REGISTRATION FORM **EVERETT FOOT CLINIC**

Patient Information

Date____________

Name:______________________________ Date of Birth:_____________ Social Security #:_________________

Address:_________________________________ City:___________________ State:______ Zip:_____________

Phone: (_____)______________ Work Phone: (_____)______________ Cell Phone: (_____)_______________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient's Employer:___________________________ City/State:__________________________ ☐ FT ☐ PT

Spouse or Parent's Name:___________________ Employer:______________ Work Phone:________________

Referred by?_____________________Emergency contact:__________________ Phone: (____)_____________

Email Address:_________________________________ Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

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

Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name:____ Relationship to Patient:_________________________

Address:____

City:________________________________ State:_______ Zip:_____________ Phone: (_____)______________

Employer:__________________________ Work Phone: (_____)______________ SSN#:____________________

Insurance Information

Name of Insured:_________________________ DOB:___________ Relationship to Patient:________________

SSN#:______________________ Name of Employer:_________________ Work Phone:(_____)______________

Address of Employer:__________________________ City:________________ State:______ Zip:_____________

Insurance Company:________________________ Grp #:______________________ ID#:___________________

------ DO YOU HAVE ANY ADDITIONAL INSURANCE ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ------

Name of Insured:_________________________ DOB:___________ Relationship to Patient:________________

SSN#:______________________ Name of Employer:_________________ Work Phone:(_____)______________

Address of Employer:__________________________ City:________________ State:______ Zip:_____________

Insurance Company:________________________ Grp #:______________________ ID#:___________________

I understand that the above information must be complete, correct and current in order for my services to be billed to my insurance. I authorize payment of medical benefits, both private and Medicare to Everett Foot Clinic for any services furnished to me by the physician. I understand I am financially responsible for any amount not covered by my insurance. I authorize you to release to my insurance company, their agent, or HCFA information concerning healthcare, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluation and administering claims of benefits.

Signature:____ Date:____

Medical History

PLEASE CHECK PAST AND PRESENT CONDITIONS

- ☐ Anemia
- ☐ Artificial joints
- ☐ Arthritis
- ☐ Arthritis RA
- ☐ Anxiety disorder
- ☐ Alzheimer's
- ☐ Asthma
- ☐ Bowel disorders
- ☐ Bladder dysfunction
- ☐ Bleeding tendency
- ☐ Back pain
- ☐ Bell's palsy
- ☐ Bi-polar
- ☐ Cardiac valve replacement
- ☐ Chest pain
- ☐ Cardiac arrhythmias
- ☐ Cardiac disease
- ☐ Cellulitis
- ☐ Cancer: Breast
- ☐ Cancer: Colon
- ☐ Cancer: Kidney
- ☐ Cancer: Liver
- ☐ Cancer: Lung
- ☐ Cancer: Pancreas
- ☐ Cancer: Skin
- ☐ Cancer: Stomach
- ☐ Cancer: Other
- ☐ Crohn's disease
- ☐ Chemical dependency
- ☐ C.O.P.D
- ☐ Dermatitis
- ☐ Diabetes 1
- ☐ Diabetes Type 2
- ☐ Diverticulitis
- ☐ Degenerative joint disease
- ☐ Depression
- ☐ Ear conditions
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Fractures
- ☐ Grave's disease
- ☐ Gerd
- ☐ Gall bladder disorder
- ☐ Ganglion cyst
- ☐ Gout
- ☐ HIV / AIDS
- ☐ Hypertension
- ☐ Hypotension
- ☐ Herpes oral
- ☐ Hormone disorder
- ☐ Hernia
- ☐ Hepatitis
- ☐ Headaches
- ☐ Ingrown toenail
- ☐ Insomnia
- ☐ Kidney disorder
- ☐ Liver disease
- ☐ Lupus
- ☐ Migraines
- ☐ Multiple sclerosis
- ☐ Neuropathy
- ☐ Ovarian cyst
- ☐ Osteoporosis
- ☐ Peripheral vascular disease
- ☐ Polio
- ☐ Psoriasis
- ☐ Pancreatitis
- ☐ Phlebitis
- ☐ Psychiatric care
- ☐ Renal Failure
- ☐ Rheumatic fever
- ☐ Raynaud's
- ☐ Radiation therapy
- ☐ Scleroderma
- ☐ Shingles
- ☐ STD
- ☐ Sinus conditions
- ☐ Spinal stenosis
- ☐ Sciatica
- ☐ Stroke
- ☐ Shortness of breath
- ☐ Sleep apnea

Surgeries or hospitalizations you have had:

____

____

h h ……………………………………………………

Primary care physician:____ Last visit date:____________

MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins:

____

____

____

____

____

ALLERGIES

- ☐ Adhesive/Tape
- ☐ Anticoagulant Therapy
- ☐ Aspirin
- ☐ Codeine
- ☐ Demerol
- ☐ Iodine
- ☐ Local Anesthetics
- ☐ Novocain
- ☐ Penicillin
- ☐ Seafoods
- ☐ Sulfa

Other ________________________________

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

____ ______________________

Signature of Patient, Parent, Guardian or Personal Representative Date

____ ______________________

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Initial Treatment History

What is your Shoe size? _________ Weight? _________ Height? _________
Has there been an increase or decrease in your weight over the past 5 years? ________

Do you smoke? _________ How much? _________ Do you consume alcohol? _________

Do you consume caffeinated beverages? ☐ Coffee ☐ Tea ☐ Cola ☐ Other ______________

When was your last visit with your Primary Care Physician? __________________

When are you scheduled to see your Primary Care Physician? __________________

Have you had a FLU VACCINE this year? __________________

When was your last BLOOD ANALYSIS? __________________

Do you have a family history of any of the following? And state with whom.
☐ Cardiovascular disease ☐ Diabetes ☐ Gout ☐ Liver disease ☐ Lupus ☐ Foot problems
Family Member: __________________

Can Dr. McCord review your medication history to prevent complications or interactions from prescribed medications? __________________

Do you exercise? ___________ How? And how many times per week? _________________________________

What types of shoes do you wear?
☐ Boots ☐ Cross Trainers ☐ Flip flops ☐ High heels ☐ Sandals ☐ Steel toes ☐ Tennis

Have you seen another PODIATRIST before? _______ Have you been treated by any of the following:
☐ Anti-inflammatory medications ☐ Injections ☐ Orthotics

What is the reason for your visit today? ____
____
____
____
Is this injury related? ______ Date of this injury? _________________

How would you describe your pain? ☐ Aching ☐ Bruising ☐ Burning ☐ Sharp ☐ Tingling
Is it worse in the morning? ____________ Is it getting worse? _____________

Do you have trouble with? ☐ Sleeping ☐ Leg Cramps

STATEMENT OF BILLINGCREDIT/MEDICAL INSURANCE FOR THE BENEFIT OF OUR PATIENTS

Everett Foot Clinic

TO OUR PATIENTS:

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

FOR OUR CONTRACTED INSURANCE PLANS:

We accept payment based on insurance company's allowable fee structure and the contract your insurance group has with the carrier. Any allowable balances are the responsibility of the patient and are due in full upon receipt of statement. Co-payments are due at the time of service.

It is the patient's responsibility to obtain any necessary referrals. If no referral is received by your appointment date, we will request you either reschedule or pay for your visit.

Please provide the office staff with a current insurance identification card for photocopying. If your insurance should change while you are undergoing treatment please inform the office staff so the information can be updated. If you fail to inform our office of a change and the claim is not filed in a timely manner to the appropriate insurance carrier you will be responsible for the charges.

Not all services are a covered benefit in all contracts. Our office cannot advise you of your benefits. If you have a question or concern regarding coverage please refer to your insurance handbook or call your insurance representative to check on exclusions or non-covered services.

NON – CONTRACTED AND/OR OUT-OF-NETWORK PLANS:

We will do the billing from this office for your Primary Insurance as a courtesy. Please furnish us with a current insurance card. For insurances where payment MUST be made directly to you, we request payment at the time of service.

We request payment at the time of service for any co-insurance/co-pays and deductible.

Please understand, private insurance re-imbursement is based on the contract between YOU and your carrier, so payment for our services is YOUR responsibility. We do not accept the responsibility for collecting an insurance claim or negotiating a disputed claim, however, we will assist you in this effort as a courtesy.

NO INSURANCE/AUTO/OTHER INURY CLAIMS:

Payment in full is expected at the time of service. In some instances other payment arrangements, such as subrogation (3rd party), may be allowed; however, such arrangements must be made with our office prior to your first visit. A letter from your medical insurance carrier to accept subrogation would be required. In most circumstances, we do not accept 3rd party claims.

INSURANCE "SET" CO-PAYMENTS:

Co-payments are due at time of service and it is your responsibility to know the amount and when they are due.

METHODS OF PAYMENT/MONTHLY STATEMENTS:

We accept cash, personal checks, money orders and MasterCard/Visa. For any balances we expect payment in full upon receipt of statement. If full payment is not made, applicable service charges will apply (Interest fee 1.5% per month).

There will be a charge of $25.00 for all checks returned.

MEDICAID

Please provide the office staff with a current copy of your MAID card. If you should forget your MAID card, your appointment will be rescheduled. Since eligibility for Medical Assistance is on a month to month basis, a MAID card will need to be presented each month. If you are enrolled in a Basic Health Plan, a referral will be needed to be seen. If a referral is not present in our office your appointment will be rescheduled and you will need to contact your Primary Care Physician.

☐ **I am on Medicaid** ☐ **I am not on Medicaid**

SIGNATURE REQUIRED

I have read and understand this policy and acknowledge full responsibility for the payment of services rendered. This information provided by me is current, accurate and complete to the best of my knowledge. I authorize all payments to be made directly to the Everett Foot Clinic or my provider on my behalf for any services or supplies furnished by my doctor or the Everett Foot Clinic and for my doctor to act as my agent to help obtain payment. I authorize the release of medical information or documentation in their possession about me to all my insurance companies as well as to Medicare in order to determine benefits payable for related services, now or in the future.

Signature: ______________________________ Print Name: ______________________ Date:______________________

EVERETT FOOT CLINIC

u '@U #) hU ˙ u ˙KU #) hU

3401 Rucker Ave, Everett, WA

CONSENT TO SHARE INFORMATION WITH FAMILY/FRIENDS
CONSENT FOR LEAVING MESSAGES

I understand that my healthcare information at the **Everett Foot Clinic** is protected and I have received a copy of their Notice of Privacy practices.
In order for the Everett Foot Clinic's office to leave detailed messages on my voice mail or answering machine, I need to give permission to Dr. Timothy I McCord / Dr. Timothy J McCord.

Consent for leaving messages

I consent to information regarding me or my child's (under the age of 18) Lab Test results or detailed appointment reminders/instructions to be left on my voice mail or answering machine.

Oral communications are limited to: ☐ Home ☐ Cell ☐ Work May we leave a message ☐ Yes ☐ No

Written communications are limited to: ☐ Home ☐ Work ☐ Other:_________________________

Consent for shared information with Family and Friends

I wish family members or friends to have access to my healthcare information. The names listed below are family members or friends to whom I grant access to my healthcare information. I will rely on the professional judgement of my provider and his/her designee to share such information, as they deem necessary.

I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Health Information Release Authorization form.

	NAME	RELATIONSHIP
1.	______________________________________	____
2.	______________________________________	____
3.	______________________________________	____

____ ______________________________

PATIENT NAME **DATE OF BIRTH**

____ _______________________________

PATIENT/PARENT SIGNATURE **DATE**

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. I understand that to revoke this consent, I must provide written notice to the Everett Foot Clinic/Dr. Timothy I McCord/Dr. Timothy J McCord. It will be my responsibility to keep this information up to date, as I recognize that any cancellation can only apply to future disclosures or actions regarding my protected health information and cannot cancel actions taken or disclosures made while the designation was in effect.

EVERETT FOOT CLINIC

Timothy I McCord DPM | Timothy J McCord DPM

3401 Rucker Ave, Everett, WA 98201-4228

Phone (425) 259-3757 Fax (425) 259-6565

Our website is: www.everettfootclinic.com

Fellow, American College of Foot & Ankle Surgeons

Diplomate, American Board of Podiatric Orthopedics & Primary Podiatric Medicine

All communications regarding our privacy practices including form requests and complaints, should be directed to:

Connie Lucero
3401 Rucker Avenue
Everett, WA 98201
Phone: (425) 259-3757
Fax: (425) 259-6565

SUMMARY OF NOTICE OF PRIVACY PRACTICES

Trust and confidentiality between you and your physician are not new. Wide electronic transmission of information, and casual travel and relocation of people's jobs and lives, however, are new. It is because of the latter that these agreements between doctors and patients have been formalized into law. This summary will assist you in understanding the attached ***Notice of Privacy Practices*** which contains detailed descriptions of how our office protects your health information, protects your rights as a patient, and outlines our common practices in dealing with patient health information. Please refer to that *Notice* for further information.

Health Information Uses and Disclosures

In our medical practice, we routinely record, use and disclose your health information in order to treat you and to assist other health care providers in treating you. We 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 that we or other health care providers give to you. Finally, we may need to use and disclose your health information for certain limited business operational activities such as practice management, training, licensing, accreditation and quality assessment.

Other Uses and Disclosures Not Under Your Control

We may need to disclose your health information without your written authorization in the following situations:

- To contact you by telephone, fax and regular or electronic mail to remind you of your appointments or to respond to your questions.
- To family members or close friends who are involved in your health care;
- For purposes of public health and safety, such as to the FDA to report product defects or incidents;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- For research purposes of a limited nature in a limited manner;
- For providing benefits under Workers Compensation;
- To the Military and Department of Veterans Affairs;
- To law enforcement authorities to assist in apprehending criminal offenders;
- To government authorities for prevention of child abuse or domestic violence;
- When required by law, search warrants, subpoenas or court orders;
- To Federal, State and Local law enforcement authorities involved in security activities as required;

Uses and Disclosures Controlled by You

We will not use or disclose your health information without your prior written authorization, except for those uses we have stated in greater detail in the *Notice of Privacy Practices.*

Your Patient Rights

As our patient, you have the following rights:

- To receive a Notice of Privacy Practices, which this summarizes.
- To get access to and/or a copy of your health information;
- To request that we communicate with you confidentially, by reasonable alternative means;
- To request restrictions on how we handle or disclose your health information;
- To request amendments to your health information;
- To request and receive an accounting of certain disclosures which we made of your health information;

Should you have any questions, concerns or complaints regarding our privacy practices, now or in the future, you will find the details of whom to contact on the current *Notice of Privacy Practices.*

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices from the above named Medical Care Organization/Provider for me to keep and that I have read (or had the opportunity to read if I so chose) and understood the Notice. This acknowledgement is requested per government statute.

____
PATIENT Name (please print)

____
Print Name of Parent/Responsible Party (if applicable)

____
SIGNATURE of Patient/Parent/Responsible Party

_____/_____/_________
DATE

____
Relationship to Patient

Patient's
Date of Birth _____/_____/_________

Patient Identification #
(or Social Security No.) ______________________________________