METROLIANCE FOOT AND ANKLE GROUP PLLC

DBA EASTSIDE PODIATRY CLINIC
2950 Northup Way Suite #115
Bellevue, WA 98004
P 425.893.8100 F 425.893.8111

INTAKE PAGE ONE

Name (Print name):____ Male Female
Last Name First Name Middle Initial

DOB____/____/____ **Age**:_________________ **Email**: ___________________@______________________________

Address:____
Street/PO BOX City State Zip Code

☐ **HIPAA Authorization**: I authorize Metroliance Foot and Ankle Group PLLC, DBA Eastside Podiatry and Eastside Podiatry Clinic, its physicians, its officers, and staff to correspond through voicemail, secure email, or telemedicine methods such as “Teams” or “Zoom”. Metroliance Foot and Ankle Group PLLC and its physicians, officers and staff may leave messages on my voicemail or email in regards to information regarding appointments, treatment related issues and billing issues. This authorization will remain in effect until you revoke it in writing. I consent to receive correspondence via phone, voicemail or email and understand the numbers I have provided. I understand that if there is a person OTHER than the patient that may speak for the individual patient at this number (example: spouse, caregiver) this authorization to speak with them on your behalf will also remain in effect unless specifically revoked in writing.

Home#:_____________________________ **Cell#**______________________________ **Alternate#**___________________

Emergency Contact: ___________________ **Relationship**:_______________________ **Phone#**_____________________

Primary Care Doctor:__________________ **Minors Only: Medical Guardian Name**:______________________________

Insurance Information: ☐ Self Pay ☐ Insurance

Primary Insurance: ____
ID #:____Group # :____
Primary Insured’s Name: ________________________ Insured DOB:___________ Relationship:____________________

Secondary Insurance: ____
ID #:____Group # :____
Primary Insured’s Name: ________________________ Insured DOB:___________ Relationship:____________________

Tertiary Insurance: ____
ID #:____Group # :____
Primary Insured’s Name: ________________________ Insured DOB:___________ Relationship:____________________

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO THE PHYSICIAN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE. I ALSO AUTHORIZE METROLIANCE FOOT AND ANKLE GROUP AND/ OR INSURANCECOMPANY TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIMS

Patient Signature (or Parent/Guardian): _______________________________________ **Date:**____________________

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PATIENT CONFIDENTIAL MEDICAL HISTORY: INTAKE PAGE 2

TODAY'S DATE: _____________ Patient Name: _______________________________________ DOB: ________________
Age: ______________________Height: ________________ Weight: _______________ Sex/Gender: ______________

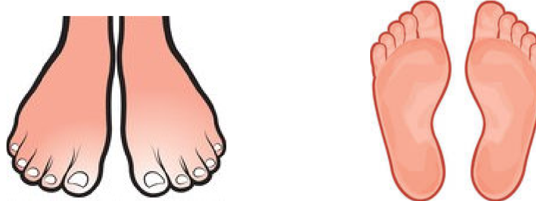
RACE AND ETHNICITY:
Race:
___Caucasian __African American __American Indian/Alaska Native
___Asian __ Native Hawaiian/ Pacific Islander ___ Other
Ethnicity:
___Hispanic or Latino ___Not Hispanic or Latino ___Decline to Disclose

Marital Status: ◯ Married ◯ Widow/er ◯ Dependent Domestic Partner

Employer: ____________________________________ **Occupation**: ____________________ ◯ Retired ◯ Student

CHIEF COMPLAINT:

Please Indicate Areas of Pain:



RIGHT LEFT BOTTOM RIGHT BOTTOM LEFT

What is your foot/ankle problem?
____
____
____

Where is the location of your problems? ◯ Right ◯ Left ◯ Both

How/When did the problem Start? ____
____

If you are in pain: Please specify when: ◯ In shoes ◯ Standing ◯ Walking ◯ Running ◯ Resting

How would you describe the pain: ◯ Sharp ◯ Dull ◯ Aching ◯ Burning ◯ Other:
____
____

Severity of pain: 0 1 2 3 4 5 6 7 8 9 10 (0 is no pain, 10 being greatest pain level)

Any previous treatments/surgeries? ◯ YES ◯ NO If "YES" Please Indicate treatments/surgeries:
____
____

Are you currently under the care of a physician? ◯ YES ◯ NO IF YES: Name of Doctor/Hospital _____________
____
____

PATIENT CONFIDENTIAL MEDICAL HISTORY INTAKE PAGE 3

Health History:

Do you have a history of the following?

YES	NO		YES	NO	
___	___	Heart Problems	___	___	Cancer
___	___	High Cholesterol	___	___	Arthritis
___	___	Diabetes A1c______ Blood Sugar _______	___	___	Neurological Problems
___	___	Gastrointestinal Problems	___	___	Low Blood Pressure
___	___	Stomach Problems taking Medicine	___	___	High Blood Pressure
___	___	Bleeding/Clotting Disorders/Anemia	___	___	Other: Please Specify Below:

____

____

Pregnancy: Are you currently pregnant? **YES** **NO** If yes, how many weeks? ________________________________

Alcohol Consumption: Do you drink alcoholic beverages? **YES** **NO** **If yes, how much?**________________________

Drug Dependency: Do you have a dependency on drugs? **YES** **NO** **If yes, how much?**________________________

Smoking: Do you smoke? **YES** **NO** If so, how many a day?

ALLERGIES/FOOD ALLERGIES/MEDICATION ALLERGIES:____

____

CURRENT MEDICATIONS LIST: (Include any natural supplements/IV Drip Medications) ___________________________

____

____

PHARMACY INFORMATION: What Pharmacy do you currently use? Name:_____________________________________

Address: (If Known) _________________________________ Phone Number (if Known):_________________________

How did you hear of us? Who should be thank for your referral? ____

I Hereby give my permission to administer treatment that is deemed medically necessary for my condition. I acknowledge that the above information is accurate and true, and any inaccurate information presented or withheld, resulting in complications of conditions will not be the responsibility of Metroliance Foot and Ankle Group, the entity, or any members of the practice. I understand that I am responsible for all fees regardless of insurance coverage. Non-Coverage due to incorrect disclosure of benefits and or failure to provide correct insurance information in a timely manner resulting in non-payment from your insurance will be patient responsibility. It is ultimately the patient responsibility to ensure that the services and physicians are in network with your particular insurance plan with your insurance carrier. I acknowledge that I have been offered a copy of the Notice of Privacy for Eastside Podiatry Clinic. The statement describes uses and disclosures of my protected health information that may occur in my treatment, payment for services, or in the performance of office healthcare office operations. The statement describes my rights and the responsibilities of this office with respect to my protected health information. The phone number, email address, etc. (not employers) on this intake form may receive reminder appointment calls, messages, emails, etc. unless I specify to the front office who may only be contacted regarding my protected healthcare information. In addition to the allowable disclosures described, I authorize disclosure of my protected health information to the persons indicated on this intake form or verbally to the staff.

________________________________	______________________________	_______________________________
PRINTED NAME	SIGNATURE	DATE

POSSIBLE FEES & PENALTIES POLICIES

General Payment Policy:

Self-Pay patient payments are due in full at time of service. Insurance Payments or balances due owning from insurance coverage are due in full due upon receipt of billing statement. There are no partial payment nor payment plans offered at this facility. Any benefits checked for you are done as a courtesy, as quoted to us by your insurance company upon the date checked, and is not a guarantee of payment as per your insurance company's disclaimer. Patients are responsible for understanding his or her own individual benefits and coverage. **Payments made later than 30 days past statement issue will incur a $30.00 late fee, 60 days past due date, $60.00 late fee, and 90 days incur a $100.00 late fee with possible assignment to our collection agency.** Once an account has been released to a collection agency after final notice, it is no longer under our control. This may cause a negative impact on your credit or credit report. We do not have control of attempts the agency may make to collect the payment from you.

Surgery Fee Policy:

Surgical Scheduling requires extensive hospital co-ordination and administrative time and paperwork in preparation for your procedure. A non-refundable $150.00 scheduling fee is assessed to "hold" your surgery day. Any **cancellations or re-scheduling** of your surgery will forfeit the $150.00 This does not apply if scheduling changes are made by the Doctors, Hospital, or Surgical Center, or "Acts of God" in which surgical services are deemed unrenderable by the physicians or the surgical facility and/or its directors or local authorities.

If you keep your surgery day as scheduled, the $150.00 will be applied to any balance you may have from the surgery.

Documentation Fee Policy:

Documentation requested by the patient such work related or medical disability forms require extensive time by physicians and staff. This may include but is not limited to completion of a medical history commensurate with the patient's condition; performance of an examination commensurate with the patient's condition; formulation of a diagnosis, assessment of capabilities, letters on behalf of the patient. The standard and acceptable fees will be charged for this time. Non-disability documentation may incur a flat $50.00 fee per hour required by the physician. This does not include reproduction fees.

Reproduction Fee Policy:

Digital copies of X-rays are $15.00 a disc. Document requests are charged a flat clerical fee of $26.00 plus $1.17 per page for the first 30 pages. Additional pages are $.88 per page. This is per Washington State Legislature regulation WAC 24608400 Healthcare Duplication. If the provider edits confidential information from the record, as require by statute, the provider can charge the usual fee for a basic office visit.

Missed Appointments Policy:

Missed appointments without prior cancellation will be assessed a $95.00 Missed Appointment Fee, which is the cost of a low level office visit. This fee will be automatically be billed to you. You must cancel at least 24 hours prior to your appointment time or you will be assessed a $95.00 fee. 3 missed appointments without notice or late cancellation will result in dismissal of the patient.

Bad Checks/Bounced Checks Policy:

Bad Checks will be assessed a $30.00 Fee to cover "bad check" penalties assessed to our practice from the bank.

Non-Compliance/Disruptive Patients:

The Physicians and Staff of the Metroliance Foot and Ankle Group make it our utmost priority to care for our patients in a respectful and professional manner. This is also expected of our patients and their accompanying parties. It is our policy that patients or persons who are non-compliant or display behavior that is disruptive, disrespectful, or inappropriate may be asked to leave the premises, and/or their care may be turned over to their primary doctors.

Agreement: ***I have read the above and understand the above policies, and when applicable, be bound by their terms. This agreement is binding and cannot be rescinded.***

________________________________ __________/_________/________ ____

(Patient Name) (Date) (Patient Signature) Rev 03/06/23