

**Patient Information**

Last Name	<input type="text"/>	First Name	<input type="text"/>	Middle Name	<input type="text"/>	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Social Security #	<input type="text"/>	Date of Birth	<input type="text"/>	Age	<input type="text"/>	<input type="checkbox"/> Single	<input type="checkbox"/> Married <input type="checkbox"/> Other
Street Address	<input type="text"/>				City	<input type="text"/>	
State	<input type="text"/>	Zip Code	<input type="text"/>	E-mail Address <input type="text"/>			
<input type="checkbox"/> Subscribe to E-Newsletter	Responsible Party <input type="text"/>			Relationship <input type="text"/>			
Spouses Name	<input type="text"/>			Primary Care Dr. <input type="text"/>			
Emergency Contact Name	<input type="text"/>			Emergency Contact Phone Number <input type="text"/>			

**Patient's Phone Numbers/Employment**

Home	<input type="text"/>	Work	<input type="text"/>	Cell	<input type="text"/>	Employer	<input type="text"/>
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**Referred to Clinic by** (Please let us know how you found us)

Referred by Doctor:	<input type="text"/>	<input type="checkbox"/> Friend/Family	<input type="text"/>
<input type="checkbox"/> Internet Search	<input type="checkbox"/> Insurance Provider	<input type="checkbox"/> Yellow Pages Online/DEX	<input type="checkbox"/> Phone Book
Other: <input type="text"/>			

**Insurance Information** (Please bring your insurance card with you to your appointment)

Insurance Provider (Primary)	<input type="text"/>	Subscriber's First Name	<input type="text"/>	Subscriber's Last Name	<input type="text"/>
Employer	<input type="text"/>	Co-Pay	<input type="text"/>	Group Number	<input type="text"/>
I.D. Number	<input type="text"/>	Subscribers Social Security #	<input type="text"/>	Birth Date	<input type="text"/>
Patient's Relationship to Subscriber	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	Other <input type="text"/>	

**Secondary Insurance Information - If Applicable** (Please bring your insurance card with you to your appointment)

Insurance Provider	<input type="text"/>	Subscriber's First Name	<input type="text"/>	Subscriber's Last Name	<input type="text"/>
Group Number	<input type="text"/>	Policy Number	<input type="text"/>	Subscribers Social Security #	<input type="text"/>
Patient's Relation to Subscriber	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	Other <input type="text"/>	Birth Date <input type="text"/>

**Podiatric History**

Primary Reason for Visit	<input type="text"/>				
Current Physical Activities	<input type="text"/>				
Shoe Size	<input type="text"/>	Weight	<input type="text"/>	Height	<input type="text"/>

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Dr. Timothy Young and Dr. Brandon Nelson. I understand that I am financially responsible for any balance, whether billed to insurance or not. I also authorize Issaquah Foot & Ankle Specialists and my insurance company to release any protected health information required to gain authorization information and process my claims.

\_\_\_\_\_  
Patient/Guardian Signature

Date

**Patient Information  
Health History**

**Allergies**

<input type="checkbox"/> <b>No Known Drug Allergies</b>	<input type="checkbox"/> Adhesive/Tape	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Demerol	<input type="checkbox"/> Sulfa	<input type="checkbox"/> Iodine	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Anticoagulant Therapy	<input type="checkbox"/> Seafood	<input type="checkbox"/> Novocaine	Other <input type="text"/>				

**Current Medications (Please Include Prescriptions, Over-the-Counter and Vitamins)**

Medications

**Medical History (Please indicate past and present medical diagnosis)**

**Major Disease:**

Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No
HIV/Aids	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Skin:**

Rash	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Skin Discoloration	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer, Tumors, Cysts	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ulceration	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Psoriasis	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Musculoskeletal:**

Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Joint Diseases	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fractures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fibromyalgia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sciatica	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Respiratory:**

Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lung Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Foot Problems:**

Ankle Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bunion	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Corns, Callouses	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Flat Feet	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heel Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ingrown Toenails	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Plantar Warts	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Plantar Fasciitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tired Feet	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Other Conditions Not Listed:

**Cardiovascular:**

Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Poor Circulation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Peripheral Vascular Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Swelling of Feet or Ankles	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Phlebitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Varicose Veins	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Leg Pain when Walking	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anticoagulation Therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**HEENT:**

Difficulty Swallowing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eye Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hearing Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ear Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Surgeries**

Name of Surgery and Date

**Family Medical History**

Check all conditions that apply to immediate family and indicate the relationship to patient	<input type="checkbox"/> High Blood Pressure	Relation <input type="text"/>	<input type="checkbox"/> Diabetes	Relation <input type="text"/>
	<input type="checkbox"/> Heart Disease	Relation <input type="text"/>	Other <input type="text"/>	Relation <input type="text"/>

**Alcohol/Tobacco Use**

Do you use tobacco products?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, How Much? <input type="text"/>	<input type="checkbox"/> Quit	Years Ago <input type="text"/>
Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, How Much? <input type="text"/>		

**Consent**

I certify that the above information is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

\_\_\_\_\_  
Patient/Guardian Signature

Date

### Financial Policy

We are committed to providing you with the highest medical and surgical care. In return, we ask you to be equally committed to being fully responsible for paying our fees. This will help in reducing our billing and administrative burdens, leaving more time for helping you. This dual commitment is the foundation of our relationship. Our goal is to minimize misunderstanding regarding fees and payments. We accept many different insurance plans, however all health plans are not the same and do not cover the same services.

**0 Managed Care Patients/Private Insurance**

If you are in a managed care plan (HMO, PPO, IPA) with which we participate, we abide by our contract with them. In either managed care plans or private plans, we will bill your insurance company; however you are responsible for paying the copays and deductible required by your plan at the time of treatment. In 30-45 days your insurance company will send you a statement that will tell you what you balance, if any, is to our office.

**0 Medicare Patients**

We accept assignment from Medicare; however, that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any co-payments, which are usually 20% of the allowed amount for and item or service.

**0 Uninsured Patients**

Payment is due at the time of service.

**0 All Patients**

For your convenience, we will accept Visa, MasterCard, cash or check.

Any insurance balance over 90 days will become the entire responsibility of the patient.

Any patient balance over 30 days will be charged a \$3.00 monthly billing fee.

There is a service fee of \$40.00 for all returned checks.

Please note: It is the responsibility of the each patient to know his or her contract limitations. Specifically, if your policy requires a written referral prior to your visit, it is the patients responsibility to obtain that referral (or have it sent to our office) prior to making an appointment with our office. Denials from your insurance company based on lack of appropriate referral will be billed directly to the patient/responsible party.

I have read, understand and accept all responsibilities associate with this financial policy.

\_\_\_\_\_ Date

Patient/Guardian Signature

### Durable Medical Equipment Policy

In the event that the patient leaves the office with an item recommended in the care and treatment of their foot condition (including, but not limited to custom made foot orthotics, ankle/foot orthotics, night splints, walking boots, pads, creams, solutions, etc.) it is understood that such items are non-returnable and non-refundable.

It is the policy of this office to help obtain insurance benefits regarding a patient's individual coverage of these items, by contacting the insurance company. This is a courtesy service that we are happy to provide; however the doctors or agents of the Issaquah Foot and Ankle Specialists are not held responsible for the accuracy of the information received. Information received by phone is not a guarantee of payment and if any doubt exists as to coverage of an item, it is highly recommended that you check your plan booklet for a detailed outline of your benefits or make a personal phone call to your insurance company. Please note, if these items are denied by insurance due to coverage limitations, the patient hereby accepts responsibility for the cost.

I have read, understand and accept all responsibilities associated with this Durable Medical Equipment Policy.

\_\_\_\_\_ Date

Patient/Guardian Signature

## Authorization to Leave Personal Health Information by Alternate Means

Patient Name: \_\_\_\_\_  
(Please Print)

Date of Birth

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Please check all that apply:

- May leave detailed message on voice mail at home
- May leave detailed message on voice mail at work
- May leave detailed message on cell phone
- May leave detailed with spouse

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify health care provider should I change my preferences or any provided phone numbers.

\_\_\_\_\_  
Patient/Guardian Signature

Date

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The Federal Government requires us to collect the following information.

Language:

<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Russian	<input type="checkbox"/> Japanese
<input type="checkbox"/> Chinese	<input type="checkbox"/> Other		

Race:

<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> White	

Ethnicity:

<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Not Hispanic or Latino
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**Acknowledgement of Receipt  
of  
Notice of Privacy Practices**

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 so choose) and understand the notice.

Patient Name: \_\_\_\_\_  
(Please Print)

\_\_\_\_\_  
Patient/Guardian Signature

Date

**Cancellation / No Show Policy**

If you need to cancel or reschedule your appointment, kindly give us 24-hour notice. Patients who do not show for their appointment or cancel without providing 24-hour notice will be charged a \$75.00 fee.

\_\_\_\_\_  
Patient/Guardian Signature