoma	☐ Rheumatic Fever	☐ Varicose Veins
☐ Other _____				☐ Weight Change

Please check any that apply: ☐ Eating Disorder ☐ Anxiety ☐ Depression ☐ Psychiatric ☐ Alcoholism ☐ Other _____
Current Medications _____
Are you allergic to any medications? ☐ No ☐ Yes |Please specify below|

☐ Penicillin	☐ Codeine	☐ Cortisone	☐ Anesthetics/ Novocain	☐ Latex
☐ Vicodin	☐ Demerol	☐ Aspirin	☐ Iodine/ Betadine	☐ Other _____

List surgeries, serious injuries, and illnesses _____

Former foot and ankle physician _____ Last visit _____
Primary Care Physician _____ Practice Name _____ Location _____
Preferred Pharmacy _____ Location _____ Phone _____

REFERRAL SOURCE

☐ Doctor _____ Location _____
☐ Patient/ Friend (please list) _____ ☐ Preferred Provider (PPO) Directory ☐ ZocDoc ☐ Google
☐ Other _____

Signature _____ **Date** _____

Thank you for choosing Valley Foot and Ankle as your podiatric physicians. We are committed to the success of your treatment. The following is a statement of our FINANCIAL POLICY. We request that you read and sign this policy prior to any treatment.

To avoid any misunderstanding, please contact our office if you have any questions about our policies.

CREDIT/ DEBIT CARD ON FILE: As of August 1, 2015 we require a credit or debit card on file with our office if we will be billing your insurance company. When you arrive for your appointment we will ask for a credit/debit card to place on file which will be held securely. Once your portion of the bill is determined (following a review of your copay, co-insurance and deductible) we will notify you (via email) that we will be charging your card. Seven days later, we will then process and charge your card. A copy of the receipt will be emailed to you. This will allow for us to only swipe your card once per year. Please note: you can cancel your contract at any time.

PAYMENTS FOR SERVICES: Payment for services are due at the time that those services are provided to you. This includes: copay amounts, program deductibles, previous charges that remain unpaid and charges for services that we believe are not covered by your insurance. Payments must be paid by cash, check, and or credit/debit card. There will be a $25.00 charge for any returned checks.

UNPAID BALANCES AND AUTOMATIC PAYMENTS: Patient balances are due upon final insurance determination of patient balance and will be charged to your credit or debit card on file. You will receive an email notification that we will be charging your credit or debit card and then a follow-up email with the receipt. All balances owed after the state mandated (120 days) may be subject to Collective actions, if no formal payment arrangements are made with billing department or management.

CO-PAYS AND UNPAID BALANCES DUE AT THE TIME OF VISIT: Please be prepared to pay all co-payments and unpaid balances at the time of service. We do not mail statements out for co-payments, so your visit will be rescheduled if you are not prepared to pay the co-payment.

MISSED APPOINTMENTS: We ask for at least 24 hours notice if you are unable to keep an appointment. You may be subject to a cancellation fee if you do not cancel your appointment at least 24 hours in advance.

INSURANCE: If your doctor is a participating provider with your insurance plan, we will submit the claim to your insurance company. To do this we must have *complete* and *accurate* insurance information and a copy of your identification card or claim form. Your insurance policy is a contract between you and your insurance company; therefore you are responsible for payment. **It is your responsibility to contact your insurance company regarding pre-authorizations, obtaining required referrals, second opinions, etc.** Failure to do so may reduce the amount of benefits paid by your insurance and the balance may then be passed on to you.

NO INSURANCE: If you do not have insurance or the doctor is not a participating provider with your insurance plan, please be prepared to fully cover the fees for each visit at the time of treatment.

DEDUCTIBLES: If you have an annual deductible which has not yet been paid in full then any charges incurred up to that amount are due at the time of your visit.

MINOR PATIENTS: The adult or the parent (custodial guardian) accompanying a minor is responsible for payment of services. For unaccompanied minors, non-emergency treatment will be denied unless prior authorization from the parent or guardian has been made for the charges and treatment.

SUPPLIES: For your convenience we make some supplies available for purchase in the office. If you choose to purchase these items, payment is due at the time of purchase. Unfortunately, we cannot bill your insurance for these items.

ASSIGNMENT OF BENEFITS: I authorize my insurance benefits to be paid directly to Valley Foot and Ankle. I understand that the doctor's office will bill my insurance as a courtesy and that I am responsible at the time of service for all co-payments, deductibles, unpaid balances and non-covered services. I authorize the release of information required to process my claims. (If not signed payment due at time of service)

I have read and agree to the terms set forth in the above financial policy. I authorize my insurance benefits to be paid directly to Valley Foot and Ankle. If I am financially responsible for any balance due, I agree to make all payments for any co-payments, charges due within my current deductible and any unpaid balances from previous visits at the time of my appointment.

Print Name _____

Patient or Guardian Signature _____ **Date** _____

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

NAME OF PATIENT (PLEASE PRINT): _____ **DATE OF BIRTH:** _____

I request that all communications to me (by telephone, mail or otherwise) by Valley Foot and Ankle staff be handled in the following manner:

- For written communications — Patient Address: _____
- For oral communications

Home Phone:
( ) _____ - _____
☐ OK to leave message with detailed information
☐ Leave message with call back number only

Cell Phone:
( ) _____ - _____
☐ OK to leave message with detailed information
☐ Leave message with call back number only

Work Phone:
( ) _____ - _____
☐ OK to leave message with detailed information
☐ Leave message with call back number only

Who is the responsible party for outstanding balances: _____

Address: _____

Home Phone: _____
Cell Phone: _____
Work Phone: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

At Valley Foot and Ankle we keep record of the health care services we provide to you. You may request a copy of those records. You may also request to correct your records. Your private health information will not be disclosed to others unless you authorize us to do so or if we are required to by law authorities. If you have any questions regarding our Privacy Practice please call Valley Foot and Ankle and ask for the Privacy Officer.

Aimee S, Office Manager – 425.226.5656

Whom may we share your private health and financial information with?
Name: _____ Relationship: _____ Contact Number: _____
Name: _____ Relationship: _____ Contact Number: _____

I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area.

Print Name: _____

Patient or Guardian Signature: _____ **Date:** _____

☐ I would like to receive a copy of any amended Notice of Privacy Practices by email at:
_____

|For Practice Use Only|

Practice: ☐ Accept ☐ Denies

Privacy Officer Signature: _____

Date: _____

CREDIT CARD ON FILE OR PAYMENT IN FULL WILL BE REQUIRED FOR ALL PATIENTS
VALLEY FOOT AND ANKLE HAS DISCONTINUED SENDING PATIENT STATEMENTS

Dear Patients,

As of MAY 1, 2015 we have discontinued sending patient statements. Therefore, you will no longer receive bills from us in the mail. We now require a credit or debit card to be placed on file with our office if we will be billing insurance for you. If you do not have insurance we require that payment is due in full at the time of service.

You will be asked for a credit card at the time you check in and the information will be held securely. When your portion of the bill is determined (following a review of your copay, co-insurance, and deductible) we will send you an email notification that informs you that we will be charging your card in 7 days. A copy of the receipt will be emailed to you. You can also request a paper copy from the receptionist at check-out. We only have to swipe your card once per year. On follow-up visits you will be able to pay for co-pays and other charges with the card on file. You can cancel the contract at any time. Please note that your card will not be charged unless you have a charge due and no funds are held. This simply allows your card to be charged when a bill is due.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

If you have any questions about this payment method, do not hesitate to ask.

FREQUENTLY ASKED QUESTIONS

Why the change? Many changes are occurring in the healthcare as of January 1st, 2014 due to implementation of the Affordable Care Act (Obamacare). In order to continue providing care and to keep medical costs as low as possible we need to ensure that we have guarantee of payment on file in our office. You will find that over the next year or so most medical practices will require full payment up front or a credit/debit card on file for payment of patient balance.

But I always pay my bills, why me? We have to be fair and apply the policy to all patients. We have wonderful patients and we know that more of you pay your balances. But with the healthcare changes that are occurring, it is not cost-prohibitive to send out bills to collect balances.

How will I know how much you are going to charge me? You will receive a letter in the mail from your insurance carrier that explains how much of your office visit they pay and how much you pay. This is called an Explanation of Benefits, or EOB. This letter tells you exactly, according to your health insurance coverage how much of your health care bill is your responsibility and how much is the responsibility of your insurance provider to pay.

Then What? We receive the same letter that you do. It arrives about 10 – 30 days after your appointment. We look at each Explanation of Benefits (EOB) carefully, and determine what your insurance has determined as patient responsibility. This is the same way we normally determine how much to send you a bill for in the mail.

But wait, I'm nervous about leaving you my credit card. We do not store your sensitive credit card information in our office. It is stored on a secure gateway that is completely compliant as required by law. We access your information only on this site to process a payment. If you absolutely do not want your credit card on file, then you can choose to pay the entire billed amount at the time of service. If your insurance pays after you have made payment, we will send you a refund.

What if I need to dispute my bill? We will always work with you to understand if there has been a mistake, and we will refund you if we have made a billing error. We will only charge the amount that we are instructed to by your insurance carrier via the EOB. In addition, we will also email you 7 days prior to charging your card. This email will notify you that a charge will be processed for a prior visit at our office.

What if I don't have a credit or debit card? If you do not have a credit card, you can be seen as a self-pay patient and pay 100% for all services at the time of service.

How can I see my bill? You can either look at the EOB from your insurance company or log onto our secure patient portal to view your statements and receipts at anytime.

What if don't have insurance? If you do not have insurance, payment in full is due at the time of service. In this case we do not need to have a credit card on file.

I have read and understand the previous information regarding my credit card on file.

Signature_____

Print Name _____

Date _____

AUTHORIZATION TO TREAT A MINOR PATIENT IN ABSENCE OF PARENT/ GUARDIAN

Minor patient name: _____ Date of birth: _____

Parent/ Legal Guardian's Name: _____

Home Phone Number: _____ Work Phone Number: _____

Cell Phone Number: _____ Other Phone Number: _____

I certify that I am the parent and/or legal guardian of _____
(Name of child)

☐ I authorize _____ to bring my child to office visits with Dr. _____
(name of person bringing child to office) (name of physician)

☐ I authorize the minor child named above to come alone to office visits with Dr. _____
(name of physician)

and I consent to the examination and/or treatment of my child.

This authorization:

☐ is effective on _____

☐ is effective from _____ to _____

☐ is effective until revoked by me in writing

I reserve the right to revoke this authorization at any time by writing to the above named physician.

Parent/ Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

The HIPAA Privacy Rule, a federal regulation, requires that we provide detailed notice in writing of our privacy practices. We recognize this is a lengthy document, however the rule requires many specific issues to be addressed. We must follow the privacy practices that are described in this notice while it is in effect. **This notice takes effect July 1, 2014 and will remain in effect until we replace it.**

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that applicable law permits such changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes. A copy of our notice, or any subsequent revised notice, may be requested at any time. For more information about our privacy practices, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

We will use and disclose your protected health information of "PHI" about you for treatment, payment and health care operations.

The following are examples of the types and uses of disclosures of your PHI that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

TREATMENT: We will use and disclose your PHI to provide, coordinate and manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. We would also disclose PHI to other physicians who may be treating you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your PHI from time to time to another physician or health care provider (e.g. another specialist, laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

PAYMENT: Your PHI will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommended for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities. For example, obtaining approval for surgical procedure may require that your relevant PHI be disclosed to the health plan to obtain approval for the surgical procedure.

HEALTH CARE OPERATIONS: We may use or disclose, as needed, your PHI in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the reception desk or we may call you by name in the waiting room when your doctor is ready to see you. We may use and disclose PHI, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your PHI with third party Business Associates that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a Business Associate involves the uses or disclosures of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.

We may use or disclose your PHI, as necessary, to provide you with treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your PHI for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact us to request that these materials not be sent to you.

USES AND DISCLOSURES BASED ON YOUR WRITTEN AUTHORIZATION: Other uses and disclosures of your PHI will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your PHI or to disclose it to anyone for any purpose. If you have an authorization, you may revoke it in writing at anytime. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without written authorization, we will not disclose your PHI except as described in this notice.

OTHERS INVOLVED IN YOUR HEALTH CARE: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify, or assist in notifying, a family member, personal representative, or any other person that is responsible for your care of your location, general condition or death.

MARKETING: We may use your PHI to contact you with information about treatment alternatives that may be of interest to you. We may disclose your PHI to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further information by telling us using the contact information at the end of this notice.

RESEARCH | DEATH | ORGAN DONATION: We may use or disclose your PHI for research purposes in limited circumstances. We may disclose the PHI of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

PUBLIC HEALTH AND SAFETY: We may disclose your PHI to the extent necessary to avert a serious and imminent threat to your health and safety, or the health and safety of others. We may disclose your PHI to a governmental agency authorized to oversee the health care system or governmental programs or its contractors, and to public health authorities for public health purposes

HEALTH OVERSIGHT: We may disclose your PHI to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information including government agencies that oversee the health care system or government benefit programs, other government regulatory programs and civil rights laws.

ABUSE OR NEGLECT: We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

FOOD AND DRUG ADMINISTRATION: We may disclose your PHI to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

CRIMINAL ACTIVITY: Consistent with applicable federal and state laws, we may disclose your PHI, if we believe the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose your PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

REQUIRED BY LAW: We may use or disclose your PHI when we are required to do so by law. For example, we must disclose your PHI to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in a compliance with federal privacy laws. We may disclose your PHI when authorized by workers' compensation or similar laws.

PROCESS AND PROCEEDINGS: We may disclose your PHI in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your PHI to law enforcement officials.

LAW ENFORCEMENT: We may disclose limited information to law enforcement official concerning the PHI of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the PHI of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose PHI where necessary to assist law enforcement officials to capture an individual who as admitted to participation in a crime or has escaped from lawful custody.

Patient Rights

ACCESS: You have the right to look at or request copies of your PHI, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your PHI. You may also request access by sending us a letter to the address at the end of this notice. If you prefer, we will prepare a summary of an explanation of your PHI for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

ACCOUNTING OF DISCLOSURES: You have the right to receive a list of instances in which we, or our business associates, disclosed your PHI for purposes other than treatment, payment, health care operations and certain other activities. The accounting will be provided for the past six (6) years. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your PHI, a description of the PHI we disclosed, the reason for the disclosure and certain other information. If you request this list more than once in a 12 month period, we may charge you for a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

RESTRICTION REQUEST: You have the right to request that we place additional restrictions on our use and disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to request for additional restriction must be in writing, signed by the person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing. Please use the contact information at the end of this form to obtain a Restriction Request form.

CONFIDENTIAL COMMUNICATION: You have the right to request that we communicate with you in confidence about your PHI by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request it if is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you. Please use the contact information at the end of this notice to obtain a Request for Confidential Communications form.

AMENDMENT: You have the right to request that we amend your PHI. Your request must be in writing and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement to be appended to the people or entities you name of the amendment and to include the changes in any future disclosures of that information. Please use the contact information at the end of this form to obtain a Request for Amendment form.

ELECTRONIC NOTICE: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this information in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

QUESTIONS & COMPLAINTS If you want more information about our privacy practices or have questions or concerns, please contact us using the information below.

If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI or in response to a request you made, you may submit a complaint to us using the contact information below. When possible, please use our Patient Complaint form, which can be obtained using the contact information below. You may also submit a written complaint to the U.S. Department of Health and Human Services. If you wish to file a complaint with them, we will provide you with their address upon request.

We support your right to protect the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Name of Contact Person: Aimee S.
Telephone: 425.226.5656
Fax: 425.271.1488

Address: 433 SW 41st St
Renton, WA 98057