

# Foot & Ankle Center of Washington

*The skill, experience and advanced solutions to put you back on your feet.*

**Douglas S. Hale, DPM**  
**Lawrence Z. Huppin, DPM**

600 Broadway  
Suite 220  
Seattle, Washington 98122

PHONE: (206) 344-3808  
FAX: (206) 860-0907

[www.FootAnkle.com](http://www.FootAnkle.com)

Medicine of the Foot and Ankle

Foot Orthotic Therapy

Ankle-Foot Orthotic Therapy

Biomechanics of the Lower  
Extremities

Gait and Running Analysis

Surgery of the Foot and Ankle

Arch and Heel Pain

Sports Medicine

Shoe Therapy

Children's Foot Disorders

Trauma of the Foot and Ankle

Nail and Skin Disorders

## Welcome to the Foot & Ankle Center of Washington!

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 visit a convenient and pleasant experience.

Prior to your appointment, please contact your insurance company to clarify your coverage requirements.

### URGENT INFORMATION ABOUT REFERRALS:

**You cannot assume that your referral has been approved unless you have received written confirmation from your insurance company. If you are not sure your referral has been approved, please contact your insurance company prior to your appointment. *If we do not have a paper copy of the referral in the office you may be financially responsible for the appointment, unless other arrangements are made at the time of service.***

### When you come for your appointment, please bring the following: (Do not send prior to your appointment)

- Written Referral (If required by your insurance company)
- Completed *Registration Form*
- Completed *History Form*
- Completed *Sports Medicine History Form* (If a sports or exercise injury)
- Completed and Signed *Financial Policy Form*
- Medical Insurance card
- Previous x-rays and medical records, if applicable
- Shoes (bring a sample, only need one shoe per pair, of the more common shoes you wear - including athletic and walking shoes)

**Note:** As you will be receiving advice on the proper shoes for your feet, we recommend you do not purchase any new shoes prior to your visit.

### Please be prepared to pay for the following at the time of your visit:

- Co-Payment (if applicable)
- Deductible (If not fully paid for this year)
- If no insurance, the full cost of visit

For your convenience, we do accept Visa and Mastercard.

Our entire staff is here to help you in whatever manner we can. We look forward to serving you in the near future.

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Your Scheduled Appointment is \_\_\_\_\_ at \_\_\_\_\_ AM PM  
*As a courtesy to other patients who are waiting to get in, please call at least 24 hours in advance if you must cancel your appointment. We reserve the right to charge for missed appointments.*

### Directions From I-5

Southbound - take Exit 165A (Columbia - James)  
Northbound - take Exit 164 (Madison - James)

After exiting North or Southbound:

- Go East (uphill) on James
- North (left) on Broadway
- East (right) on Cherry
- Park in the third/last entrance on the right.

Please allow plenty of time for traffic in order to be on the time for your appointment. Arrive 15 minutes prior to your appointment if forms are complete. Arrive 30 minutes prior if forms are not complete.

**Parking: Available in parking garage at \$3.00 for first hour and \$3.00 for each additional hour. *Sorry, we do not validate parking.***

## PATIENT REGISTRATION

### Patient Information

Patient Name: Last	First	M.I.	<input type="checkbox"/> M <input type="checkbox"/> F
By what name do you preferred to be addressed?		Single Married Widowed Other	
Patient's Address:			
City	State	Zip	
Home Phone:	Work Phone:	e-mail address	
Social Security #:	Birthdate:	Age:	
Employer:		Occupation:	
Emergency Contact:		Phone#:	
Would you like to receive quarterly email updates to our list of recommended shoes? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Email addresses are never sold or used for any purpose other than these updates</i>			

### Insurance

Name of insured (if other than self)	Birth Date:
Name of insured's employer:	Insured's work phone number:
Patient is: <input type="checkbox"/> Subscriber <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	
Name of person responsible for paying the bill (the Guarantor): <input type="checkbox"/> Same as patient <input type="checkbox"/> Same as insured	
Guarantor's Address:	
Guarantor's Telephone:	

### L&I Injury

Date of Injury:	Type of Injury:	<input type="checkbox"/> Work	<input type="checkbox"/> Auto	<input type="checkbox"/> Other
Has a claim been filed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Claim#:	Where was claim filed?		
Cause of injury:				

### Referral

Referred By: <input type="checkbox"/> Returning patient of this office <input type="checkbox"/> Friend / Relative <input type="checkbox"/> Web search ( <input type="checkbox"/> Google <input type="checkbox"/> Bing <input type="checkbox"/> Other) <input type="checkbox"/> Yelp <input type="checkbox"/> Angie's List <input type="checkbox"/> Insurance Web Site or Book Referral <input type="checkbox"/> Online Yellow Pages <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Doctor (name): _____ <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DC <input type="checkbox"/> ND <input type="checkbox"/> Other: _____
Primary Care Physician and Clinic Name <span style="float: right;">Phone #:</span>

### Signature

**Release of Benefits Information :**  
 I authorize my insurance benefits to be paid directly to the doctor. I understand that the doctors office will bill my insurance as a courtesy and that I am responsible at the time of service for all co-payments, deductibles and non-covered services. I authorize the release of information required to process my claims. (If not signed payment due at time of service)  
**ALL CO-PAYMENTS DUE ON DAY OF SERVICE.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Medical History - Confidential Information

### Lower Extremity Medical History

What is the chief complaint(s) which brings you to our office for medical treatment ?  
(Include foot, ankle, leg, knee and hip complaints)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Former foot and ankle physician:

Name: \_\_\_\_\_

Last visit: \_\_\_\_\_

Any previous injuries or problems to the feet, ankles or legs?

\_\_\_\_\_

### Symptoms

Which Side:    Right    Left    Both

Type of Pain:    Dull        Achy        Throbbing  
                         Burning    Sharp        Shooting

Area of Pain: \_\_\_\_\_

Onset:    Slow    Sudden    Traumatic

Duration: \_\_\_\_\_ Days    Weeks    Months    Years

Has pain gotten:    Better    Worse    Stayed the Same

What aggravates condition?    walking    running  
   standing shoes

What have you tried to help the pain?    Changing shoes  
   anti-inflammatories    Decrease activities  
   Arch Supports or Orthotics    Ice    Stretch

Other: \_\_\_\_\_

How long does pain last? \_\_\_\_\_

Have you ever had a similar pain? (describe, including treatments received)

### Exercise and Orthotics

In what athletic activities do you participate ?

\_\_\_\_\_

# days per week exercising? \_\_\_\_\_

Do you wear store-bought arch supports?    yes    no

Do you wear custom orthotics?    yes    no

If yes, who made them: \_\_\_\_\_

How old are the orthotics: \_\_\_\_\_

### Allergies and Drug Intolerance

Adhesive/Tape                      Aspirin

Codeine                                      Iodine

Local Anesthetics                      Penicillin

Seafoods                                      Sulfa

No known drug allergies                      \_\_\_\_\_

### Medications

List all medications you are taking:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### General

What is your weight: \_\_\_\_\_

What is your height: \_\_\_\_\_

What is your shoe size: \_\_\_\_\_

### Mental / Emotional

yes    no    Eating Disorder

yes    no    Anxiety

yes    no    Depression

yes    no    Psychiatric

yes    no    Alcoholism

### Surgeries, Injuries, Illnesses

List surgeries, serious injuries, and illnesses not previously listed:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Social History

Your occupation?

\_\_\_\_\_

Do you smoke?                      yes    no

Are you a past smoker?    yes    no

How Much? \_\_\_\_\_ packs/ \_\_\_\_\_.

Years Smoked: \_\_\_\_\_

Drink Alcohol?:    yes    no

How Much: \_\_\_\_\_

Recreational Drugs?    yes    no

What: \_\_\_\_\_

Pregnant or possibly pregnant?    yes    no

### General Medical History

Mark "yes" or "no" to indicate if you or a family member have any of the following:

Personal		Family Member
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yes	no	Anemia	
-----	----	--------	--

yes	no	Arthritis: Type: _____	yes
-----	----	---------------------------	-----

yes	no	Artificial Heart Valve or Joints	
-----	----	----------------------------------	--

yes	no	Asthma	yes
-----	----	--------	-----

yes	no	Back Problems	
-----	----	---------------	--

yes	no	Bleed easily	yes
-----	----	--------------	-----

yes	no	Cancer	yes
-----	----	--------	-----

yes	no	Chemical Dependency	yes
-----	----	---------------------	-----

yes	no	Chest Pain	yes
-----	----	------------	-----

yes	no	Circulatory Problems	yes
-----	----	----------------------	-----

yes	no	Diabetes	yes
-----	----	----------	-----

yes	no	Epilepsy	yes
-----	----	----------	-----

yes	no	Fibromyalgia	
-----	----	--------------	--

yes	no	Gout	
-----	----	------	--

yes	no	Heart Disease	yes
-----	----	---------------	-----

yes	no	Hemophilia	yes
-----	----	------------	-----

yes	no	Hepatitis	
-----	----	-----------	--

yes	no	High Blood Pressure	yes
-----	----	---------------------	-----

yes	no	HIV Positive	
-----	----	--------------	--

yes	no	Kidney Problems	yes
-----	----	-----------------	-----

yes	no	Leg Cramps	
-----	----	------------	--

yes	no	Liver Disease	yes
-----	----	---------------	-----

yes	no	Lung/Respiratory	yes
-----	----	------------------	-----

yes	no	Menopause	
-----	----	-----------	--

yes	no	Mental Illness	yes
-----	----	----------------	-----

yes	no	Phlebitis / Clots	yes
-----	----	-------------------	-----

yes	no	Psoriasis	yes
-----	----	-----------	-----

yes	no	Rheumatic Fever	
-----	----	-----------------	--

yes	no	Stroke	yes
-----	----	--------	-----

yes	no	Thyroid Problems	
-----	----	------------------	--

yes	no	Tuberculosis	
-----	----	--------------	--

yes	no	Ulcers—Stomach	
-----	----	----------------	--

yes	no	Venereal Disease	
-----	----	------------------	--

yes	no	Weight Change, Recent. _____lbs	
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# FINANCIAL POLICY

We Accept Visa, Mastercard, and Discover

## Welcome To Our Office

Thank you for choosing us as your podiatric physicians. We are committed to your treatment being successful, as you, the patient, are our first and foremost concern. As part of our service, we try to contain the cost of health care. In an effort to do this, we have implemented a Financial Policy.

The following is a statement of our **FINANCIAL POLICY** which we request you read and sign prior to any treatment. To avoid any misunderstandings, please contact us should you have any questions about our policies.

**INSURANCE:** If your doctor is a participating provider with your insurance plan, we will submit the claim to your insurance company. To do this we must have *complete and accurate* insurance information and a copy of your identification card or claim form. Your insurance policy is a contract between you and your insurance company; therefore you are responsible for payment whether or not your insurance company pays. **It is your responsibility to contact your insurance company regarding pre-authorizations, obtaining required referrals, second opinions, etc.** Failure to do so may reduce the amount of benefits paid by your insurance, and the balance will then become your responsibility to pay. All co-payments must be paid at the time of service.

**NO INSURANCE:** If you do not have insurance or the doctor is not a participating provider with your insurance plan, please be prepared to fully cover the fees for each visit at the time of treatment.

**PAYMENT:** Payments for the balance due, co-payments, deductibles, etc., are due at the time of service and may be made by *cash, check or credit card* (Visa, MasterCard, Discover). There will be a \$25.00 charge for *returned checks*. *Delinquent accounts* will be referred for collection at the discretion of the office manager.

**CO-PAYMENTS:** **Please be prepared to pay all co-payments at the time of service.** We do not send bills out for co-payments, so your visit will have to be re-scheduled if you are not prepared to pay the co-payment.

**DEDUCTIBLES:** If you have an annual deductible which has not yet been paid in full then any charges incurred up to that amount are due at the time of your visit.

**MINOR PATIENTS:** The adult or the parent (custodial guardian) accompanying a minor is responsible for payment of services. For unaccompanied minors, non-emergency treatment will be denied unless prior authorization from the parent or guardian has been made for the charges and treatment. Young adults (age 18 & over) are legally responsible for their accounts unless a parent accompanies them to the initial appointment and signs this financial agreement, regardless of insurance coverage.

**MISSED APPOINTMENTS:** Please help us serve you better by keeping scheduled appointments. If it is necessary to cancel, please call our office 24 hours in advance. This allows us to accommodate our other patients. We reserve the right to charge for missed appointments.

**ORTHOTICS:** Orthotics are a non-covered service by some insurance plans. Please check with your insurance company *prior* to the examination and casting for orthotics to determine your orthotic benefits. A deposit of \$150.00 is requested at the time of the examination and casting and full payment is due when the orthotics are dispensed.

**SUPPLIES:** For your convenience we make some supplies available for purchase in the office. If you choose to purchase these items, payment is due at time of purchase. We cannot bill for these items. In addition, we contract with outside suppliers to provide some supplies through our office. If any of these supplies are used for your treatment you or your insurance will be billed for these supplies by the outside provider. The Foot and Ankle Center of Washington has no part in billing for these supplies.

### Please complete the following items:

What is your co-payment per visit: \$ \_\_\_\_\_

What is your insurance annual deductible: \$ \_\_\_\_\_ How much of the deductible is current (not yet paid): \$ \_\_\_\_\_

*(if you are not sure what your current (not yet paid) deductible is, please call your insurance company prior to your visit.)*

*Please be prepared to pay your co-payment and any charges within your current deductible at the time of your visit*

**I have read and agree to the terms set forth in the above financial policy. I am financially responsible for any balance due.**

**SIGNED** \_\_\_\_\_

**DATE** \_\_\_\_\_

## **No-show and On-time Appointment Policy**

We have developed this no-show and on-time appointment policy to best meet the needs of our patients. We welcome your feedback and suggestions and will make updates to this policy as needed.

At the Foot and Ankle Center of Washington we pride ourselves on keeping our appointment schedule on time. One of the ways we do this is by giving each patient ample time to meet with their doctor.

At a busy podiatric practice like the Foot & Ankle Center it is often impossible to predict what a day will bring. A sudden emergency such as a fracture or an infection throws our well-planned schedule into chaos. On the rare occasion we have to cancel an appointment, we will call and explain and reschedule as soon as possible.

Unpredictable traffic jams or a toddler who throws a tantrum can cause our patients to be late or miss an appointment altogether. We understand that sometimes being late is unavoidable and usually a quick phone call to the office explaining your tardiness or last-minute cancellation is sufficient.

### **Late Arrivals**

When a patient arrives late for an appointment, if the schedule allows, we will see the patient. There may be a lengthy wait, however, as we will see all on-time patients first. If there isn't any flexibility in that day's schedule, the patient will be asked to wait if it is for urgent care or to reschedule if the problem is not urgent.

### **No-Shows**

If you must miss an appointment please call us as soon as you know you cannot make it. Patients who habitually do not show and do not contact us take time away from other patients and will be asked to find another provider.

### **Work-ins**

If you have an urgent problem, we will likely work you into an already busy schedule. In this situation, be aware that there may be a lengthy wait once you arrive at our office. Usually we will see you within 30 minutes of your scheduled appointment time, but occasionally the wait may be up to a few hours.