Last Update: 11/7/13

WASHINGTON FOOT & ANKLE SPORTS MEDICINE

12911 120th Ave. NE, Suite C50, Kirkland, WA 98034
T 425-899-3234 F 425-899-3235 www.rundoctor.com

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	_____

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			

Past Medical History

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 (explain below)

Condition and relative: _____

Weight: _____ Height: _____ Shoe Size: _____

Continued on Reverse

WASHINGTON FOOT & ANKLE SPORTS MEDICINE

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

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:

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

WASHINGTON FOOT & ANKLE SPORTS MEDICINE

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

Patient Registration

(Please Print)

LAST NAME: _____ **FIRST:** _____ **MIDDLE INITIAL:** _____ ❑M❑F

BY WHAT NAME DO YOU PREFER TO BE ADDRESSED? _____ **D.O.B:** _____ AGE: _____

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

PRIMARY PHONE # (_____) _____ **SS #** _____ OCCUPATION: _____

SECONDARY PHONE# (_____) _____ **EMAIL:** _____

EMPLOYER: _____ WORK # (_____) _____ MARITAL STATUS: ❑SINGLE ❑MARRIED

EMERGENCY CONTACT: _____ **PHONE #** (_____) _____

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

PHONE # (_____) _____ WORK # (_____) _____ EMPLOYER: _____

PLEASE TELL US HOW YOU CHOSE US TO PROVIDE YOUR FOOT & ANKLE CARE:

❑ REFERRED BY: _____ CLINIC NAME/LOCATION: _____

PRIMARY CARE PHYSICIAN: _____ CLINIC NAME/LOCATION: _____

PRIMARY INSURANCE COMPANY: _____

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

RELATIONSHIP TO PATIENT: _____ INSURED D.O.B: _____ SS # _____

DO YOU NEED A REFERRAL TO SEE A SPECIALIST? ❑YES ❑ NO **CO-PAY $** _____

SECONDARY INSURANCE COMPANY: _____

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

RELATIONSHIP TO PATIENT: _____ INSURED D.O.B: _____ SS # _____

MILITARY: ❑ **Y** ❑ **N** BRANCH: _____

DO YOU NEED A REFERRAL TO SEE A SPECIALIST? ❑YES ❑ NO **CO-PAY $** _____

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: _____

WASHINGTON FOOT & ANKLE SPORTS MEDICINE

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

NOTICE OF PRIVACY PRACTICES —ACKNOWLEDGEMENT

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. For a summary or full privacy practice notice, please contact Dawn Nicks, Privacy Officer.

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):

[ ] Home Telephone _____
[ ]O.K. to leave message with detailed information
[ ]Leave message with call-back number
[ ] Work Telephone _____
[ ]O.K. to leave message with detailed information
[ ]Leave message with call-back number

[ ] Cell Telephone _____
[ ] O.K. to leave message with detailed information
[ ] Leave message with call-back number
[ ] Written Communication
[ ] OK to mail to home address
[ ] OK to fax to this number _____

I consent to the use or discloser of my protected health information by Lawrence M. Maurer, D.P.M., Peter M. Vincent, D.P.M. and Phillip A. Shaw, 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., Peter M. Vincent, D.P.M., and Phillip A. Shaw, D.P.M.

I understand that diagnosis or treatment of me by Dr. Maurer, Dr. Vincent, Dr. Shaw 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, Dr. Shaw 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., Phillip A. Shaw, D.P.M. agrees to a restriction that I request, the restriction is binding on Lawrence M. Maurer, D.P.M., Peter M.Vincent D.P.M., Phillip A. Shaw, D.P.M. 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 Dr. Shaw, and their Associates or Lawrence M. Maurer, D.P.M., Peter M. Vincent, D.P.M. and Phillip A. Shaw, 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 Relationship (Parent, legal guardian, personal representative)

This form will be retained in your medical record.

WASHINGTON
FOOT & ANKLE
SPORTS MEDICINE

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

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 eighteen (18%) 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.

WASHINGTON
FOOT & ANKLE
SPORTS MEDICINE

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

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)_____