

THIS INFORMATION IS CONFIDENTIAL

OFFICE USE ONLY EHS PT# _____

PATIENT INFORMATION

Name _____

Date of Birth _____

Address _____

City _____

State _____ Zip _____

Home Phone (____) _____

Cell Phone (____) _____

E-mail _____

Social Security # _____

Preferred Language _____

Male Female Veteran

Single Married Widowed Divorced

Optional

White Asian Black/African American

American Indian Alaska Native Native Hawaiian

Hispanic Latino Other _____

Occupation _____

Employer _____

Address _____

Work Phone (____) _____ Ext _____

PRIMARY CARE DOCTOR & PHARMACY

Primary Physician _____

Address _____ City _____

Pharmacy Name _____

Address _____ City _____

INSURANCE INFORMATION

Primary Company _____

Policy # _____

Subscriber Name _____

Date of Birth _____ Copay _____

Self Spouse Parent (to the patient)

Secondary Company _____

Policy # _____

Subscriber Name _____

Date of Birth _____ Copay _____

Self Spouse Parent (to the patient)

**SPOUSE INFORMATION OR
PARENT/GUARDIAN: IF PATIENT IS UNDER 18**

Name _____

Relationship _____

Date of Birth _____

Social Security # _____

Address _____

Cell Phone _____

Occupation/Employer _____

Address _____

Work Phone (____) _____ Ext _____

EMERGENCY CONTACT (NOT LIVING WITH YOU)

Name _____ Relationship _____

Phone # (____) _____

Name: _____ DOB: _____

MEDICAL HISTORY

What is your **chief foot complaint** for which you came to be treated today? When did it begin?

Have you received treatment for this condition before? If **Yes** please describe:

Circle the degree of **pain** you are currently experiencing:
Minimal 0 1 2 3 4 5 6 7 8 9 10 Severe

List of current medications:

Please X any of the following Allergies & list reaction:

- Adhesive Tape _____
- Anti-inflammatory Meds _____
- Aspirin _____
- Codeine _____
- Cortisone _____
- Iodine _____
- Latex _____
- Metal/Jewelry _____
- Novacaine _____
- Peanuts _____
- Penicillin _____
- Seafood _____
- Other antibiotics _____
- Other Pain Meds _____
- Other _____

List all past surgeries and approximate date:

Do you consider yourself to have **good exercise habits**?
Yes No

Have you been treated for any of the following conditions? Put an **X** all that apply to you;

Put an **M** if on your Mother's side;
Put an **F** if on your Father's side.

- _____ Anemia
- _____ Anesthetic Reaction
- _____ Arthritis
- _____ Asthma
- _____ Bleeding Disorders
- _____ Cancer
- _____ Circulation Problems
- _____ Diabetes
- _____ Epilepsy
- _____ Foot Problems
- _____ Gout
- _____ Heart Disease
- _____ Hepatitis
- _____ High Blood Pressure
- _____ High Cholesterol
- _____ HIV / AIDS
- _____ Injury/Trauma Major
- _____ MRSA
- _____ Kidney Disease
- _____ Liver Disease
- _____ Mental Illness
- _____ Mitral Valve Prolapse
- _____ Multiple Sclerosis
- _____ Nail Disorders
- _____ Nerve Disorders
- _____ Obesity
- _____ Phlebitis
- _____ Pulmonary Disease
- _____ Rheumatic Fever
- _____ STD
- _____ Skin Problems
- _____ Stomach/Intestine Problems
- _____ Stroke
- _____ Thyroid Disorders
- _____ Varicose Veins
- _____ Other _____

Height _____ **Weight** _____ **Shoe Size** _____

Cigarettes or Tobacco use? Yes No

If yes, for how long? _____ How much per day? _____

If quit, when? _____

Alcohol use? Yes No

If yes, quantity: daily _____ weekly _____

Recreational drug use? Yes No

If yes, what type? _____

Caffeine use? Yes No

If yes, quantity: daily _____ weekly _____



RODNEY A. GRAVES, DPM
 925 STEVENS DRIVE, SUITE 1B
 RICHLAND, WA 99352
 PHONE (509)943-2325 FAX (509)943-3021

Name: _____ DOB _____

WHOM MAY WE THANK FOR SENDING YOU TO OUR OFFICE?

- | | |
|---|---|
| <input type="checkbox"/> Doctor _____ | <input type="checkbox"/> Frontier Yellow Pages |
| <input type="checkbox"/> Patient _____ | <input type="checkbox"/> The Dex/Yellow Book |
| <input type="checkbox"/> Internet _____ | <input type="checkbox"/> Insurance Provider List |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Mid Columbian Phone Book |

WORKER'S COMP OR AUTO CLAIM

Is your treatment today due to:

-a work related injury Yes No Injury Date _____
- Do you have written authorization from your employer and comp carrier to be treated Yes No
-a motor vehicle accident Yes No Accident Date _____
- an accident/ liability case Yes No Accident Date _____

MEDICARE SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made either to me or on my behalf of **River City Foot & Ankle** for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider of supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

PATIENT'S NAME (Please Print)		PROVIDER: Name, Address, and Zip	
PATIENT'S SIGNATURE		River City Foot & Ankle 925 Stevens Suite 1B Richland, WA 99352	
PATIENT'S MEDICARE NO.	DATE		

SIGNATURE ON FILE & PERMISSION TO TREAT

I understand that the information provided on this form is true and correct to the best of my knowledge. I hereby give permission to **River City Foot and Ankle, PLLC** and any qualified staff to evaluate, diagnose and treat my foot and/or ankle condition as may be deemed necessary.

Signature of patient or responsible party _____ **Date** _____



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PRIVACY POLICY

River City Foot and Ankle will use and disclose your health information for the following purposes: to treat you, to assist other healthcare providers in treating you, to allow insurance companies to process insurance claims for services rendered to you, to obtain payment for services rendered to you and for certain limited operational activities, such as quality assessment, licensing, accreditation and training of students. 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. If you have any questions, concerns or complaints regarding our privacy practices, please refer to the actual Notice of Privacy Practices provided to you for the person(s) whom you may contact.

In addition to the allowable disclosures described in the State of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

Name _____ Phone _____ Relationship _____
 Name _____ Phone _____ Relationship _____
 Name _____ Phone _____ Relationship _____

FINANCIAL POLICY

Thank you for choosing River City Foot and Ankle as your foot care provider. We are committed to providing you with quality and affordable health care. Please read the following office payment policy and feel free to ask us any questions that you may have. Once you accept this policy, kindly sign in the space in the space provided. A copy will be provided to you upon request.

- 1. Insurance.** We participate in most insurance plans, including Medicare. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
- 2. Co-payments.** All co-payments must be pain at the time of service. This arrangement is part of your contract with your insurance company.
- 3. Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be uncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
- 4. Proof of insurance.** We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. If required, obtaining the proper referral from your Primary Care Physician is your responsibility.
- 5. Nonpayment.** Your prompt payment will assist us in keeping the cost of healthcare down. If your account is over 60 days past due, you will receive a letter requesting immediate payment. Please be aware that if a balance remains unpaid, we may refer your account to an outside collection agency.
- 6. Missed appointments.** Our policy is to charge **\$30.00** for missed appointments not canceled within a reasonable amount of time or for an understandable reason. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the Privacy Policy and Financial Policy and agree to abide by their guidelines:

I hereby authorize the release of any medical information pertaining to my treatment or information necessary for processing insurance claims and payment of medical benefits to myself or the party who accepts assignments. This authorization will remain valid until revoked by me in writing. I understand that I am legally responsible for all charges whether or not reimbursed by my insurance company.

Signature of patient or responsible party _____ Date _____