Western Washington Medical Group
Podiatry

Diplomate, American board of Podiatric Surgery
Fellow American College of Foot & Ankle Surgeons

Jeffrey W. Boggs, DPM, FACFAS, DABPS
Kristen B. Boyce, DPM, FACFAS, DABPS
Phillip A. Shaw, DPM

WELCOME TO OUR OFFICE

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 first visit a convenient and pleasant experience.

Prior to your appointment, **please contact your insurance company to clarify your coverage requirements.**
When you come for your appointment, please bring the following:
(Please do not send prior to your appointment)

- Completed Patient Registration and History Forms
- **Medical** Insurance card(s)
- Written referral or referral number, if required by your insurance
- Previous x-rays/MRIs and medical records
- List of current **Medications** (include all over the counter meds) with dosages and milligrams
- Shoes (bring a sample of the more common shoes that you wear, including athletic and walking shoes) **NOTE:** As you will be receiving advice on 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 no insurance, the full cost of the visit
- Supplies that may be purchased through our office (pads, orthotics, etc.)

For your convenience, we do accept *Visa, MasterCard and Discover.*

A Note about referrals: You cannot assume that your referral has been approved unless you have received confirmation ***from your insurance company or your doctor's office.***

PLEASE ARRIVE @ _____AM/PM

TO YOUR SCHEDULED APPOINTMENT ON: _____

WITH: [ ] JEFFREY BOGGS, DPM
[ ] KRISTEN BOYCE, DPM
[ ] PHILLIP SHAW, DPM

3802 Broadway, Suite B • Everett, Washington 98201
Tel: 425.259.0855 • Fax: 425.259.0856

WESTERN WASHINGTON MEDICAL GROUP
DEPARTMENT OF PODIATRY

REGISTRATION FORM

ACCOUNT#_____ NEW _____ UPDATE _____

PATIENT LAST NAME	FIRST NAME (legal)	MI	PREFERRED OR NICKNAME

DATE OF BIRTH	SEX M F	RACE / ETHNICITY	PREFERRED LANGUAGE

MAILING ADDRESS	APT #	CITY	STATE	ZIP CODE 4 DIGIT

STREET ADDRESS	APT #	CITY	STATE	ZIP CODE 4 DIGIT

HOME PHONE ( )	WORK PHONE ( ) EXT	CELL PHONE ( )

REFERRING DOCTOR	MARITAL STATUS MARRIED ____ DIVORCED ____ OTHER ____
PRIMARY CARE DOCTOR	SINGLE ____ WIDOWED ____ SEPARATED ____
PHARMACY NAME, PHONE NUMBER AND LOCATION	PREFERRED EMAIL ADDRESS

PATIENT EMPLOYER (IF NOT EMPLOYED ARE YOU RETIRED____ OR DISABLED____)

EMPLOYER NAME	OCCUPATION

STREET ADDRESS	CITY	STATE	ZIP CODE 4 DIGIT

PRIMARY INSURANCE

INSURANCE COMPANY NAME	RELATION TO SUBSCRIBER	COPAY

SUBSCRIBER'S NAME	SUBSCRIBERS EMPLOYER

SUBSCRIBERS DATE OF BIRTH	SUBSCRIBER'S SEX MALE___ FEMALE___	SUBSCRIBERS ID #	GROUP NUMBER

SECONDARY INSURANCE

INSURANCE COMPANY NAME	RELATION TO SUBSCRIBER	COPAY

SUBSCRIBER'S NAME	SUBSCRIBERS EMPLOYER

SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBERS SEX MALE___ FEMALE___	SUBSCRIBERS ID #	GROUP NUMBER

EMERGENCY CONTACT (NOT LIVING WITH YOU)	NAME	RELATIONSHIP	PHONE NUMBER- HOME/WORK/CELL ( )

RESPONSIBLE PARTY WHO IS RESPONSIBLE FOR THE REMAINING BALANCE ON THIS ACCOUNT?

____ SELF (* If self do not fill in right field.) ____ SPOUSE ____ PARENT ____ GUARDIAN		LAST NAME	FIRST NAME	MI

	STREET ADDRESS	CITY	STATE	ZIP CODE 4 DIGIT

	HOME PHONE ( )	WORK OR CELL PHONE ( ) EXT	DATE OF BIRTH	SEX M F

WORKERS COMP CLAIM #	DATE OF INJURY	EMPLOYER	STATE OR SELF INSURED?

I, the patient or guardian, certify that the information contained on this form is true to the best of my knowledge. I accept responsibility for the charges incurred by the patient, and agree to pay all bills at the time of service, unless prior arrangements have been made. I authorize the physician and clinic to release any information to process insurance claims. I authorize my insurance claim to be paid directly to the clinic. I authorize **Western Washington Medical Group** to leave messages, which may contain details of my medical condition on my voicemail box if they are unable to reach me.

INITIALS VOICEMAIL #

PATIENT SIGNATURE _____ ***DATE***

For office use only
Dr._____ Ins. code_____ Acct #_____ Initials _____

PATIENT HISTORY FORM

Name: _____ DOB: ____/____/____ Height: _____ Weight: _____

Primary Care Physician: _____ Referring Doctor (if not your PCP): _____

Do you, or have you ever smoked: [ ] NO, [ ] YES – If yes, Year started: _____, How many years: _____, Year quit: _____

Do you drink alcohol: [ ] NO, [ ] YES – If yes, Rarely: _____, Occasionally: _____, Other: _____

Please list ***ALL*** medications, including over the counter medication (or provide a list of medications): _____

_____

_____

PAST MEDICAL CONDITIONS:

YES NO (CHECK YES or NO)

____ ____ Rheumatic Fever
____ ____ Scarlet Fever
____ ____ Epilepsy/Convulsions
____ ____ Heart Disease
____ ____ Hypertension (High Blood Pressure)
____ ____ Tuberculosis
____ ____ Diabetes, type? _____ how many years _____
____ ____ Skin problems
____ ____ Kidney problems
____ ____ Anemia
____ ____ Cancer, type? _____
____ ____ AIDS
____ ____ MRSA
____ ____ Liver disorder (Hepatitis, Jaundice)
____ ____ Stroke
____ ____ Lung/Respiratory problems
____ ____ Stomach/Intestinal Ulcers
____ ____ Gout
____ ____ Circulation problems
____ ____ Bleeding disorders
____ ____ Arthritis, type? _____

ALLERGIES/SENSITIVITIES TO MEDICATIONS & REACTIONS

YES NO (CHECK YES or NO)

____ ____ Penicillin: _____
____ ____ Sulfa: _____
____ ____ Other Antibiotics: Type _____
____ ____ Codeine: _____
____ ____ Novocain/Local Anesthesia: _____
____ ____ Iodine: _____
____ ____ Adhesive Tape: _____
____ ____ Latex: _____
____ ____ Soap: _____
____ ____ Aspirin: _____
____ ____ Other, what? _____

FAMILY HISTORY

(Immediate ***blood relatives*** who have the following)

YES NO

____ ____ Diabetes, who: _____
____ ____ Heart Disease, who: _____
____ ____ Stroke, who: _____
____ ____ Cancer, type: _____
who: _____
____ ____ Arthritis, type: _____
who: _____

PLEASE LIST ANY ANESTHESIA-INVOLVED SURGERIES WITH APPROXIMATE DATES: _____

_____

_____

_____

SYMPTOMS/SYSTEM REVIEW: Are you currently experiencing any of the following symptoms? (Please check all that apply)

**** IF NONE APPLY, CHECK BOX [ ]**

GENERAL: ___Nausea ___Fever ___Chills ___Muscle Aches ***EYES***: ___Double Vision ___Blurring ***ENT***: ___Ringing in Ears ___Dizziness

CV: ___Chest Pain ___Swelling in Legs ___Leg Cramps/Ache with Exertion ***DERM***: ___Rash ___Thickening of Skin ___Poor Wound Healing

GI: ___Blood in Stool ___Diarrhea ***GU***: ___Blood in Urine ___Frequency in Urination

RESP: ___Sleep Disturbances ___Shortness of Breath ___Chest Discomfort ___Wheezing ***PYSCH***: ___Anxiety ___Depression

MS: ___Joint Pain/Swelling ___Numbness ___Tingling in Hands/Feet ___Muscle Aches

NEURO: ___Prior Stroke/TIA ___Poor Balance ___Numbness ___Tingling ___Seizures

HEME: ___Abnormal Bruising ___Skin Discoloration ___Bleeding Disorder ***ENDO***: ___Excessive Thirst ___Cold Intolerance ___Heat Intolerance

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I _____, acknowledge that I received a copy of the Notice of Privacy Practices for Western Washington Medical Group.

_____ _____

Signature of client (or personal representative) Date

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:
Personal Representative's Name: _____

Relationship to Client: _____

For Office Use Only

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign
_____ Communications barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement
_____ Other (Please Specify)

_____
_____

_____ _____

Employee Name Date

This form will be retained in your medical record

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FINANCIAL AGREEMENT

We consider all patients as "**private**" unless their insurance is one with whom we have a contractual agreement. We will bill your insurance as a courtesy but the balance for "**private**" patients is due and payable within 30 days. Many insurance plans cover a certain percentage only of the fees charged. The insurance normally only covers the "usual and customary" fees. Your insurance, as a result, may cover less than you thought they might, or you may have a deductible to meet first. You may have scheduled a visit that is not covered by your insurance, such as Preventative Care. It is the patient's responsibility to check their benefits prior to being seen.
*Please be familiar with the benefits provided by your health plan.

If your insurance requires a referral or if we need insurance authorization prior to your visit, it is YOUR responsibility to see that your health plan requirements are met. If your insurance information or other documents needed are not provided at, or prior to, your first visit, any charges incurred will be your responsibility.

Co-pays are due at time of service, if you are unable to pay your co-pay at time of service there may be an **additional $15.00 fee** charged to your account.

Should the account be referred over to our collection agency the undersigned, or their agent, will be responsible for payments of interest on the unpaid balance of 1% per month from the date of the service, collection fees, reasonable attorney fees and court costs.

We charge $35.00 for any NSF checks. (per RCW 62A-3-515 & 520)

With my signature, I acknowledge that I have read the above statement and agree to pay any charges within 30 days of receipt of statement unless other arrangements (such as contractual insurance) have been made. I authorize the physician to release my information required to process my insurance claims and authorize my insurance company to make payment directly to my physician.
I HAVE READ THE FINANCIAL AGREEMENT. I UNDERSTAND AND AGREE TO THIS POLICY.

Printed Name_____ DOB_____

Signature_____ Date_____

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Consent to Release Information - Family and Friends

I give the providers and office staff of Western Washington Medical Group (WWMG) permission to discuss my medical condition. *(NOTE: if a specific topic box is not checked, we will be unable to discuss <u>any</u> treatment related to that topic.)* **WWMG may disclose health care information regarding testing, diagnosis and treatment for the following conditions:**

[ ] HIV (Aids virus)
[ ] Sexually Transmitted Infections (STIs)
[ ] Psychiatric disorders / Mental health
[ ] Alcohol / Substance abuse
[ ] All other health information
Other: _____

The consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information current, as I recognize that relationships and friendships change over time.

Name	*Relationship*	*Phone*
Name	*Relationship*	*Phone*
Name	*Relationship*	*Phone*

<u>Patient's Personal Phone Information: NOTE! This is DIFFERENT than the above info.</u>
Please provide us with **YOUR best, most** current phone contact information. This information will become part of your permanent medical record *<u>unless/until you change it.</u>* You can change this information simply by asking to complete a new form.
Please note: by approving the option to leave a detailed message you are allowing us to leave sensitive health information and specifics related to referrals.

First phone number	**Second phone number**	**Third phone number**
Cell Work Home OK to leave detailed message?: Y N	Cell Work Home OK to leave detailed message?: Y N	Cell Work Home OK to leave detailed message?: Y N

_____ _____
Signature of client (or personal representative) *Date*

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

_____ _____
Personal Representative's Name *Relationship to Client*

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No Show/Cancellation Policy

We strive to provide excellent medical care to our patients. In order to be consistent with this, we have a Patient No-Show and Cancellation Policy that we have adopted for our clinic. When an appointment is scheduled, that time has been reserved for you and when it is missed or cancelled on short notice, that time cannot be used to see another patient.

Our policy is as follows: You may cancel your appointment up until **24 hours before** your scheduled appointment with no consequences. We will be happy to reschedule the appointment for you and leave the open time for another patient. If you miss your appointment or cancel any time the day of your appointment, Western Washington Medical Group, Department of Podiatry, reserves the right to bill you **$50.00** for each no-show or late cancellation. This fee is the patient's responsibility and is not billable to insurance.

Additionally, if a patient is more than 15 minutes late to his/her appointment without prior notification, we reserve the right to cancel the appointment and the cancellation fee of **$50.00** will apply.

We do realize that on rare occasions emergencies or circumstances may arise beyond your control. We will address these situations with you should that occur.

If you have any questions regarding this policy, please direct them to the practice administrator. We thank you for working with us to ensure that we are able to provide the best service possible to all of our patients.

I have read and understand the Patient No-Show and Cancellation Policy of the practice and I agree to the terms. I also understand that such terms may be amended periodically by the practice.

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

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