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

FINANCIAL POLICY
ASSIGNMENT OF BENEFITS

We Accept Visa, Mastercard, and Amex

Thank you for choosing us as your foot and ankle physicians. We are committed to your treatment being successful. 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.

INITIAL: _____ **CREDIT / DEBIT CARD ON FILE:** We require a credit or debit card on file with our office if we will be billing insurance for you. You will be asked for a credit card at the time you check in and the information will be held securely. When your portion of the bill is determined (following a review of your copay, co-insurance, and deductible) we will charge your card and a copy of the receipt will be emailed to you. We swipe your card once per year. You can cancel the contract at any time.

We kindly request 24 business hours notice of any changes to your appointment time. Less than 24 business hours notice may result in a $50 cancellation fee.

PAYMENT FOR SERVICES: Payment for services is due at the time that those services are provided to you, and we expect that all charges we present to you at a visit will be paid at the time of the visit. This includes copay amounts, program deductibles, earlier charges that remain unpaid, and charges for services that we believe are not covered by, or are left over as your responsibility to pay after coverage by, insurance or government programs. Payments may be made by *cash, check or credit card*. There will be a $25.00 charge for *returned checks. Delinquent accounts* will be referred for collection at the discretion of the office manager.

UNPAID BALANCES AND AUTOMATIC PAYMENTS. Patient balances are due upon final insurance determination of patient balance and will be charged to your credit card on file. You will receive an email notification that we will be billing your credit card, and then follow-up with an email receipt

CO-PAYS AND UNPAID BALANCES DUE AT TIME OF VISIT: Please be prepared to pay all co-payments and unpaid balances 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.

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.

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.

BILLING COMMUNICATIONS: We may present charges to you by written statement via the mail or patient portal following a visit. If we do this, we expect that each charge will be paid in full by return mail or via our patient portal the first time it is presented to you.

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.

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.

ASSINGMENT OF BENEFITS: I authorize my insurance benefits to be paid directly to the doctor. I understand that the doctor's office will bill my insurance as a courtesy and that I am responsible at the time of service for all co-payments, deductible, unpaid balances and non-covered services. I authorize the release of information required to process my claims. (If not signed payment due at time of service).

I have read and agree to the terms set forth in the above financial policy. I am financially responsible for any balance due. I agree to make all payments for any co-payments, charges due within my current deductible and any unpaid balance from previous visits at the time of my appointment. I agree to the Assignment of Benefits.

Patient or Guardian Signature: _____ **Date:** _____

Print Name: _____

Foot & Ankle Center of Washington **(206)344-3808**

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Seattle, WA 98122
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ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

We keep a record of the health care services we provide you. You may ask to see and copy that record. If you would like to obtain a copy of your medical records, a base clerical fee of $19.00 is due upon receipt. Our office has up to 30 days to respond to the request.

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 chose) and understood the Notice.

_____ _____
Patient Name (please print) Date

_____
Parent or Authorized Representative (if applicable)

_____
Signature

This form will be retained in your medical record.

PATIENT REGISTRATION

Patient Information

Patient Name: Last	**First**	**M.I.**	**□ M □ F**
By what name to you preferred to be addressed?		**Single Married Widowed Other**	
Patient's Address:			
City	**State**	**Zip**	
Home Phone:	**Cell Phone:**		
E-mail address:	**Birthdate:**	**Age:**	
Employer:	**Occupation:**		
Emergency Contact:	**Phone#:**		
Would you like to receive occasional foot heatlh information on E-mail? □ Yes □ No			

Insurance

Name of insured (if other than self)	**Birth Date:**
Name of insured's employer:	**Insured's work phone number:**
Patient is: □ Subscriber □ Spouse □ Dependent	
We are required to have a copy of your insurance card(s) on file in order to bill your insurance for you. If we do not have this information on file, you will be billed directly and are solely responsible for all charges. Payment is due at the time of service. If you submit you insurance card at a later date we will be glad to bill your insurance company and reimburse you when payment is received.	

L&I Injury

Date of Injury:	**Type of Injury: □ Work □ Auto □ Other**
Has a claim been filed? □ Yes □ No Claim#:	**Where was claim filed?**
Cause of injury:	

Referral

Referred By:	
Primary Care Physician and Clinic Name	**Phone #:**
If you were not referred how did you find out about our office? □ Yellow Pages □ Web Page □ Other:	

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 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:_____

Lower Extremity Medical History, Referral Information, Doctors and Pharmacies

All patients please complete this page

Name: _____ **Date**: _____

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

_____

_____

_____

Symptoms of Current Problem (circle or fill in your answer)

Which Side: Right Left Both **Type of Pain:** Dull Achy Throbbing Burning Sharp Shooting

Area of Pain: Bottom of Heel Back of heel Arch Ball of foot Big toe Top of foot Ankle No Pain

Other / Details: _____

Onset: Slow Sudden Traumatic **Has pain gotten**: Better Worse Stayed the Same

How long has this been a problem for you?: _____ Days Weeks Months Years

What aggravates condition? Walking Running Standing Shoes Activities First steps after rest

Other: _____ **Severity**: Mild Moderate Severe

What have you tried to relieve the pain? Changing shoes Anti-inflammatory meds Decreasing activities Ice Heat Prefabricated Arch Supports Custom Orthotics Stretching Injections Physical Therapy Surgery

Antibiotics Other OTC Meds Padding Massage Acupuncture Soaking

Other:_____

After it starts, how long does pain last? _____

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

Who Referred you to our office?

☐ I am a returning patient ☐ Friend / Relative ☐ Web search (☐ Google ☐ Bing ☐ Other) ☐ Yelp ☐ Angie's List

☐ My Doctor (name):_____ ☐ MD ☐ DO ☐ ND ☐ DPM ☐ DC ☐ PA

☐ Insurance Web Site or Book Referral ☐ Other: _____

Who is your primary care physician and what other doctors treat you regularly?

Primary Care Physician : _____ ☐ MD ☐ DO ☐ ND

☐ I don't have a primary care physician

Other doctors and their specialties: _____

_____

List your primary pharmacy (name and location) - This is where we will send any prescriptions

Primary pharmacy (include city and street): _____ _____

Other pharmacies you may use (include online pharmacies: _____

All patients please complete this form in addition to the online health history forms in the patient portal. If you did not complete the online health forms, complete history and registration forms also.

NAME: _____DATE: _____ :

Past Medical History,
Social and Family History Form

Complete this page only if you did not complete the online history forms in the patient portal.

General

What is your weight:_____

What is your height: _____

What is your shoe size:_____

Allergies and Drug Intolerance

- ☐ Adhesive/Tape
- ☐ Aspirin
- ☐ Codeine
- ☐ Iodine
- ☐ Local Anesthetics
- ☐ Penicillin
- ☐ Seafoods
- ☐ Sulfa
- ☐ Other: _____
- ☐ No Known Allergies

Medications

List all medications you are taking:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Surgeries, Injuries, Illnesses

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

_____
_____
_____
_____
_____
_____
_____
_____

General Medical History

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

Personal			Family
yes	no	Anemia	yes
yes	no	Arthritis: Type:_____	yes
yes	no	Artificial Heart Valve or Joints	yes
yes	no	Asthma	yes
yes	no	Back Problems	yes
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
yes	no	Heart Disease	yes
yes	no	Hemophilia	yes
yes	no	Hepatitis	yes
yes	no	High Blood Pressure	yes
yes	no	HIV Positive	yes
yes	no	Kidney Problems	yes
yes	no	Leg Cramps	yes
yes	no	Liver Disease	yes
yes	no	Lung/Respiratory	yes
yes	no	Menopause	yes
yes	no	Mental Illness	yes
yes	no	Phlebitis / Clots	yes
yes	no	Psoraisis	yes
yes	no	Rheumatic Fever	yes
yes	no	STD	yes
yes	no	Stroke	yes
yes	no	Thyroid Problems	yes
yes	no	Tuberculosis	yes
yes	no	Ulcers—Stomach	yes
yes	no	Weight Change, Recent. _____lbs	yes

Mental / Emotional

yes	no	Eating Disorder
yes	no	Anxiety
yes	no	Depression
yes	no	Psychiatric
yes	no	Alcoholism

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: _____

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

The US HITECH Act requires us to ask the following questions:

Preferred Language: ☐ English
☐ Other: _____

Ethnicity: ☐ Hispanic/Latino
☐ Non Hispanic / Latino
☐ **Decline**

Race: ☐ American Indian or Alaska native
☐ Asian ☐ Black / African American
☐ Native Hawaiian / Pacific Islander
☐ White ☐ **Decline**

If your appointment is with Dr. Doug Hale, please complete this page.

If your appointment is with Dr. Larry Huppin, you can complete this page on the patient portal.

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.

I understand we kindly request 24 business hours notice of any changes to your appointment time. Less than 24 business hours notice may result in a $50 cancellation fee.

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.