Welcome to the Foot and Ankle Center of Lake City
Patient Information

First Name:________________________________**MI**_____**Last Name:**______________________________**Suffix** ____

Birthdate:_________________**Age**_____ **Male**____ **Female**____ **Gender Identity**______________________________

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

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

Primary Language______________________________ SS# optional)____

Address: ____**Home Phone** _________________**Preferred**☐

____**Cell Phone*** __________________**Preferred**☐

City ________________________**St**____________**Zip**__________ **Email**_______________________________☐

*Electronic Notifications: By selecting email and/or text messaging, the patient agrees to receive text and email notifications from the practice for educational, promotional, and confirming appointments. Email☐ Text Messaging☐

Marital Status: Single☐ Married☐ Divorced☐ Widowed☐ Partnered☐

Spouse: ____ Phone #_____________________________

Employment: Employed☐ Unemployed☐ Full Time Student☐ Part Time Student☐

Employer:_______________________________________ Occupation _______________________________________

Emergency Contact First Name ______________________MI_____ Last Name__________________________________

Relationship to Patient:______________________________________ Phone #___________________________________

CareGiver: First Name ____________________________MI_____LastName__________________________________

Relationship to Patient____________________________________Phone#____________________________________

Primary Insurance Name:____

Subscriber ID____Group No ______________________________

Subscriber Name ______________________________ DOB _________ Relationship to Patient______________________

Secondary Insurance Name:____

Subscriber ID____Group No ______________________________

Subscriber Name______________________________DOB__________Relationship to Patient______________________

Primary Physician Name: ______________________________Phone No _________________Fax_________________

Address____City__________________State_____Zip Code__________

Specialty Physician Name: ____________________________Phone No _________________Fax_________________

Address____City__________________State_____Zip Code__________

How Did You Hear About Our Practice?

Referred by Provider__________________________Internet☐ Google☐ Website☐Facebook☐Pinterest☐Yelp☐

Insurance☐ Family ___________________________Friend_________________Other____________________

By signing below, I authorize to release or use information for treatment, payment, or health care operations.

Signature: ____ Date: _______________________

Updated 02/08/2021

Current Medical History

Are you currently experiencing:
- Fever☐
- Chills☐
- Headache☐
- Malaise☐
- Dizziness☐
- Poor Balance☐
- None of the Above☐

Eyes, Ears, Nose, Throat
- Blurred vision☐
- Glaucoma☐
- Cataracts☐
- Diabetic Retinopathy☐
- Congestion☐
- Rhinitis☐
- Iritis☐
- Poor Hearing☐
- None of the Above☐

Allergies
- Seasonal☐
- Tape/adhesives☐
- Iodine☐
- Latex☐
- Metals☐
- Drugs: please list on next page
- Skin____________________________
- Foods___________________________
- None of the Above☐

Musculoskeletal
- Rheumatoid Arthritis☐
- Weakness☐
- Fibromyalgia☐
- Gout☐
- Osteo Arthritis☐
- None of the Above☐

Neurologic
- CVA, TIA (stroke)☐
- Seizures☐
- Dizziness☐
- Tingling☐
- Numbness☐
- Burning☐
- Tremor☐
- Radiating Pain down my legs☐
- None of the above☐

Genitourinary
- Excess Frequency of Urination☐
- Burning on Urination☐
- Renal Disease Stage________
- Prostate Disease☐
- Bladder or urinary tract infection☐
- None of the above☐

Endocrine
- Excessive Thirst☐
- Excessive Hunger☐
- Constant Fatigue☐
- Diabetes Type____
- Hypothyroid☐
- None of the above☐
- FBS____________
- A1C____________

Do you currently take blood thinners? Yes☐ No☐

Respiratory
- Wheezing☐
- Coughing☐
- Asthma☐
- Pneumonia☐
- Emphysema☐
- COPD☐
- None of the Above☐

Gastrointestinal
- Heartburn☐
- GERD☐
- Nausea☐
- Colitis☐
- Constipation☐
- History of Stomach Ulcers☐
- None of the Above☐

Cardiovascular
- Chest pain☐
- Shortness of breath☐
- Palpitations☐
- Arrhythmia☐
- History of Heart Attack☐
- Chronic Heart Failure☐
- Hypertension☐
- None of the Above☐

Blood Disorder
- Bleeding or Clotting Disorder☐
- History of Deep Vein Thrombosis (blood clots in your leg(s))☐
- History Of HIV☐
- History of Cancer (Type)________

Balance
- Have fallen___times this year
- Difficulty getting out of Chair☐
- Lose balance easily when walking☐
- Difficulty turning around while Standing☐
- Unsure of where your feet are☐
- Unsteady going up or down stairs☐
- Use assistive device due to poor balance☐

Psychiatric
- Depression☐
- Anxiety☐
- Bipolar☐
- Schizophrenia☐
- None of the Above☐

Are you Pregnant? Yes☐ No☐

Do you smoke? Yes☐ No☐

Packs per Day _____ for ________years

Former Smoker for _______years

Chew Tobacco☐ Smoke a pipe☐

Do you Drink? Yes☐ No☐

I drink_____glasses of wine/day_____beers/day

I drink_____glasses of hard alcohol/day

I drink seldom☐ occasional☐

List Surgeries you've had in last 5 years

____

____

____

Do you have Complications from anesthesia? Yes☐ No☐

Influenza Vaccine Date of last Vaccine___________

Covid 19 Vaccine Date of Vaccines _______. ______

Patient Name:______________________________ **DOB**_____________ **Date**__________

Updated 02/08/2021

MEDICATIONS AND SUPPLEMENTS

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

	CHECK BOX IF NOT MEDICATIONS OR SUPPLEMENTS ☐		
	Medication	Dosage	Times Per Day
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			

Drug Allergies and Reactions

	CHECK BOX IF NO KNOWN DRUG ALLERGIES ☐	
	Drug/Medication	Reaction
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Pharmacy Name:____

Location/Zip Code:____________________ City____________________

To the best of my knowledge, all the preceding answers of my medical history, medications, supplements, and allergies list are true and correct. By signing below I agree to treatment by Rion A. Berg, DPM. If I have any changes in my health history, medications, supplements, or allergies I will inform the doctor at my next appointment.

Patient Signature: ____________________________ Date:______________

Print Patient Name: ____________________________ Date of Birth: ______________

Foot & Ankle Center of Lake City

FINANCIAL POLICY – Effective February 1, 2021

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: *If you have an unmet deductible, we pre-collect 60% of the charges incurred. Your insurance will apply the charges towards your deductible at the time of each visit until deductible has been met. In certain cases, where there is a large deductible balance, we may be able to arrange a payment plan 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 **$10.00 rebilling fee** will be added to each additional 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.*

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**

Parent/Guardian
Print Name ________________________________ Signature____________________________

Relationship to Patient________________________ Date______________________________

Foot & Ankle Center of Lake City
2611 NE 125th St Ste 130 Seattle WA 98125
206.368.7000 Fax 206.361.9273
www.bergdpm.com

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 four exam rooms available for daily patient care. Two of these rooms are open as in a dental setting. Conversations 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 to treat you or to assist other health care providers in treating you. We will also use and disclose your health information 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 purpose:
- 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 repot 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 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 request restrictions as to how email and text messaging and cell phone number are used:
- To receive explanation of services prior to treatment of medical care:
- To receive explanation of any charges and/or payments made for your medical care:
- To receive the full notice of our privacy practices.

If you have a question, concern, or complaint regarding our privacy practices, please contact the office manager, Lucy Gleeson at the number above.

Updated 02/15/2021

Foot & Ankle Center of Lake City
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Seattle WA 98125
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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 Privacy Officer Review Date

______________________________ ______________
Print Patient's Name Date

____
Signature of Patient/Parent/Authorized Representative

______________________________ ______________
Print Parent or Authorized Representative (if applicable) Relationship to Patient