

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 <u>from your insurance company or your doctor's office.</u>

PLEASE	E ARRIVE @	AM/PM
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WITH:	[] JEFFREY BOGGS, DPM	
	[] KRISTEN BOYCE, DPM	
	[] PHILLIP SHAW, DPM	

WESTERN WASHINGTON MEDICAL GROUP DEPARTMENT OF PODIATRY

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For office use only					INITIALS			VOICEMAIL	#		
or office use only	PATIENT SIGNATURE							DATE			
	For office use only										

PATIENT HISTORY FORM

Name:	DOB:	/	_/	Height:	Weight:
Primary Care Physician:	Refer	ring Doo	ctor (f not your PCP):	
Do you, or have you ever smoked: [] NO, [] YES – If ye	s, Year star	ted:		, How many years: _	, Year quit:
Do you drink alcohol: [] NO, [] YES – If yes, Rarely:	Occ	asionall	v.	Other:	_
Please list <i>ALL</i> medications, including over the counter					
rease list 7122 medications, metading over the counter	medication	i (or pre	viue		
PAST MEDICAL CONDITIONS:		ALLE	RGII	S/SENSITIVITIES TO I	MEDICATIONS & REACTIONS
(ES NO (CHECK YES or NO)		YES		O (CHECK YES or N	
Rheumatic Fever					
Scarlet Fever					
Epilepsy/Convulsions					Туре
Heart Disease					
Hypertension (High Blood Pressure)					nesthesia:
Tuberculosis				Iodine:	
Diabetes, type? how many years		F			
Skin problems	-	***		Latex:	
Kidney problems				_	
Anemia		=		Aspirin:	
Cancer, type?	_		_	Other, what?	
AIDS		FAM	шν	HISTORY	
MRSA				e <i>blood relatives</i> who l	nave the following)
Liver disorder (Hepatitis, Jaundice)		YES		Ю	Ç,
Stroke			_	Diabetes, who:	
Lung/Respiratory problems				Heart Disease, wh	0:
Stomach/Intestinal Ulcers					
Gout					
Circulation problems			_		
Bleeding disorders					
Arthritis, type?	÷		_		
				wiio;_	
EASE LIST ANY ANESTHESIA-INVOLVED SUR	CERIFC V	ATTH A	PPR	OXIMATE DATES	
LEIGH HOT THAT THANKS THE HAVE BUT THANKS HOLD BOX	GLICILS V	VIIII Z		OMBITE DATES	
MPTOMS/SYSTEM REVIEW: Are you currently ex	periencing	any of t	he fo	llowing symptoms? (Please check all that apply)
IF NONE APPLY, CHECK BOX []					
NERAL:NauseaFeverChillsMuscle Aches	EYES: T)ouble Vi	ision	Blurring ENT:	Ringing in Ears Dizziness
				•	
:Chest PainSwelling in LegsLeg Cramps/Ache wi				_	okinroor Wound Healing
			ation		
:Blood in StoolDiarrhea <i>GU</i> :Blood in Urine	Frequenc	y in Urin	auon		
					Depression
Blood in StoolDiarrheaGU:Blood in Urine SP:Sleep DisturbancesShortness of BreathChest	Discomfort	tWhe	eezing		Depression
Blood in StoolDiarrheaGU:Blood in Urine _	: Discomfort	tWhe	ezing hes		Depression



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I	, acknowledge that I or Western Washington Medical
Signature of client (or personal representative)	Date
If this acknowledgment is signed by a personal recomplete the following: Personal Representative's Name:	
Relationship to Client:	
E.	
For Office Use O	only
I attempted to obtain written acknowledgement of repractices, but acknowledgement could not be obtain Individual refused to sign Communications barriers prohibited obtaining An emergency situation prevented us from of Other (Please Specify)	ed because: g the acknowledgement
Employee Name This form will be retained in your medical record	Date



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	



Consent to Release Information - Family and Friends

medical condition. (NOTE: if a specific		
to that topic.) WWMG may disclose h	ealth care information regarding testi	ng, diagnosis and treatment for the
following conditions: [] HIV (Aids virus)	[] Connally Townsie d	I. f4' (CTI-)
[] Psychiatric disorders / Mental health	[] Sexually Transmitted [] Alcohol / Substance a	
[] All other health information	[] Alcohol - Substance a	Duse
Other:		
The consent will be considered valid un	til such time that I revoke it. I reserve th	e right to revoke it at any time. It will
be my responsibility to keep this inform		
time.		
Name	Relationship	Phone
Nume	Retutionsmp	1 none
Name	Relationship	Phone
Name	Relationship	Phone
Nume	Retationsmp	rnone
Patient's Personal Phone Information	: NOTE! This is DIFFERENT than t	he above info.
Please provide us with YOUR best, mo	st current phone contact information. The	his information will become part of
your permanent medical record unless/u	until vou change it. Vou can change this	information simply by asking to
	nui you change u. I ou can change uns	
complete a new form.	ma you change it. I ou can change this	
complete a new form. Please note: by approving the option	to leave a detailed message you are al	
complete a new form.	to leave a detailed message you are al	
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complete a new form. Please note: by approving the option information and specifics related to r First phone number Cell Work Home OK to leave detailed message?: Y N Signature of client (or personal represe	to leave a detailed message you are aleferrals. Second phone number Cell Work Home OK to leave detailed message?: Y N ntative) Date personal representative on behalf of	Third phone number Cell Work Home OK to leave detailed message?: Y N





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.