Welcome To The Foot And Ankle Center of Lake City

PATIENT INFORMATION

Last_____ First_____ MI_____ ☐ Male ☐ Female

Generation (I, II, III, Jr., Sr. etc)_____ Email*_____

Home

Address_____ City_____ St_____ Zip_____

Billing

Address_____ City_____ St_____ Zip_____

Check Preferred Phone #:Home____-____-_____ Work____-____-_____ Cell____-____-_____

Employer_____ Occupation_____

Birthdate _____/_____/_____ Age_____ SS#_____/_____/_____

Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered ☐

Spouse/Partner

Name_____ Phone_____

Emergency Contact Relationship Phone

Primary Language_____

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Decline

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Decline

Contact Message: Ok to leave voicemail or email messages with ☐ patient only ☐ spouse or ☐ anyone answering phone

INSURANCE INFORMATION

Is your insurance through an employer? ☐ Yes ☐ No

Primary Insurance Plan

Name_____ ID#_____ Group#_____

Subscriber Name_____ DOB___/___/_____ Relationship to Patient_____

Secondary Insurance Plan

Name_____ ID#_____ Group#_____

Subscriber Name_____ DOB___/____/____ Relationship to Patient_____

PRIMARY CARE PHYSICIAN

Name_____

Address_____ City_____ St____ Zip Code_____

Phone Fax

SPECIALTY PHYSICIAN ☐

Name_____

Address_____ City_____ St____ Zip Code_____

Phone Fax

HOW DID YOU HEAR ABOUT OUR PRACTICE?

Referred by Dr._____

☐ Internet search ☐ Insurance ☐ Family _____ ☐ Friend_____

☐ Other_____

*We will periodically send you medical, educational, and promotions via email.

Patient/Parent

Signature_____ **Date**_____

12.13.17 updated

Current Medical History

For each area, check all that apply:

Date_____

Are you currently experiencing:

- ☐ Fever
- ☐ Chills
- ☐ Headache
- ☐ Malaise
- ☐ Dizziness
- ☐ Poor balance
- ☐ None

Eyes, Ears, Nose, Throat

- ☐ Blurred vision
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Diabetic retinopathy
- ☐ Congestion
- ☐ Rhinitis
- ☐ Iritis
- ☐ Poor Hearing

Allergies

- ☐ Seasonal
- ☐ Tape/adhesives
- ☐ Iodine
- ☐ Latex
- ☐ Metals
- ☐ Drugs; please list on next page
- ☐ Skin_____
- ☐ Foods_____

Musculoskeletal

- ☐ Arthritis
- ☐ Weakness
- ☐ Fibromyalgia
- ☐ Rheumatoid arthritis
- ☐ Gout
- ☐ No pain other than my feet

Neurologic

- ☐ CVA
- ☐ Seizures
- ☐ Dizziness
- ☐ Tingling
- ☐ Numbness
- ☐ Radiating pain down my legs
- ☐ Tremor
- ☐ Burning

Genitourinary

- ☐ Excess frequency of urination
- ☐ Burning on urination
- ☐ Renal Disease Stage___
- ☐ Bladder or urinary tract infection
- ☐ Prostate disease
- ☐ None of these

Endocrine

- ☐ Excessive thirst
- ☐ Excessive hunger
- ☐ Constant fatigue
- ☐ Diabetes
- ☐ Hypothyroid
- ☐ Other
- ☐ None

Respiratory

- ☐ Wheezing
- ☐ Coughing
- ☐ Asthma
- ☐ Pneumonia
- ☐ Emphysema

Other: _____

Gastrointestinal

- ☐ Heartburn
- ☐ GERD
- ☐ Nausea
- ☐ Colitis
- ☐ Constipation
- ☐ History of stomach ulcers
- ☐ None

Cardiovascular

- ☐ Chest pain
- ☐ Shortness of breathe
- ☐ Palpiltations
- ☐ Arrhythmia
- ☐ History of heart attack
- ☐ Chronic heart failure
- ☐ Other

Blood

- ☐ Bleeding or clotting disorder
- ☐ History of Deep Vein Thrombosis or Blood Clots in your leg

Other_____

History/Poor Balance

- ☐ Have fallen ___ times this yr
- ☐ Difficulty getting out of chair
- ☐ Lose balance easily when walking
- ☐ Difficulty turning around while standing
- ☐ Unsure of where my feet are
- ☐ Unsteady going up or down stairs
- ☐ Use assistive device like walker due to poor balance.

History of HIV

☐ Yes ☐ No

Psychiatric

- ☐ Depression
- ☐ Anxiety/Bipolar
- ☐ Schizophrenia
- ☐ Other_____

Influenza

Date of my last flu shot_____

Date of scheduled flu shot_____

☐ I don't intend to have a flu shot

Women:

☐ Are you pregnant ☐ Yes ☐ No

Smoking: I don't smoke cigarettes

☐ I smoked cigarettes for ____ years but no longer smoke

☐ I have smoked ___ pks of cigarettes/day for ___ years

☐ Chew tobacco ☐ I smoke a pipe

Alcohol ☐ I don't drink alcohol ☐ I seldom drink alcohol

☐ I occasionally drink alcohol

I drink ___ glasses of wine/day I drink___ beers/day

I drink ___ glasses of hard alcohol/day

List surgeries you've had in the last 5 years

_____

_____

Complications from Anesthesia ☐ **Yes** ☐ **No**

Do you currently take blood thinners? ☐ **Yes** ☐ **No**

Print Name:_____**Birthdate**_____

MEDICATIONS and SUPPLEMENTS

Please attach your list of current medications or complete the form below.

	Medication	Dosage	Times Per Day
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
	NO MEDICATIONS OR SUPPLEMENTS		

List of Drug Allergies:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Pharmacy Name: _____

Location/Zip Code: _____ City _____

To the best of my knowledge, all the preceding answers of my medical history and medications and supplements list are true and correct. If I have any changes in my health history or medications and supplements, I will inform the doctor at my next appointment.

Patient Signature Name: _____ Date: _____

Print Patient Name: _____ Date of Birth: _____

Patient Name_____DOB_____Date_____

What are the top 3 foot problems you wish to discuss with Dr. Berg today?

1._____

2._____

3._____

Foot Problem #1_____

1. I'm experiencing: (check all that apply)
- ☐ pain
- ☐ swelling
- ☐ lump
- ☐ discoloration
- ☐ ulcer
- ☐ ingrown toenail
- ☐ thickened toenails
- ☐ itching
- ☐ rash
- ☐ growth/mass
- ☐ other_____

On my:
- ☐ left foot
- ☐ right foot

2. The problem has been present for #____
(circle one) days wks mos yrs

3. The pain/discomfort is located primarily on the (choose one only)
- ☐ top of foot
- ☐ bottom of foot
- ☐ top of toes
- ☐ bottom of toes
- ☐ tip of toes
- ☐ toenail
- ☐ great toe
- ☐ bunion
- ☐ bottom of heel
- ☐ back of heel
- ☐ front of ankle
- ☐ side of ankle closest to the other foot
- ☐ side of ankle farthest away from other foot
- ☐ middle of the foot/instep
- ☐ arch
- ☐ ball of foot
- ☐ Other_____

4. The problem began:
- ☐ gradually
- ☐ suddenly
- ☐ originally occasional or intermittent, then becoming more constant

5. Discomfort is aggravated by or associated with
- ☐ no specific activity
- ☐ getting up in AM
- ☐ occurs mainly at night in bed
- ☐ going barefoot
- ☐ when wearing sandals
- ☐ when wearing boots or shoes with heels
- ☐ normal walking/ daily activities
- ☐ standing for prolonged periods of time
- ☐ standing on feet at work
- ☐ exercise walking
- ☐ working out in the gym such as on elliptical trainer or treadmill
- ☐ playing tennis
- ☐ hiking
- ☐ running
- ☐ climbing
- ☐ playing soccer
- ☐ golfing
- ☐ skiing
- ☐ other _____

6. Pain is
- ☐ sharp
- ☐ dull
- ☐ aching
- ☐ burning
- ☐ shooting
- ☐ radiating
- ☐ pulsating
- ☐ throbbing
- ☐ stabbing
- ☐ tingling
- ☐ constant
- ☐ intermittent
- ☐ fluctuating

7. My overall pain level with this problem is:

On a scale of 1-10 where **1** is no pain and **10** is the worst pain

In the AM _____
By end of day _____

8. Amount of time I spend each day on my feet:
- ☐ little
- ☐ moderate
- ☐ extensive

9. Treatment to date has included:
- ☐ none
- ☐ rest
- ☐ cast
- ☐ taping
- ☐ brace
- ☐ injection
- ☐ anti-inflammatory medication
- ☐ physical therapy
- ☐ arch supports
- ☐ prescriptive orthotics
- ☐ total offloading with crutches walker or wheelchair
- ☐ surgery
- ☐ treatment of wound at other clinic
- ☐ other_____

10. Overall progress since onset is
- ☐ no change
- ☐ slight improvement
- ☐ moderate improvement
- ☐ worse
- ☐ temporary improvement with therapy

11. My goals are to:
- ☐ eliminate pain
- ☐ be able to stand and walk without pain
- ☐ be able to work without pain
- ☐ exercise without pain
- ☐ return to running
- ☐ return to sports activities
- ☐ improve stability
- ☐ improve balance

12. Flu shot Yes____ No____ If yes, Date __/__

Diabetics only:

13. My fasting blood sugar today is ____. Mo/Yr
14. My most recent HgA1c eg. 5,6,7 is ____. Date __/__
15. Last eye exam with ophthamologist Date __/__
16. Urine tested for kidney disease Date __/__
17. Have you fallen or had poor balance in the last year? Yes____ No____

10/2015

Foot & Ankle Center of Lake City

FINANCIAL POLICY – Effective June 20, 2017

Thank you for choosing our office for your podiatric needs. We are committed to your treatment being successful, as you, the patient, are our first and foremost concern. Your clear understanding of our Financial Policy is important to our professional relationship and as part of our service we try to contain the cost of health care. To avoid any misunderstandings, please feel free to ask us any questions about our policies.

INSURANCE: Dr. Berg is contracted with most insurance plans. Your insurance policy is a contract between you and your insurance company. It is your responsibility to contact your insurance company regarding pre-authorizations, obtaining required referrals and second opinions.

INSURANCE DEDUCTIBLES: *All deductible balances are due within 14 days of receipt of patient statement. In certain cases, where there is a large deductible balance, we may be able to arrange a payment program of automatic deductions on a credit card.*

CO-PAYMENTS: *Please be prepared to pay all co-pays at the time of service.*

PATIENT BALANCES: *All remaining patient balances, are due by the end of the month in which you receive your statement. If you need more time to pay your balance we can arrange for you to apply for CARE CREDIT. Please ask at the front desk for an application. A **$12.00 rebilling fee** will be added to each statement sent for an unpaid balance. Past due accounts, more than **90 days,** will be sent to our collection agency and a fee of up to 35% of the balance due will be added to cover collection costs.*

CANCELLATIONS and RESCHEDULING: *A 24-hour notice is expected for cancellations and/or rescheduling of appointments. We will try to accommodate you in rescheduling your appointment as soon as possible Cancellations without 24 hour notice and No-Shows will result in **a $75 Missed Appointment Fee.** This fee must be paid before your next appointment.*

*Initial*_____

NO INSURANCE: If you do not have insurance, please be prepared to fully cover the fees for each visit at the time of treatment.

SECONDARY INSURANCE: If you have secondary insurance, we will bill them one time. If your secondary insurance does not pay the balance within 45 days, that balance will be billed to you and due at that time.

MINOR PATIENTS: The adult or parent (custodial guardian) accompanying a minor is responsible for payment of services. Young adults (age 18 or over) are legally responsible for their accounts unless a parent accompanies them to the initial appointment and signs this financial agreement, regardless of insurance coverage.

SUPPLIES: To provide the best possible treatment plan for you, our doctor offers every level of podiatric care. Often, the use of a foot care product is an appropriate treatment for a successful outcome. For your convenience, we make some supplies available for purchase through R&M Medical and Supply. R&M Medical and Supply is located here in our office but is not contracted with any insurance companies, so payment is due at time of sale. Our doctor is happy to offer a prescription for a comparable product if you would prefer to obtain the supplies through your pharmacy.

AGREEMENT: I have read and agree to the terms set forth in the above financial policy. I also understand that I am financially responsible for any treatment rendered to me or minor child by Foot & Ankle Center of Lake City. I, therefore, authorize Foot & Ankle Center of Lake City to release and or exchange medical records, billing and collection information for the purpose of obtaining payment for services rendered.

Print Patient Name_____ Signature_____ Date_____

Financially Responsible Party: ☐ **same**

Print Name _____ Signature_____

Relationship to Patient_____ Date_____

FOOT AND ANKLE CENTER OF LAKE CITY
2611 NE 125th St Ste 130, Seattle WA 98125
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ _____
Print Patient's Name Date

_____
Print Parent or Authorized Representative (if applicable)

_____
Signature of Patient/Parent/Authorized Representative

For Practice Use Only

Documentation of Good Faith Effort to Obtain Acknowledgement

( ) Patient refused to sign
( ) Communication barrier prohibited obtaining acknowledgement
( ) Emergency circumstances
( ) Form was not presented to patient at initial visit
( ) Minor, parent/legal guardian not present
( ) Other_____

_____

_____ _____
Signature of Employee Date

_____ _____
Signature of Privacy Officer Review Date

Adopted 02.21.2006, revised 02.05.16

FOOT&ANKLE

CENTER of LAKE CITY

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding the
Notice of Privacy Practices

The Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information. You may obtain this notice from our receptionist if you have not already been given one at the time of check in.

Office setting. Our office has three exam rooms available for daily patient care. Two of these rooms are open as in a dental setting. Conversation can be heard by others. You may request to be seen in our closed exam room at the time you check in with our receptionist. Please note that this may cause a delay in your treatment if you do decide on this option. Our office will do everything possible to maintain your privacy.

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 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;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the Notice of Privacy Practices for the person or persons whom you may contact.

Rion A. Berg, D.P.M.
Board Certified in Foot Surgery

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