METROLIANCE FOOT AND ANKLE GROUP PLLC

DBA EASTSIDE PODIATRY CLINIC
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PATIENT INTAKE FORM

DEMOGRAPHICS:

Todays Date ____-_____-_____ Name (Last)_____ (First)_____(MI)_____
Date of Birth ____-_____-_____ Gender Male Female Other (Please Circle One)

Address:_____ City_____State _____Zip_____
Home Phone: _____-_____-_____ Cell Phone:_____-_____-_____ Email_____@_____
Marital Status: Married Not-Married Primary Language:_____

MINORS OR DEPENDENTS:

Legal Guardian Name_____ Relationship to Patient_____
Does this guardian also have medical guardianship? YES NO
If you circled NO: Who is Medical Guardian _____ Phone#_____-_____-_____

PRIMARY CARE DOCTOR:
Primary Care Doctor:_____ Hospital or Facility of Primary Care_____

EMERGENCY CONTACT: (Note: Listing the emergency contact gives us permission to discuss your medical history and/or pertinent information as necessary)

Emergency Contact Name:_____ Emergency Phone#_____-_____-_____
Relation to Emergency Contact Person _____

RACE AND ETHNICITY:

RACE: ____ White ____ Black or African American ____ American Indian or Alaska Native
____ Asian ____ Native Hawaiian or Other Pacific Islander
ETHNICITY: ____ Hispanic or Latino ____Not Hispanic or Latino ____Decline to Disclose

EMPLOYMENT: Employer:_____ Employer Phone:_____- _____-_____
WHO REFERRED YOU TO US?_____
INSURANCE INFORMATION:
Primary Insurance:_____ ID#_____ Primary Subscriber:_____
Secondary Insurance:_____ID#_____ Primary Subscriber:_____
Tertiary Insurance:_____ ID#_____ Primary Subscriber:_____

I hereby give my permission to administer treatment that may be deemed necessary for my condition. 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 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 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 PATIENT NAME PATIENT SIGNATURE DATE

EASTSIDE PODIATRY CLINIC- PATIENT MEDICAL HISTORY FORM

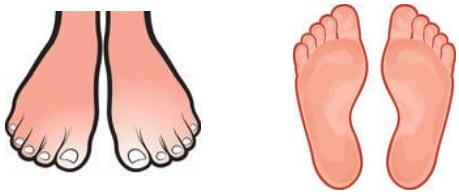
PATIENT NAME:_____ **DATE**:_____

WHAT IS THE PRIMARY PROBLEM YOU ARE HAVING?_____

_____

WHAT TREATMENT WAS DONE FOR IT?_____

PLEASE INDICATE AREA OF PAIN:



RIGHT LEFT RIGHT BOTTOM LEFT BOTTOM

HOW LONG HAS THIS BEEN A PROBLEM?_____

PAIN FROM 0-10, 0=NO PAIN, 10=VERY PAINFUL:_____

ANY OTHER FOOT PROBLEMS: YES NO

1 _____

2_____

CURRENT MEDICATION LIST:_____

_____

HEIGHT:_____ **WEIGHT**:_____

HOSPITALIZATIONS/SURGERIES:_____

_____

CURRENT OR HISTORY OF ALLERGIES/ALLERGIC REACTIONS TO LOCAL ANESTHETICS OR ANTIBIOTICS:

_____

DO YOU HAVE A HISTORY OF THE FOLLOWING:

YES	**NO**	
___	___	HEART PROBLEMS?
___	___	HYPERTENSION?
___	___	DIABETES? IF YES, HOW MANY YEARS? ____A1C? ___BLOOD SUGAR LEVEL?
___	___	NEUROLOGICAL PROBLEMS?
___	___	STOMACH PROBLEMS WITH TAKING MEDICATIONS?
___	___	BLEEDING DISORDERS?
___	___	ARTHRITIS?
___	___	ALCOHOL CONSUMPTION DAILY? HOW MANY? _____
___	___	SMOKER? (CHECK ONE) ___NEVER ___FORMER SMOKER ___CURRENT DAILY ___CURRENT SOME DAYS ___STATUS UNKNOWN

DATE____/____/_____ SIGNATURE OF PATIENT OR REPRESENTATIVE_____

REV8/3/2020

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 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 $35.00 Missed Appointment Fee. 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 $35.00 fee. 3 missed appointments inside the 24 hour window without notice or late cancellation will result in dismissal of the patient.

Bad Checks/Bounced Checks Policy:

Bad Checks will be assessed a $50.00 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 01/30/20

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