Family Foot Clinic, Inc. Patient Information

Patient Name_____ Date of Birth_____

Address_____ City_____ Zip Code_____

Home Phone _____ Cell Phone_____

Employer Name_____ Phone Number_____

Email_____ Social Security #_____

Emergency Contact Name_____

Emergency Contact Phone Number_____Relation_____

Primary Care Physician_____ MD/DO/PA/NP

Clinic Name _____ Phone Number _____

Insurance

Primary Insurance Policy Holder _____ Date of Birth_____

Secondary Insurance Policy Holder _____ Date of Birth_____

Insurance, Co-pay and Collection Authorization and Assignment

Co-payments are due at the time of service. A $10 billing fee will be applied to all uncollected co-pays. To avoid late payment fees and/or finance charges, all unpaid balances must be paid within 30 days. If your account is sent to collections you will be responsible for any additional fees.

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to the Doctor, or group indicated on the claim. I understand I am financially responsible for any balance not covered by my insurance.

NO SHOW, LATE CANCELLATION POLICY AGREEMENT

We are committed to providing excellent medical care and effectively utilizing physician and staff resources. As a courtesy we do our best to call you prior to your appointment, however there is no guarantee that we will be able to reach you and this is not an acceptable reason for a late cancellation or missed appointment. A late cancellation is any appointment that is canceled less than 24 hours in advance.

A fee of $105.00 may be assessed for each missed appointment or late cancellation. This fee is not covered by insurance and will be your responsibility. This fee may change without further notification. All no show/late fees must be paid in full before we will continue with your care.

We realize that unavoidable situations occasionally arise that may make it impossible to keep your appointment. When these rare situations arise, we ask that you give us as much notice as possible so that we may accommodate another patient.

Patient, Guardian &/or Insured Signature_____ Date_____

Family Foot Clinic, Inc.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Family Foot Clinic, Inc. to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

Family Foot Clinic Inc.'s Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Family Foot Clinic, Inc. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by sending a written request to Family Foot Clinic Inc.'s Privacy Officer at 205 15th Ave SW Ste D, Puyallup, WA 98371.

With this consent, Family Foot Clinic, Inc. may call my home or other alternative locations and may leave a message in person, via voice mail or text, in reference to any items that assist the practice in carrying out TPO; such as appointment reminders, insurance items, and any calls pertaining to my clinical care; including laboratory results among others.

With this consent, Family Foot Clinic, Inc. may mail/email to my home or other alternative locations any items that assist the practice in carrying out TPO; such as appointment reminder cards and patient statements.

I have the right to request that Family Foot Clinic Inc. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Family Foot Clinic, Inc.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Family Foot Clinic Inc. may decline to provide treatment to me.

_____ _____

Patient's Name (Printed) **Date**

_____ _____

Signature of Patient or Legal Guardian **Printed Name if signing as Legal Guardian**

Family Foot Clinic, Inc. Medical History Assessment

Name:_____ Birth Date:_____

Shoe Size: _____ Height:_____ Weight:_____ Age:_____

Medical History (please check all that apply)

- ❑ High Blood Pressure
- ❑ Kidney Disease
- ❑ High Cholesterol
- ❑ Anxiety
- ❑ Depression
- ❑ Heart Disease/Attack
- ❑ Asthma/Wheezing
- ❑ History of Strokes
- ❑ Immune Deficiency _____
- ❑ Lung Disease
- ❑ HIV/AIDS
- ❑ MRSA
- ❑ Heartburn/Reflux
- ❑ Sinusitis
- ❑ Thyroid Disease
- ❑ Sleep Apnea CPAP/BIPAP
- ❑ Hepatitis A/B/C
- ❑ Gout
- ❑ Cancer Type:_____
- ❑ Diabetes: Type 1/Type 2 Last A1C_____ Date_____

If other: please explain:_____

Review of Systems (please check all that apply)

- ❑ Chills/Fever in the last 2 weeks
- ❑ Chest Pain
- ❑ Excessive Bleeding
- ❑ History of Blood Clots
- ❑ Neurological Disease _____
- ❑ Easy Bruising
- ❑ Fibromyalgia
- ❑ Shortness of Breath
- ❑ Jaundice
- ❑ Weakness/Numbness What Part of the Body _____
- ❑ Neuromuscular
- ❑ Substance Abuse
- ❑ Coughing up Blood
- ❑ Seizures
- ❑ Chronic Pain What Part of the Body _____

Past Surgical History

(within 10 years and/or any foot procedures)

Procedure	Date (month/year)

Family Health History (check all that apply)

- ❑ High Blood Pressure Family Member_____
- ❑ Diabetes Family Member_____
- ❑ Cancer Family Member_____
- ❑ Cardiac Disease Family Member_____
- ❑ Other Family Member_____

Social History

	Frequency
Tobacco Use	_____
Alcohol Consumption	_____
Recreational Drug Use	_____

Family Foot Clinic, Inc. Medications and Allergies

Patient Name_____

Pharmacy

_____

Name Location

Allergies

Medication/Food	Reaction

Medications

Name	Dose	How Often	Prescribing Physician