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, FACFAS, DABPS

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:**

- Completed Patient Information & History forms
- **Medical Insurance Card(s).** **We do not have access to this information regardless of referral status.*
- **Previous X-rays/MRI's & medical records.** **Kaiser patients MUST BRING images on a disc.*
- **List of current Medications** (include all over the counter medications, vitamins and herbal supplements) with dosages and milligrams.
- Please bring **ONE PAIR** of your current, most worn shoes for review. **ONE PAIR ONLY.*
- It is a requirement to wear a surgical grade mask within a medical office. If you do not have one, we can supply that for you. N95 and KN95 are also acceptable. **NO CLOTH MASKS.*
- We prefer to limit the number of people within the office at this time. Please limit your company to one individual besides yourself.

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, insoles, orthotics down payment, etc.)

** For your convenience, we do accept Visa, Mastercard, and Discover **

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

YOUR APPT IS SCHEDULED ON: _____

WITH: [ ] Jeffrey Boggs, DPM [ ] Kristen Boyce, DPM [ ] Phillip Shaw, DPM

PLEASE ARRIVE AT: _____ AM/PM, with the above mentioned items.

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Dear WWMG Podiatry Patients,

We hope this letter finds everyone healthy and happy. The world has changed in the last few years, and we are all still coming to grips with the COVID-10 pandemic and the sacrifices everyone has had to make. In our practice, we are taking steps to ensure we do everything possible to keep our patients and our team healthy. We will be following rigorous scheduling protocols and measures to make this as smooth of an experience as possible.

Appointments:

- We will be decreasing our daily patient load by 1/3 to 1/2 to ensure social distancing.

Visits:

- We will require EVERYONE to wear a mask. Please come to your appointment with a mask or face covering.
- When you arrive for your appointment, please wait at the front desk where you will be greeted by a team member. **Please do not sit down.**
- We prefer that **ONLY** the patient that is being treated enter our office. But if there is a special circumstance and you need someone with you, a second person will be allowed on a case by case basis. We ask that absolutely no other friends or family members enter our office.
- Every individual entering our office will be asked screening questions to assess for COVID-19 risk factors and symptoms. Any answer indicating recent exposure to someone with COVID-19 or having any related signs and symptoms will be rescheduled after the 14-day self-quarantine requirement.

Offices:

- We will continue to follow the strictest and rigorous disinfection and sterilization protocols, along with disinfecting commonly-touched surfaces several times a day.
- The 6-foot social distancing guidelines will be maintained in our offices, and all treatment chairs are positioned at least 6-feet apart.
- Other changes in the offices include limited chairs in our reception areas, and the removal of all magazines/ reading materials.

Team:

- We will be screening each one of our team members, including our providers, for any signs and symptoms related to COVID-19 and will be completed every morning.

We are so grateful for every single one of our patients, and this time away has only served to make us even more **thankful for each of you**. If you have any questions, please feel free to contact us. Stay healthy, stay calm, and stay positive.

Sincerely,

WWMG Podiatry Providers & Staff

PATIENT HISTORY FORM

Your name: _____ **Date of birth:** ___/____/____ **Height:** _____ **Weight:** _____

Primary Care Doctor: _____ **Referring Doctor:** _____

Do you smoke? ____ **If yes, how much** _____ **Do you drink alcohol?** ____ **How much?** _____

Please list ANY medications/vitamins: _____

_____

_____

Please list ANY allergies/sensitivities you may have to medications: _____

_____

Please list any anesthesia involved surgeries w/ age or date performed: _____

_____

_____

PAST MEDICAL CONDITIONS: (please check if you have had or are experiencing currently.

___AIDS____Anemia ____Anesthesia complications

___Anxiety ____Arthritis ____Asthma

___Atrial fibrillation ____Autoimmune disorder

___Bleeding disorders ____Blood transfusions

___Brain tumor ____Cancer, type: _____

___Circulation problems ____Cirrhosis

___Colon Cancer _____COPD ____Crohn's disease

___Depression ____DVT(bloodclot) ____Dialysis

___Diabetes, type____, how long: _____

___ Endocarditis ___Eczema ___Fibromyalgia

___GERD ___GI Bleed ___ Gout

___Heart disease, Type: _____

___Hepatitis, A, B or C ____HIV

___Hyperlipidemia ____Hypertension

___Hypo or Hyperthyroidism (circle one)

___Impotence ___Infertility ___Kidney disease

___Liver disease ___MRSA, when:_____

___Neurological disorder

___Osteoarthritis ___Osteoporosis

___Pulmonary Embolism ___PVD ___PUD

___Rheumatic fever ___Rheumatoid Arthritis

___Scarlet fever ___Seizure disorder

___Sleep Apnea ___Stomach/Intestinal Ulcers

___Stroke, How long ago: _____

___Syncope (fainting) ___Tuberculosis

___Hx of UTI (Urinary tract infection

___Varicose Veins/phlebitis

___Ventricular Tachycardia

Family History: (Immediate blood relatives)

___Diabetes, who:_____

___Heart disease, who:_____

___Stroke, who:_____

___Cancer, who & type:_____

_____

____Arthritis, who & type:_____

_____

TURNOVER & COMPLETE PLEASE.....

Systems review: please check ALL that apply to you

General:

___sweats ___fever ___anorexia ___fatigue ___weakness ___chills ___malaise ___weight loss ___sleep disorder

Eyes:

___vision loss ___1 eye or ___ both eyes ___double vision

___halos___ eye irritation

___blurring ___eye pain

___discharge ___light sensitivity

ENT:

___ears ringing ___hoarseness ___nosebleed ___ear discharge

___earache ___sore throat

___decreased hearing

___nasal congestion

___difficulty swallowing

Cardiovascular:

___ difficulty breathing at night

___near fainting ___fatigue

___chest pain/discomfort

___racing/skipping heartbeats

___lightheadedness

___weight gain

___Shortness of breath w/ exertion or ___lying down

___palpitations ___fainting

___swelling of hands/feet

___leg cramps w/ exertion

___bluish discoloration of lips/nails

Respiratory:

___ Sleep disturbances due to breathing

___ cough ___wheezing

___shortness of breath

___coughing up blood

___chest discomfort

___excessive sputum

___excessive snoring

Gastrointestinal:

___excessive/loss of appetite ___gas ___indigestion ___nausea ___vomiting ___vomiting blood

___yellowish skin color

___abdominal pain

___bloating ___hemorrhoids

___diarrhea ___bowel changes

___constipation ___bloody stools

Urinary:

___ dysuria (painful urinating)

___hematuria (blood in urine)

___discharge ___genital sores

___urinary frequency/ hesitancy ___incontinence

___nocturia (urinating at night)

___decreased libido (sex drive)

___ erectile dysfunction

Musculoskeletal:

___muscle cramps ___joint pain

___joint swelling ___back pain

___presence of joint fluid

___stiffness ___arthritis

___muscle weakness

___gout ___loss of strength

___muscle aches

Derm (skin):

___excessive perspiration ___night sweats ___flushing

___suspicious lesions ___rash

___dryness ___poor healing

___unusual hair distribution

___skin cancer ___itching

___change in skin color

__change in nailbeds

Neurological:

___concentration difficulty

___poor balance ___headaches

___coordination problems

___numbness ___tingling

___inability to speak

___falling down ___brief paralysis ___visual disturbances ___seizures ___weakness ___sense of spinning

___tremors ___fainting

___excessive daytime sleeping

___memory loss

Psychological:

___sense of danger ____anxiety ___suicidal thoughts ___mental problems ___depression ___violent thoughts ___frightening visions or sounds

Endocrine:

___excessive hunger ___cold intolerance ___heat intolerance ___excessive urination ___excessive thirst ___weight change

Heme (blood):

___enlarged lymph nodes

___bleeding ___skin discoloration

___abnormal bruising ___fevers

Allergy:

___persistent infections

___hives or rash ___seasonal allergies

___HIV exposure

Western Washington Medical Group

REGISTRATION FORM

ACCOUNT#_____ NEW _____ UPDATE _____

PATIENT LAST NAME	FIRST NAME (legal)	MI	PREFERRED OR NICKNAME	DATE OF BIRTH

RACE	ETHNICITY	PREFERRED LANGUAGE	SOCIAL SECURITY #

SEX M___ F___ Other: _____ (Please List)	GENDER IDENTITY: __Genderqueer identifies as neither Male or Female __Identifies as Male __Female-to-male __Additional gender category or other, please specify _____ __Identifies as Female __Male-to-female __Choose not to disclose	SEXUAL ORIENTATION __ Choose not to disclose __ Heterosexual (straight) __ Bisexual __ Homosexual (gay/lesbian) __ Other _____

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 ( )	PREFERRED EMAIL ADDRESS

REFERRING DOCTOR	HOW DID YOU HEAR OF US? Internet ___ Google Maps ___ Friend/Family ___ Drove by location ___ Insurance Company ___ Mailer/ Marketing ___	MARITAL STATUS MARRIED ____ DIVORCED ____ OTHER ____ SINGLE ____ WIDOWED ____ SEPARATED ____
PRIMARY CARE DOCTOR		

PHARMACY NAME, PHONE NUMBER AND LOCATION

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___ OTHER___	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___ OTHER___	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	SOCIAL SECURITY #	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___ Other___

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

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Consent to Release Information - Family and Friends

Name:

I give the providers and office staff of Western Washington Medical Group (WWMG) permission to discuss my medical condition. (NOTE: ifa specific topic box is not checked, we will be unable to discuss any 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*

Patient's Personal Phone Information: NOTE! This is DIFFERENT than the above info.

Please provide us with YOUR best, most current phone contact information. This information will become part of your permanent medical record unless/until you change it. 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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FINANCIAL AGREEMENT

We consider all patients as "private" unless their insurance is one whom with 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, may be responsible for payments of interest on the unpaid balance of 9% 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 _____