

REFURBISH ORTHOTICS

NOTICE OF NON-COVERED SERVICES FOR PODIATRY

Refurbishment of custom orthotics is not covered by insurance. Other non-covered services may include, but not limited to: orthotic devices; e.g. arch supports, shoe inserts, or other supportive devices of the feet, such as: wedges, specialized fillers, heel straps, pads and shanks, protective shields or molds and orthopedic shoes.

YOUR DOCTOR: **BOGGS[]** **BOYCE[]** **SHAW[]**

Phone number: _____

Shoe Size: _____ **Weight:** _____

EXISTING ORTHOTICS:

Refurbish same as last time.

Refurbish with modification: _____
.....

PATIENT AGREEMENT

By reading and signing this agreement, I agree that I have been properly notified of possible non-covered services or products under my insurance policy. ***I agree that I will be personally responsible for full payment of all non-covered services.***

Patient Signature: _____ **Date:** _____

Office use only: Attach original prescription[] ; Verify patient registration[] ; Make sure "Name Label" is legible[] Initial _____

CONSENT FOR MINORS

I, _____, the parent or legal
guardian of my child, _____
date of birth: _____, authorize and consent to routine and
emergency medical treatment for my child when deemed necessary by
qualified medical personnel. This authorization will be in effect until
revoked in writing by me.

Signature of parent/legal guardian

Date

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

ACCOUNT# _____ NEW _____ UPDATE _____

PATIENT LAST NAME		FIRST NAME (legal)		MI	PREFERRED OR NICKNAME		
DATE OF BIRTH	SEX M F	RACE		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			SUBSCRIBER'S EMPLOYER				
SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SEX MALE _____ FEMALE _____		SUBSCRIBER'S ID #		GROUP NUMBER		
SECONDARY INSURANCE							
INSURANCE COMPANY NAME			RELATION TO SUBSCRIBER			COPAY	
SUBSCRIBER'S NAME			SUBSCRIBER'S EMPLOYER				
SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SEX MALE _____ FEMALE _____		SUBSCRIBER'S 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?							
<input type="checkbox"/> SELF <small>(* If self do not fill in right field.)</small> <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> 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

V: ___ Chest Pain ___ Swelling in Legs ___ Leg Cramps/Ache with Exertion **DERM:** ___ Rash ___ Thickening of Skin ___ Poor Wound Healing

I: ___ 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

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

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 any treatment related to that topic.)* **WWMG may disclose health care information regarding testing, diagnosis and treatment for the following conditions:**

- | | |
|--|---|
| <input type="checkbox"/> HIV (Aids virus) | <input type="checkbox"/> Sexually Transmitted Infections (STIs) |
| <input type="checkbox"/> Psychiatric disorders / Mental health | <input type="checkbox"/> Alcohol / Substance abuse |
| <input type="checkbox"/> 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
--------------------------------	------------------------

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: _____

