PROLIANCE SURGEONS

ANKLE & FOOT of Edmonds

A division of Edmonds Orthopedic Center & Proliance Surgeons

PATIENT REGISTRATION

(Please fill out front and backside of form completely)

PATIENT INFORMATION

Last Name _____ First Name _____ M.I._____

☐ Male ☐ Female Social Security # _____ Birth Date _____

Home Address _____

City _____ State _____ Zip _____ + _____

Mailing Address_____

City _____ State _____ Zip _____ + _____

Home# _____ Work # _____ Cell # _____

Best Contact Number ☐ Home ☐ Work ☐ Cell

Email Address _____ @ _____

Marital Status ☐ Divorced ☐ Married ☐Partner ☐ Single ☐ Widowed ☐ Legally Separated

Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not employed

Patients Employer_____ Student ☐ Full time ☐ Part time

PHYSICIAN INFORMATION

Primary Care Physician (first/last_____ Phone _____

Referring Physician (first/last) _____Phone_____

Another Referring Source ☐ Returning Patient of this Office Web Search ☐ Google ☐ Bing ☐ Other

☐ Insurance Website or Book ☐ Friend/Relative ☐ Phone Book ☐ Other_____

RACE

☐ Caucasian ☐ American Indian or Alaskan ☐ Asian ☐ African-American
☐ Native Hawaiian / Other Pacific Islander ☐ Decline to Answer

ETHNICITY

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer

Preferred Language _____

EMERGENCY CONTACT

Name of Local Friend / Relative _____ _____

Relationship to Patient _____ PH # _____

Please fill out back side of form →

BILLING INFORMATION

Please give insurance card and photo I.D. to the receptionist

Employer _____ PH # _____ Occupation _____

Primary Insurance _____

Subscriber Name _____ Subscriber's Date of Birth _____

ID # _____ Group # _____ Patient Is: ☐ Self ☐ Spouse ☐ Dependent

Secondary Insurance _____

Subscriber Name _____ Subscriber's Date of Birth _____

ID # _____ Group # _____ Patient Is: ☐ Self ☐ Spouse ☐ Dependent

INJURY CLAIM

(Please also provide your personal health insurance information for backup)

Insurance Name _____ ☐ Auto ☐ Work

Adjuster/Claim Manager _____ PH # _____

Address _____ City _____ State___ Zip _____ + _____

Claim # _____ Accident Date _____ Injured body part _____

PATIENT CONFIDENTIALITY

Patient Name (Please print) _____

Should the need arise, I authorize Ankle & Foot of Edmonds to disclose my medical condition (treatment, payment & health care operations) to the following person.

Name _____ Relationship _____ PH # _____

I authorize Ankle & Foot of Edmonds and / or staff to leave confidential voicemail messages concerning my health information (lab results, prescription information, etc.) ☐ Home ☐ Work ☐ Cell

Signature _____ Date _____

If the signature above is not the patient's, please state your relationship to the patient _____

CONSENT FOR TREATMENT

I hereby authorize Ankle & Foot of Edmonds, a division of Edmonds Orthopedic Center & Proliance Surgeons, to provide me with medical care and treatment.

Signature _____ Date _____

If the signature above is not the patient's, please state your relationship to the patient _____

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A division of Edmonds Orthopedic Center & Proliance Surgeons
7320 216th Street SW, Suite 320B Edmonds, WA 98026
Phone: 425.775.6996 Fax: 425.670.8905

Name_____ **Birth Date** _____ **Today's Date** _____

Age_____ Height _____ Weight _____ Shoe Size_____

Pharmacy Name & Location _____ Phone _____

Mail Order Pharmacy _____ PCP_____

REASON/NATURE OF VISIT Use the space below to describe the reason for your visit and any special concerns.

MEDICATION ALLERGIES List the medications that have caused bad reactions. Include your reaction (hives, rash, itching, headache, nausea, diarrhea, etc). ☐ **LATEX ALLERGY** ☐ **NO KNOWN DRUG ALLERGIES**

Medication Name	Type of Reaction	Medication Name	Type of Reaction

MEDICATIONS List the medications that you are taking (prescription, over-the-counter & supplements). Attach additional sheet if needed. ☐ **NONE**

Medication / Dose	How often per day?	Medication / Dose	How often per day?

PAST MEDICAL HISTORY Please check any that you have ever had. ☐ **NONE**

- ☐ Alzheimer's / Dementia
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer _____
- ☐ Congestive heart failure
- ☐ COPD / Emphysema
- ☐ Coronary artery disease
- ☐ Crohn's disease
- ☐ Deep venous thrombosis
- ☐ Degenerative joint disease
- ☐ Diabetes
  - ☐ Type I (Insulin)
  - ☐ Type II ☐ Oral Rx ☐ Insulin ☐ Diet
- ☐ Depression
- ☐ Elevated lipids / High cholesterol
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Hepatitis/liver disease
- ☐ Hypertension / High blood pressure
- ☐ Inflammatory bowel disease
- ☐ Lyme disease
- ☐ Myocardial infarction / Heart attack
- ☐ Osteoporosis
- ☐ Peptic ulcer disease
- ☐ Psoriasis
- ☐ Renal disease / Kidney disease
- ☐ Seizure disorder / Epilepsy
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Bleeding problems
- ☐ Blood clot / Phlebitis
- ☐ Heart Arrhythmia
- ☐ Multiple Sclerosis
- ☐ Neuropathy
- ☐ Pacemaker
- ☐ Reflux
- ☐ Tuberculosis
- ☐ Other _____

Please fill out back side of form →

Name_____ **Birth Date** _____ **Today's Date** _____

PREVIOUS PROCEDURES/SURGERIES ☐ **NONE**	**YEAR**

FAMILY HISTORY ☐ **NONE**

- ☐ Family History Unknown
- ☐ Arthritis
- ☐ Cancer
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Stroke

SOCIAL HISTORY ☐ **NONE**

Alcohol Use
- ☐ Beer
- ☐ Wine
- ☐ Spirits
- ☐ None

No. per day _____

Caffeine Use
- ☐ Soda
- ☐ Coffee
- ☐ Tea
- ☐ None

No. per day _____

Tobacco/Nicotine Use

☐ Yes ☐ No ☐ Former

Packs Per Day_____

☐ Vape – Use: ☐ Daily

☐ Weekly ☐ Occasionally

REVIEW OF SYSTEMS: Check any symptoms that you are CURRENTLY experiencing. ☐ **NONE**

Constitutional
- ☐ Chills
- ☐ Fever
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Sleep Problems

HEENT
- ☐ Headache
- ☐ Blurred Vision
- ☐ Dry Eye
- ☐ Vision Loss
- ☐ Hearing Loss
- ☐ Ringing in Ears
- ☐ Swallowing Difficulty
- ☐ Sore Throat

Respiratory
- ☐ Chest Tightness
- ☐ Cough
- ☐ Difficulty Breathing
- ☐ Sinus Congestion
- ☐ Snoring

Cardiovascular
- ☐ Chest Pain
- ☐ White or purple toes
- ☐ Irregular Heartbeat
- ☐ Leg Pain with Walking
- ☐ Leg Swelling
- ☐ Pacemaker

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Indigestion
- ☐ Nausea
- ☐ Stomach Ulcer

Genitourinary
- ☐ Painful/Difficult Urination
- ☐ Frequent Urination
- ☐ Bladder Infection
- ☐ Currently Pregnant
- ☐ Birth Control Medication
- ☐ Estrogen Therapy

Metabolic/Endocrine
- ☐ Cold Intolerant
- ☐ Excessive Hunger
- ☐ Always Thirsty
- ☐ Heat Intolerance
- ☐ Night Sweats
- ☐ Recent Hair Loss

Neurological
- ☐ Dizziness
- ☐ Poor Balance
- ☐ Memory Impairment
- ☐ Tingling, Burning
- ☐ Numbness
- ☐ Tremors
- ☐ Restless Leg
- ☐ Visual Aura

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Fears / Phobias
- ☐ Panic Attack

Integumentary
- ☐ Itchy Skin
- ☐ Rash
- ☐ Skin Infection
- ☐ Nail Changes
- ☐ Non-Healing Wound

Musculoskeletal
- ☐ Back Pain
- ☐ Foot Pain
- ☐ Joint Swelling
- ☐ Leg Cramps
- ☐ Stiffness

Immunologic
- ☐ Latex allergy
- ☐ Metal allergy
- ☐ Food Allergy
- ☐ Hives

Hematologic
- ☐ Excessive Bleeding
- ☐ Excessive Clotting
- ☐ Frequent Infections
- ☐ Fatigue

Other
- ☐ _____
- ☐ _____
- ☐ _____

PROLIANCE SURGEONS®

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorized or compels us to do so. You may see your record or get more information about it by contacting the administrator of the location at which you have been treated. Please call the main office phone number and ask for the administrator.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Patient or legally authorized individual signature	Date	Time
Printed name if signed on behalf of the patient	Relationship to patient (parent, legal guardian, personal representative)	

Staff notes (if any):

This form will be retained in your medical record.

PROLIANCE SURGEONS®

Patient Financial Responsibilities

Edmonds Orthopedic Center, a division of Proliance Surgeons is committed to providing you with the highest quality medical care. Because patients are ultimately responsible for the charges associated with their care, even when insurance is in place, you may find the following information helpful. We realize you have choices for your medical care and appreciate your choosing Edmonds Orthopedic Center.

Patient Responsibilities:

You can help ensure an efficient experience by assisting with the following:

- Providing us with your picture identification, insurance card and Social Security number to enable us to submit your claims timely and accurately
- Knowing your insurance benefits and limitations
- Ensuring there is an authorization for our providers to treat you if it is required by your insurance, including obtaining a referral
- Providing us with copies of any pertinent medical records, including tests (MRI/CT/Arthrogram) and x-rays
- Paying your estimated portion of the charges at the time of service
- Paying any additional amount owed when due
- Completing required incident/accident forms within 30 days of date of service
- Maintaining a current account with Proliance Surgeons at all times
- Providing us with at least 24-hour advance notice should you need to cancel or reschedule an appointment

Please note that co-payments, co-insurance and deductibles are a contractual agreement between you and your insurance carrier. We cannot change or negotiate these amounts.

Insured Patients:

We will bill your primary and secondary insurance carrier in a timely manner. If you are disputing payment with your insurance carrier or have a balance over $100.00 with us, you must notify our business office and make payment arrangements.

Co-Pays/Deductibles/Co-Insurance – Please be prepared to pay for your portion of the charges on the date of service. Office procedures (e.g., casting, scopes, tests, x-rays) will be billed separately from the office visit.

Surgery – If surgery is indicated, a pre-payment of both physician and facility fees is required for all elective, non-emergent procedures prior to the surgery being performed. Your out-of-pocket cost is estimated based on your benefits and our fees. Anesthesia and other providers are separate fees.

Non-Participating Insurance – If we do not participate in the insurance you have, we will file a claim as a courtesy. All unpaid claims will become your responsibility 45 days following filing and be immediately due and payable.

Uninsured Patients

Office Visits – A $300.00 deposit is required prior to the appointment. If visits and services are paid in full at the time of service, we offer a 20% discount (see exclusions below). Office procedures (e.g., casting, scopes, tests, x-rays) will be billed separately from the office visit.

Surgery – For uninsured patients having surgery, we offer a 20% discount when charges are paid before or on the day of service (see exclusions below).

Exclusions – The discounts referenced above do not apply in cases of cosmetic procedures, motor vehicle accidents, third party insurance claims or in other cases when the patient may be reimbursed in full.

Private pay patients who receive retroactive Medicaid coverage need to immediately notify our business office.

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Motor Vehicle Accidents (MVA) Insured and Third Party Patients

We do not extend discounts for MVA-insured accidents, third party insurance claims or in other cases when patients may be reimbursed in full. We will bill the MVA insurance carrier one time. The bill becomes your responsibility if not paid by the carrier in 30 days. We regret that we are not in a position to confer with attorneys or defer payment obligations while a case settles. If your personal injury protection benefit on your MVA policy is exhausted, we will bill your private insurance at your request provided we are furnished the necessary information at the date of service.

Workers' Compensation

If your visit is work-related, we will need the case number and carrier name prior to your visit in order to bill the workers' compensation insurance carrier. If your workers' compensation claim is not yet accepted and you have no other insurance, we require a $300.00 deposit that will be refunded after the claim has been opened.

Other Charges

No Show – Please provide us with at least 24-hour advance notice if you need to cancel or reschedule an appointment. We may charge a fee for missed appointments.

Please provide us with at least 48-hour advance notice if you need to cancel or reschedule an appointment and an interpreter has been scheduled. Otherwise, you may be charged for the interpreter.

Forms – There may be a charge associated with our completion of some forms. We require payment of the charge before returning the completed form to you. A signed Release of Information may also be necessary. Please allow five business days for us to complete forms.

Payment

Payment Options – We accept cash, checks, major credit/debit cards and money orders for payment (no post-dated or third party checks). We charge a $40.00 NSF fee for any returned checks.

Delinquent Accounts – We charge 5% interest accruing monthly on balances over 45 days old. We may assign an account to collections if balances are unpaid after 120 days. Patients assigned to collections may be denied additional service.

Alternative Payment Arrangements – If you are unable to pay your balance when due, please contact our business office to make alternative arrangements. Any patient with a past due amount may be denied additional service until the amount is paid or the patient is complying with an alternative payment arrangement.

Bankruptcy/Prior Bad Debt – Patients who have previously filed for bankruptcy or never satisfied their payment obligations for prior episodes of care with Edmonds Orthopedic Center or other Proliance Surgeons care centers may be required to pay for their portion of new charges at the time of service.

_____ _____

Signature of Patient or Responsible Party Signature of Co-Responsible Party