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Medicine of the Foot and Ankle

Foot Orthotic Therapy

Ankle-Foot Orthotic Therapy

Biomechanics of the Lower Extremities

Gait Analysis

Surgery of the Foot and Ankle

Arch and Heel Pain

Sports Medicine

Shoe Therapy

Children's Foot Disorders

Trauma of the Foot and Ankle

Nail and Skin Disorders

Welcome to the Tri-City Foot and Ankle Center in Pasco, Washington.

Thank you for selecting our office for your foot and ankle health care needs! We have prepared this packet of information and patient forms in order to help make your visit a convenient and pleasant experience.

Prior to your appointment, please contact your insurance company to clarify your coverage requirements.

Here are a couple of important points to keep in mind to make your visit easier:

Payments: Co-pays and self-pay items are due at the time of service. You are also responsible for services applied to your deductible and coinsurance, if using insurance. For your convenience, we accept Cash, Checks, Visa, MasterCard, and Discover.

Referrals: If your insurance requires a referral to see a specialist, you cannot assume that your referral has been approved unless you have received written confirmation from your insurance company. If you are not sure your referral has been approved, please contact your insurance company before your appointment.

Prior to your appointment, please complete the following forms:

- Registration Form
- Health History
- Financial Policy
- Notice of Privacy Policy

When you come for your appointment, please bring the following:

- The completed forms listed above
- Medical Insurance Card(s)
- Copayment, or Payment, if applicable
- Written referral, if required by your insurance company
- Past x-rays and medical records, if applicable
- A pair of shoes you commonly wear

Note: As you will be receiving advice on proper shoes for your feet, we recommend that you do not purchase any new shoes before your visit.

Our entire staff is here to help you in whatever manner we can. We look forward to serving you in the near future.

Directions:
We are located in Pasco, Washington off of Sandifur Way, across the street from McCurley Subaru. From I-182, take the Broadmoor exit and turn North onto Broadmoor Blvd. Take a right onto Sandifur Parkway and our parking lot entrance is just after Bedford Street. Directions and more information can be found at **www.TCPodiatry.com.**

Patient Registration

Tri-City Foot & Ankle Center

Patient Information

Patient Name: Last	First	M.I.	Gender: ☐M ☐F ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.
Preferred Name?			Single ☐ Married ☐ Widowed ☐ Other ☐
Address:		Apt.	
City	State	Zip	
Birthdate:	Preferred Phone: ☐Home ☐Cell ☐Work	Alternate Phone: ☐Home ☐Cell ☐Work	
Social Security #:	E-mail Address: (for access to your online Patient Portal)		Auto Reminders: (choose any) ☐Phone ☐Text ☐None
Employer:	Occupation:		
Emergency Contact Person:	Relationship:		
Phone Number:			

Insurance

☐ **No Insurance**: Self-pay (skip to Demographics section below)

PRIMARY INSURANCE		SECONDARY INSURANCE	
Name of Policyholder: ☐Patient (skip to next section→)		**Name of Policyholder:** ☐Patient (skip to section below)	
Birth Date:	**SSN:**	**Birth Date:**	**SSN:**
Relation to Patient: ☐ Spouse ☐ Parent ☐ Other:		**Relation to Patient:** ☐ Spouse ☐ Parent ☐ Other:	
Policyholder's Employer:		**Policyholder's Employer:**	

Guarantor

Guarantor Name (person paying the bill after insurance): ☐ Same as patient (skip to next section) ☐ Same as insured		
Guarantor's Address: ☐ Same as patient		
City	State	Zip
Guarantor's Telephone: ☐ Same as Home Phone		

Demographics

Preferred Language: ☐ English ☐ Spanish ☐ Other:______________ ☐ **Decline**

Race: ☐American Indian ☐Asian ☐Black/African American ☐European ☐White ☐Other:_____________ ☐ **Decline**

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino ☐**Decline**

How did you hear about our office?

☐ Friend ☐ Family ☐ TV ☐ Google ☐ Bing ☐ Yelp ☐ Other Web Search ☐ Insurance Company ☐ Phone Book

☐ Saw Sign Outside

☐ My Doctor (name):____ ☐MD ☐DO ☐ARNP ☐DPM ☐PA

Who is your Primary Care Physician and Pharmacy?

Primary Care Physician:____ ☐ I don't have a primary care physician

Pharmacy (Include street, city):____

Lower Extremity Medical History

Name: ____

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

____

____

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

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

Location on foot or ankle (Heel, forefoot, toes, ankle, etc…):____

Onset : Slow Sudden Traumatic **Duration?:** ____Days ____Weeks ____Months ____Years

Pain Level 1-10 (10 is worst): _____ **Severity**: Mild Moderate Severe

Progression: Improving Worsening Staying the same

Any recent x-rays or MRIs? When/Where taken? :____

Have you ever had a similar problem?: (List treatments)____

Past Medical History, Social and Family History Form

What is your Weight:___________ Height:_____________ Shoe Size:______________

Allergies:

☐ **NONE** ☐ Aspirin ☐ Anesthetics ☐ Seafoods
☐ Codeine ☐ Penicillin ☐ Iodine ☐ Sulfa
☐ Tape ☐ Other:______________________

Medications: ☐ Not taking medication ☐ I Brought in my Medication List (Please give to receptionist to copy)

Medication	Dose	Medication	Dose
____________________	___________	____________________	___________
____________________	___________	____________________	___________
____________________	___________	____________________	___________
____________________	___________	____________________	___________
____________________	___________	____________________	___________

Past Medical History:

☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Fibromyalgia ☐ GERD
☐ Gout ☐ Heart Disease ☐ High blood pressure ☐ Kidney Disease ☐ Liver Disease
☐ Phlebitis Clots ☐ Psoriasis ☐ Stroke ☐ Thyroid Disease
☐ Other:____

What problems run in the family? (Diabetes, heart disease, blood pressure, etc.):____

____

Past Surgical History (List): ____________________ ____________________ ____________________ ____________________
____________________ ____________________ ____________________ ____________________

Do you smoke? yes no

Are you a past smoker? yes no

How Much? packs/day_____ Years Smoked:______

Do you Drink Alcohol? Yes No

How much:_____________

Recreational Drugs? Yes No

Which ones:______________________

Pregnant or possibly pregnant? Yes No

FINANCIAL POLICY
ASSIGNMENT OF BENEFITS

Thank you for choosing us as your podiatric 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.

PAYMENT FOR SERVICES: Payment for services are due once services are provided to you. We expect all charges we present to you at a visit will be paid at that visit, including copays and unpaid balances. You are responsible for copay amounts, coinsurance amounts, program deductibles, earlier charges that remain unpaid, and charges for services that are not covered by insurance or government programs, as determined by your insurance plan. 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. Credit card payments may be made on your online portal or over the phone with our office at (509) 591-9454. Payments may be made in person during business hours, or checks may also be mailed to our office at:

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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 be your responsibility to pay. Your insurance company determines the price of our services. **Any pricing information from our office is an estimate.** Please contact your insurance company for full information. **Copays are due at the time of visit.** Your visit will be rescheduled if you are not prepared to pay the copayment.

NO INSURANCE: If you do not have insurance or the doctor is not a participating provider with your insurance plan, all charges for services will be due at the time of visit. Our discounted self-pay prices are available at the reception desk.

BILLING COMMUNICATIONS: We will present charges to you by written statement via the mail or patient portal following a visit. We expect that each charge will be paid in full the first time it is presented to you. We may contact you using any contact information provided to our office in regards to billing communications.

MINOR PATIENTS: The parent or 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 obtained for the charges and treatment.

ASSIGNMENT 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 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 is due at time of service).

CANCELLATION POLICY: As a courtesy to other patients, we request 24 hours notice for cancelling and rescheduling appointments. Last minute cancellations and no shows will be subject to a $25 cancellation fee.

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: ______________________________

Patient Name (if signed by guardian)**:** ______________________________

Tri-City Foot & Ankle Center

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby authorize this practice to disclose both orally and in writing all facts pertaining to the past, present and future conditions, treatments and services rendered with no exceptions. This includes diagnosis, prognosis, care and treatment, reports, testing and changes. I understand that I may change this authorization in writing at any time.

Please include any **legal guardians**.
You may release to the following people:

Name	Relationship	Telephone

I acknowledge 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 ______________

Patient Signature ______________________ Guardian Signature (if applicable) ______________________

SUMMARY OF NOTICE OF PRIVACY PRACTICES

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. 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.

Uses and Disclosures Not Requiring Your Authorization.

In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;

If you have a question, concern or complaint regarding our privacy practices, please inform your Doctor.

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 Tri-City Foot and Ankle Center we respect your time and 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 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.

Unpredictable traffic jams or a toddler who throws a tantrum can cause our patients to be late or miss an appointment altogether. We understand that sometimes being late is unavoidable and usually a quick phone call to the office explaining your tardiness or last-minute cancellation is sufficient.

Late Arrivals
When a patient arrives late for an appointment, if the schedule allows, we will see the patient. There may be a wait, however, as we will see all on-time patients first. If urgent, the patient may be asked to wait to be seen, or 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. We reserve the right to charge a $25 cancellation fee for appointments cancelled within 24 hours or not showing up to a scheduled appointment.

Walk-ins
If you have an urgent problem, we will do our best to work you into an already busy schedule. In this situation, be aware that there may be a wait but we are committed to seeing you that day.

Usually we will see you within 15 minutes of your scheduled appointment time, but occasionally the wait may be longer.