Welcome to the Plateau Foot & Ankle Clinic

Tel: 425-868-3338
Fax: 425-836-9211

Our goal is to provide patients with the best quality medical and surgical care possible.
Please take a few minutes to fill out the following information.

TODAY'S DATE_____ PATIENT #_____

PATIENT'S LAST NAME_____FIRST_____MIDDLE INITIAL_____
MAILING ADDRESS_____
CITY_____STATE_____ZIP_____
HOME PHONE # (_____)_____CELL PHONE #(_____)_____
PATIENT EMAIL ADDRESS **(PLEASE PRINT CLEARLY)** _____@_____
DATE OF BIRTH _____AGE_____ ❑MALE ❑FEMALE
SS# _____HEIGHT_____WEIGHT_____SHOE SIZE_____
OCCUPATION_____EMPLOYER_____
WORK # (_____)_____ FAX# (_____)_____
MARITAL STATUS: ❑SINGLE ❑MARRIED ❑DOMESTIC PARTNER ❑WIDOWED ❑DIVORCED ❑SEPARATED
SPOUSE NAME_____ # OF CHILDREN_____
ALTERNATE BILLING ADDRESS (IF DIFFERENT FROM THE PATIENT'S)
NAME_____Address_____City_____Zip_____

NAME AND NUMBER OF PERSON (OTHER THAN AT YOUR ADDRESS) THAT WE MAY CONTACT IN CASE OF EMERGENCY
_____

PLEASE CHECK YOUR CONTACT PREFERENCE FOR APPOINTMENT REMINDERS:
❑ HOME TELEPHONE ❑ CELL PHONE ❑ E-MAIL

NAME OF PARENTS OR GUARDIAN (IF PATIENT IS A MINOR)_____
EMPLOYER_____WORK# (_____)_____
PARENT/GUARDIAN SS# _____PARENT/GUARDIAN DATE OF BIRTH_____

REFERRAL SOURCE - HOW DID YOU FIND OUT ABOUT US? -- WHO MAY WE THANK FOR REFERRING YOU?

❑ FRIEND ❑ FAMILY (NAME:_____)
❑ DR. _____(CITY) _____
❑ INTERNET/WEBSITE_____ ❑ NEIGHBORHOOD DIRECTORY ❑ I SAW YOUR SIGN
❑ TELEPHONE BOOK (❑QWEST ❑VERIZON) ❑ OTHER:_____

INSURANCE COMPANY NAME: _____ **PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST**

LAST NAME OF INSURED_____FIRST_____MIDDLE INITIAL___
RELATIONSHIP TO PATIENT_____
INSURED SS#_____INSURED DATE OF BIRTH_____
INSURED EMPLOYER _____
DOES YOUR INSURANCE PLAN REQUIRE A COPAY? ❑YES ❑NO **COPAY AMOUNT** $_____
DOES YOUR INSURANCE PLAN REQUIRE A REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN? ❑YES ❑NO

PLEASE TURN OVER

PODIATRIC HISTORY: WHAT IS THE CHIEF COMPLAINT FOR WHICH YOU CAME TO BE TREATED?

_____

_____

DURATION OF PROBLEM _____

HAVE YOU HAD PREVIOUS TREATMENT FOR THIS CONDITION? ❑YES ❑NO

BY WHOM? _____ WHEN? _____

MEDICAL HISTORY

DO YOU CURRENTLY OR HAVE YOU EVER HAD THE FOLLOWING MEDICAL CONDITIONS:

			SURGERIES YOU HAVE HAD AND DATES PERFORMED:	
			SURGERY	**YEAR**
DIABETES	❑YES	❑NO	_____	_____
HIGH BLOOD PRESSURE	❑YES	❑NO	_____	
				____
				_____
HEART DISEASE	❑YES	❑NO	_____	_____
STOMACH DISORDER	❑YES	❑NO	_____	_____
LIVER DISEASE	❑YES	❑NO	_____	_____
KIDNEY DISEASE	❑YES	❑NO		
POOR CIRCULATION	❑YES	❑NO		
AIDS/HIV/HEPATITIS (CIRCLE ONE)	❑YES	❑NO		

OTHER _____

OTHER MEDICAL PROBLEMS THAT RUN IN THE FAMILY: _____

- **DO YOU SUFFER WITH CHRONIC BACK❑ KNEE❑ OR HIP ❑ PAIN?** **(CHECK ALL THAT APPLY)**
- **DO YOU HAVE FIBROMYALGIA OR CHRONIC PAIN CONDITION?** ❑YES ❑NO
- **DO YOU CURRENTLY OR HAVE YOU EVER BEEN TREATED FOR DEPRESSION?** ❑YES ❑NO
- **ARE YOU CURRENTLY OR HAVE YOU EVER BEEN TREATED FOR ANY PSYCHIATRIC DISORDER?** ❑YES ❑NO

IF YES TO ANY OF THE ABOVE, PLEASE EXPLAIN: _____

DO YOU ❑**CURRENTLY** OR ❑HAVE YOU EVER SMOKE(D)? ❑NO IF YES, HOW MUCH? _____

DO YOU DRINK ALCOHOL? ❑YES ❑NO IF YES, HOW MUCH? _____

FAMILY PHYSICIAN _____ CITY _____ LAST VISIT _____

If your physician referred you to our office, we will provide him/her with a medical report. If you would like a copy of your report to go to a different physician as well, please indicate the doctor's name (and address, if known) _____

PRESENT MEDICATIONS AND DOSAGE: _____

_____

_____

HAVE YOU EVER HAD ANY ADVERSE SIDE AFFECTS OR ALLERGIES TO:

PENICILLIN	❑YES	❑NO	ADHESIVE TAPE	❑YES	❑NO
ASPIRIN	❑YES	❑NO	ANTI-INFLAMMATORY MEDS	❑YES	❑NO
NOVACAINE	❑YES	❑NO	OTHER ANTIBIOTICS _____		
CORTISONE	❑YES	❑NO	OTHER PAIN MEDICATION _____		
CODEINE	❑YES	❑NO	OTHER ALLERGIES: _____		

Signature on File & Permission to Treat

I request that payments of authorized benefits be made on my behalf for any services furnished me by **Plateau Foot & Ankle Clinic**. I authorize any holder of information about me to release any information needed to determine these benefits or the benefits payable to related services to the insurance agent. I recognize my financial obligation of any co-insurance, co-pays or deductibles and non-covered services that may be required. I also hereby give permission to Dr. Howard Schaengold and his staff to evaluate via appropriate diagnostic testing and administer treatment of my foot/ankle condition.

Signed √ _____ Date _____

Financial Policy

We are committed to providing you with the highest quality 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 maximize the quality of your care and minimize misunderstandings regarding fees and payments. **To ensure quality communication, it is the patient's (and/or guardian's) responsibility to inquire about fees/insurance coverage prior to any service being performed.**

We accept many different insurance plans, however all health plans are not the same and do not cover the same services.

- **Managed Care Patients/Private Insurance**:
  If you are in a managed care plan (HMO, PPO, IPA) with whom 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 any copays, coinsurance and deductibles required by your plan at the time of treatment. In 30-45 days your insurance company will send you a statement that tells you what your balance is, if any, to our office.
- **Medicare Patients**
  We accept assignment for 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 copayments, which are usually 20% of the allowed amount for an item or service.
- **Uninsured Patients**
  Payment is due at the time of service.
- **All Patients**
  ~For your convenience, we will accept VISA, MasterCard, American Express, cash or check.
  ~Any insurance balance over 90 days will become the entire responsibility of the patient.
  ~Any patient balances over 30 days will be charged an annual finance charge of 18%
  ~There is a service fee of $40.00 for all returned checks.

Please note: it is the responsibility of each patient to know their 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 at the Plateau Foot and Ankle Clinic. 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 associated with this financial policy.

√_____ _____
Patient or Authorized Representative's Initials Date

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 (inclusive of but not limited to custom made foot orthoses, Ankle/Foot Orthoses, 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 which we are happy to provide; however, the Plateau Foot & Ankle Clinic is ***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 eligibility, 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.***

My initials below represent that I have read, understand and accept this policy

√_____ _____
Patient or Authorized Representative's Initials Date

Privacy Statement

The Plateau Foot and Ankle Clinic will use and disclose your health information for the following purposes: to treat you, to assist other health care provides in treating you, to allow insurance companies to process insurance claims for services rendered to you, to obtain payment for services rendered to you and for certain limited operational activities, such as quality assessment, licensing, accreditation and training of students. 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. If you have any questions, concerns or complaints regarding our privacy practices, please refer to the actual Notice of Privacy Practices provided to you for the person(s) whom you may contact.

Additional Disclosure Authority: In addition to the allowable disclosures described in the State of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY		YES		NO
SPOUSE ONLY		YES		NO
OTHER (PLEASE SPECIFY)		YES		NO

Acknowledgement of Receipt of Notice of Privacy Practices:

(Signature represents that I have been offered a copy of the policy)

I acknowledge that I was provided a copy of the Notice of Privacy Practices and have read (or had the opportunity to read if I so chose) and understood the Notice.

√_____ _____

Signature Date

_____

Patient Name or Authorized Representative (Print)

Howard Schaengold, DPM
466 228th Avenue NE
Sammamish, WA 98074

TO:

_____

_____

_____