WASHBURN
FOOT AND ANKLE
CENTER

New Patient Information Packet

*PATIENT NAME: _____

*MAILING ADDRESS: _____

CITY:_____STATE:_____ ZIPCODE:_____

MARITAL STATUS_____DATE OF BIRTH_____

HOME PHONE_____*CELL_____

*SOC SECURITY NO_____EMAIL_____

EMPLOYER_____WORK NUMBER_____

EMERGENCY CONTACT NAME (RELATIONSHIP)/PHONE:_____

INSURANCE/ MEMBER ID:_____

INSURANCE SUBSCRIBER (NAME/DOB) :_____

PRIMARY CARE PHYSICIAN_____

PHARMACY:_____ ADDRESS:_____

PLEASE PRESENT YOUR IDENTIFICATION AND INSURANCE CARDS TO THE RECEPTIONIST. IF YOU DO NOT HAVE VAILD DRIVER'S LICENSE OR PASSPORT, YOUR APPOINTMENT WILL BE RESCHEDULED.

IF YOU ARE 15 MINUTES LATE, THE APPOINTMENT WILL BE RESCHEDULED

YOU WILL BE REQUIRED TO PAY ANY DEDUCTIBLE, COPAYS, OR PERCENTAGES SET BY YOUR INSURANCE POLICY ON THE DAY YOU ARE SEEN.

FILL OUT FRONT AND BACK OF EACH PAGE

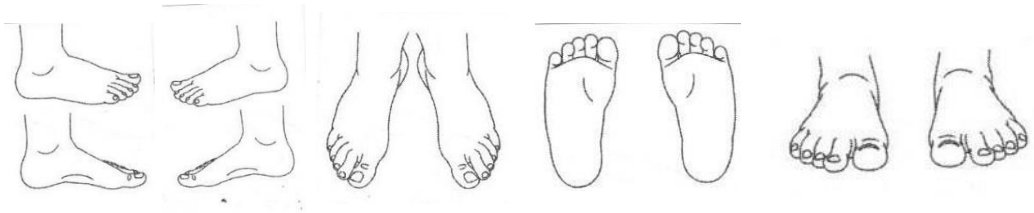
Please note that (1) complaint may only be addressed during the visit

REASON FOR VISIT: _____

_____

HAVE YOU BEEN TREATED FOR THIS CONDITION IN THE PAST: YES/ NO **WHEN/ WHERE:** _____

LOCATION:



Right Foot **Left Foot** **Top** **Bottom** **Toes**

DESCRIBE THE CONDITION/ SYMPTOM:

_____

DESCRIBE YOUR PAIN: SHARP DULL SHOOTING ACHING NUMB TENDERNESS BURNING ITCHING

HOW LONG HAVE YOU BEEN EXPERIENCING YOUR PROBLEM:

_____

HOW LONG DOES THE SYMPTOM LAST:

_____

WHAT MAKES YOUR PROBLEM/ PAIN WORSE: _____

ALLERGIES TO MEDICATIONS:

_____

LIST OF MEDICATIONS: _____

_____

_____

_____

ARE YOU CURRENTLY UNDER PAIN MANAGEMENT: (IF YES, GIVE NAME OF FACILITY) _____

PATIENT HISTORY:

PREVIOUS SURGERIES:

_____

_____

SMOKE? Y N HOW OFTEN_____ DRINK ALCOHOL? Y N HOW OFTEN_____

HEIGHT:_____ WEIGHT:_____

REVIEW OF SYSTEMS: CIRCLE ANY YOU HAVE BEEN DIAGNOSED WITH OR ARE EXPERIENCING

CONSTITIONAL:
□ CHILLS □ FEVER
□WEIGHT LOSS
□FATIGUE
□ DECLINE IN HEALTH
□WEAKNESS
□ WEIGHT GAIN

EYES:
□ BLURRY VISION □ DOUBLE VISION
□ EYEGLASSES □ PAIN WITH LIGHT
□ SENSATIONS □ CATARACTS
□ GLAUCOMA □ EXCESSIVE TEARING
□ RECENT INJURY □ VISION LOSS
□ EYE PAIN □ DISCHARGE □ INFECTIONS
□ REDNESS

HEAD:
□ DIZZINESS □ HEADACHES □ FAINTING
□ PAIN □ SWEATS □ HEAD INJURY

NOSE:
□ DISCHARGE □ INFECTIONS □ HAY FEVER
□ SINUS INFECTIONS □ FREQUENT COLDS
□ NASAL OBSTRUCTION □ NOSE BLEDS

MOUTH:
□ BLEEDING GUMS
□ POSTNASAL DRIP
□ HOARSENESS
□ TONGUE BURNING
□ CHANGE IN DENTITION
□ VOICE CHANGES

EARS:
□ DISCHARGE □HEARING IMPAIRMENT
□ RINGING IN EARS□ DIZZINESS□ PAIN
□ INFECTIONS □HEARING AIDS

THROAT AND NECK:
□ FREQUENT SORE THROAT □ LUMPS
□ TONSILS ENLARGED □ TENDERNESS

CARDIOVASCULAR:
□ CHEST PAIN □ HAIR LOSS ON LEGS □ HIGH BLOOD PRESSURE
□ PALPITATIONS □ SHORTNESS OF BREATH □ LEG SWELLING
□ VARICOSE VEINS □ COOL EXTREMITIES □ HEART MURMUR
□ HEART ATTACK □RECENT ELECTROGRAM □ HEART TEST
□ THROMBOPHLEITIS □ DISCOLORED EXTREMITIES
□ LEG PAIN (WALKING) □ RHEUMATIC FEVER □ ULCER ON LEGS

RESPIRATORY:
□ ASTHMA □ COUGHING BLOOD □ PAIN
□ POSTIVE TB TEST □ SPUTUM □ COUGH
□ BRONCHITIS □ CHEST XRAY
□ PLEAURISY □ SHORT OF BREATH

MUSCULOSKELETAL:
□ ARTHRITIS □ GOUT □ MUSCLE CRAMPS
□ RESTRICTED MOTION □ BACK PROBLEMS
□ JOINT PAIN □ MUSCLE STIFFNESS
□ WEAKNESS □ DEFORMITIES
□ JOINT STIFFNESS □ PARALYSIS

GASTROINTESTINAL:
□ ABDOMINAL PAIN □ BLACK TARRY STOOL □ HEMORRIHIODS
□ CHANGE IN STOOL COLOR □ EXCESSIVE THIRST □ JAUNDICE
□ DECREASED APPETITE □ NAUSEA □ SWALLOWING PROBLEMS
□ ABDOMINAL XRAY □ DIARRHEA □ CHANGE IN FREQUENCY
□ CHANGE IN STOOL CONSISTENCY □ HEPATITIS □ VOMITING
□ GALLBLADDER □ LAXITIVES □ RECTAL BLEEDING □ HEARTBURN
□ RECTAL BLEEDING □ ANTICAID USE □ CONSTIPATION
□ EXCESSIVE HUNGER □ INFECTIONS □ LIVER DISEASE
□ RECTAL PAIN □ VOMITING BLOOD

ENDOCRINE:
□ COLD TOLERANCE □ GOITER □ SWEATS
□ WEAKNESS □ EXCESSIVE URINATION
□ HEAT TOLERANCE □ FATIGUE
□ INCREASED THIRST □ WEIGHT GAIN
□ THYROID □ WEIGHT LOSS □ DIABETES

SKIN:
□ DRYNESS □ HAIR DYE
□ LUMPS □ ECZEMA □ HIVES □ RASHES
□ CHANGE IN NAIL APPEARANCE
□ EASILY BRUISED □ MOLE SIZE CHANGE
□ HAIR/ NAIL TEXTURE CHANGE

HEMATOLOGIC:
□ ANEMIA □ LUMPS
□ EASILY BRUSIED
□ SWOLLEN GLANDS
□ EASILY BLEEDS
□ BLOOD CLOTS
□ TRANSFUSION REACTION
□ RADITION EXPOSURE
□ HEPATITIS A B C
□ AIDS/ HIV

NEUROLOGICAL:
□ BLACK OUTS □ FAINTING □ PARALYSIS
□ TINGLING □ TREMORS □ DIZZINESS
□ SPEECH DISORDER □ HEAD INJURY
□ MEMORY LOSS □ HEADACHES □ STROKE
□ UNSTEADY GAIT □ NUMBNESS

ALLERGIC/ IMMUNOLOGIC:
□ COUGHING □ ITCHING EYES □ HIVES
□ RUNNY NOSE □ WATERY EYES
□ COUGHING WITH/ WITH OUT EXCERISE
□ WHEEZING □ SNEEZING
□ ITCHING NOSE □ STUFFY NOSE
□ RECURRENT INFECTIONS

PSYCHIATRIC:
□ BEHAVIOR CHANGES □ MEMORY LOSS
□ DISTURBING THOUGHTS □ DEPRESSION
□ PSYCHIATRIC DISORDER □ EXCESSIVE
□ MOOD CHANGES □ DISORIENTATION
□ HALLUCINATIONS □ NERVOUSNESS

OTHER:

WASHBURN
FOOT AND ANKLE
CENTER

AUTHORIZATIONS AND RELEASES

I hereby authorize Washburn Foot and Ankle Center or other providers to release any information acquired in the course of my treatment to my insurance company, employer, or third party payer as required for claims field, quality assurance, health plan administration or complaint/grievances. I understand that the specific information to be released might include, but is limited to history, diagnosis and/or treatment of all related illnesses including HIV virus and Acquired Immune Deficiency Syndrome (AIDS). I authorize direct payment to be made to Washburn Foot and Ankle Center or other providers for any and all medical or surgical services/supplies rendered. **I understand if any services or charges are not covered, or Washburn Foot and Ankle is unable to verify eligibility; I am responsible for ALL charges incurred for services rendered.**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I choose) and understand the notice.

We will file any commercial insurance, plus one supplemental insurance, IF ALL INFORMATION IS PROVIDED THE DAY OF YOUR VISIT. **You will be required to pay any deductible, copays or percentages set by your insurance company on the day you are seen.** If any balances remain after 45 days of filing your insurance, we ask that you remit to us the full balance. If we are later paid by your insurance company, we will refund the overpayment to you. If there is a balance on the account

Physician Referrals

If your insurance requires a referral from your primary care physician, it will be your responsibility to make sure the referral is in our office before you can be seen.

I hereby give Washburn Foot and Ankle Center permission to diagnose and administer treatment for my foot and ankle conditions and authorize any release of information obtained in the course of my treatment.

Financial Policy

Payment is expected at the time of service unless other arrangements have been made. This includes copayments and coinsurances and applicable deductible amounts. We accept cash, personal checks, credit cards and debit cards. Any unpaid balance over 90 days will be referred to a collection are the patient's responsibility.
agency. Collection fees

Insurance Authority and Assignment

I authorize my insurance benefits to be paid directly to Washburn Foot and Ankle Center. I understand that charges not covered by my insurance company, as well as applicable copayments, coinsurance and deductibles are my responsibility.

I authorize Washburn Foot and Ankle Center to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

Receipt of Notice of Privacy Practices

Washburn Foot and Ankle Center has provided me with an opportunity to review and obtain a written copy of their Notice of Privacy Practices in accordance with federal HIPAA regulations.

I authorize the release of pertinent information including but not limited to imaging studies and report to the referring physician(s) and or consulting physicians as requested.

In addition to the above mentioned entities and physician, as well as my referring physician, I hereby authorize the release of my medical records to the following individuals: (example: family members/friends/spouse)

1._____ 2._____ 3._____

I hereby give Washburn Foot and Ankle Center permission to diagnose and administer treatment for my foot and ankle conditions and authorize any release of information obtained in the course of my treatment.

I have read all the information and acknowledge that I have read and understand the above statements.

Signature:_____ **Patient Name:**_____ **Date:**_____

Washburn Foot & Ankle Center Financial Policy

Copays, Deductibles, Co-Insurance, Balances:

You are responsible for any copays at the time of your appointment. If your insurance policy has a deductible or coinsurance, you will be responsible for the allowed charge at the end of the visit. If you are unable to pay, your appointment will be rescheduled. You will be required to pay any balances before you are seen. Prices of treatment are given to you before treatment and will be expected when checking out.

Outstanding Balances: Patient will receive notice in the mail, it is your responsibility to settle any balances and to make sure we have updated information. Washburn Foot and Ankle may reserve the right to refuse further services to the patient without notice.

Uninsured Patients: Patients that do not use insurance will be responsible for any services performed on the day of visit. Patient is aware of prices before treatment.

Medicare-Regarding Footcare (Medicare Patients): After the Medicare deductible has been met, there is a 20% co-insurance that you are responsible for if you do not have a secondary insurance. Unfortunately, Medicare does not cover all footcare needs. You will be evaluated during your visit, and a diagnosis will be determined. If you do not qualify for covered footcare, we offer a non-covered footcare service for $70.

Lab: Our office uses outside laboratories for various imaging tests. It is possible that you could be billed separately.

Orthotics: If your insurance does not cover custom orthotics, Orthotics are $525, **you are required to pay half the price on the day of casting.** The remaining half will be expected to be collected the day your orthotics are dispensed to you. If going through insurance, you will be required to pay your portion on the day of casting. These are custom devices and cannot be refunded. We also offer over the counter inserts you can purchase for $75, they are not covered by insurance.

No Call/ No Show Fee: We require 24-Hour notice if you need to cancel or reschedule an appointment. If you fail to keep your appointment, you will be charged a NO- SHOW FEE of $30.00

- **Any children brought into the facility will need to have supervision.**
- **Any paperwork for the physician to fill out will be a $35.00 Fee. One week will be required to complete the forms. Payment must be collected before paperwork will be returned/ faxed.**
- **NO voice or video recording is allowed due to HIPPA (Health Insurance Portability and Accountability Act.)**

Personal Items: I understand that as a patient, I am encouraged to leave valuable personal items at home. If I choose not to, I understand that WFACLR is not responsible for the loss or damage to these items.

I acknowledge that I have read the billing policies listed above, agree, and understand my responsibilities as a patient at Washburn Foot & Ankle Center.

_____ _____

Patient Signature **Date**

It is always your responsibility to be sure that your account is settled, regardless of insurance or any other circumstances.

NOTICE OF PRIVACY PRACTICES (For Patient)

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other healthcare providers. Finally, we may disclose your health information for certain limited operational activities, such as quality assessment licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written consent:

To family members or close friends who are involved in your healthcare;
For certain limited research purposes;
For purposes of public health and safety;
To Government agencies for purposes of their audits, investigations, and other oversight activities;
To Government authorities to prevent child abuse or domestic violence;
To the FDA to report product defects or incidents;
To law enforcement authorities to protect public safety, or to assist in apprehending criminal offenders;
When required by court orders, search warrants, subpoenas, and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

To have access to and/or a copy of your health information;
To receive an accounting of certain disclosures we have made of your health information;
To request restrictions as to how your health information is used or disclosed;
To request that we communicate with you in confidence;
To request that we amend your health information;
To receive notice of our privacy practices.