# PATIENT INFORMATION

Patient Name: ________________________________ Date of Birth: __________

**Was this a motor vehicle or work accident? Yes____ No____ If yes, please let the receptionist know.**

Sex: M_____ F______ Patient Social Security Number:________________________

Marital Status: M___ S___ D___W____O___

Address:_____________________________________ Phone:_________________

City________________State:______Zip Code________ Cell:___________________

E-Mail Address:__________________________________________________________

Patients Employer:_______________________________________________________

Employer Address:_____________________________ Phone:_________________

Guardian: ___________________________________ Guardian Phone____________

Guardian Relationship__________________________ Guardian Cell_____________

Guardian Date of Birth:__________________

Who referred you to our office:____________________________________________
(such as doctor, internet, existing patient. If this was the phone book, please indicate which one.)

Primary Care Doctor_____________________________________________________

Emergency Contacts: Name: _____________________________Phone:_____________

Spouse:______________________________________________ Phone:_____________

Date of Birth:_____________________

**PLEASE: NO CELL PHONES & NO PETS. DRIVERS MUST STAY WITH PATIENTS.**

*Inland Northwest Foot and Ankle* *Patient Name:*______________________

**PRESENT ILLNESS**

**Chief Complaint:** ____Both ____Left ____Right

____Ankle Pain ____Foot Pain ____Heel Pain ____Diabetic Foot Exam ____Ingrown Toenail ____Ulcer

**Onset:** ____1 week ago ____1mo ago ____3mo ago ____6mo ago ____1yr ago ____2yr ago ____5yr ago ____10yr ago

**Symptom Duration:** ____All Day ____1st thing A.M. ____After Activities ______________________Other

**Nature:** ____Sharp ____Dull ____Burning ____Piercing ____Aching ______________________Other

**Gets Worse By:** ______________________________ **Relieved By:** ______________________________

**PAST MEDICAL HISTORY** ____Asthma ____Diabetes ____Heart Disease ____Stroke

____Unremarkable ____Cancer ____Emphysema ____High Blood Pressure Other______________________

____Arthritis ____Depression ____Flat Feet

Last Complete Check up____________ with Dr.______________________

Past Surgeries: ____________________________________________________________

____________________________________________________________

**FAMILY HISTORY**

____Arthritis ____Bunions ____Depression ____Emphysema ____Heart Disease ____Stroke

____Asthma ____Cancer ____Diabetes ____Flat Feet ____High Blood Pressure Other______________________

____Fibromyalgia

**ENVIRONMENTAL**

____Smoker ____Non-Smoker ____Never drinks alcohol ____Rarely drinks alcohol ____Occasionally drinks alcohol

____Drinks alcohol often

**ALLERGIES** **REACTIONS**

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

**MEDICATIONS AND DOSAGES** **SURGERIES** **COMPLICATIONS**

______________________________ ______________________________Y______N______

______________________________ ______________________________Y______N______

______________________________ ______________________________Y______N______

______________________________ ______________________________Y______N______

______________________________ ______________________________Y______N______

**PHARMACY NAME & LOCATION**____________________________________________________________

**REVIEW OF SYMPTOMS**

CHECK ALL THAT APPLY

____Fever ____Glaucoma ____Foot/Leg Swelling ____Muscle Pain

____Nausea ____Depression ____Foot/Leg Numbness ____Joint Pain

____Vomiting ____Chest Pain ____Foot/Leg Weakness ____Anxiety

____Weight Gain ____Shortness of Breath ____Unsteady Walk ____Sensitive to Sun

____Chills

**OCCUPATIONAL**

EDUCATIONAL

____Grade ____HS ____College ____Graduate ____GED ____Technical ______________Other

PHYSICAL DEMANDS

____Very Heavy ____Heavy ____Moderate ____Light ____White Collar

CURRENT WORK STATUS

____Regular ____Limited ____Not Working ____Retired ____On Disability

**EMPLOYMENT**

Employer ______________________ Occupation ______________________________

***SIGNATURE***______________________________ ***DATE***______________________

**INLAND NORTHWEST FOOT & ANKLE**

**1590 E. Polston Ave Ste A**

**Post Falls, ID 83854**

**(208) 777-9794**

www.inlandfoot.com

**OFFICE POLICY FOR INSURANCE BILLING, APPOINTMENTS & MEDICATION REFILLS (2 pages)**

Welcome to Inland Northwest Foot & Ankle. We pride ourselves in delivering prompt and excellent foot & ankle care delivered in a caring and compassionate manner. Your health and peace of mind are important to us. We look forward to seeing you as a patient in our practice.

We make every effort to remain on schedule, therefore, you must arrive on time. Please arrive 15 minutes early for your first appointment. If you fail to arrive on time for an appointment you will likely be rescheduled for a later date. Your consideration of a 48-hour notice of a cancelled appointment is greatly appreciated so that we may utilize that time for someone else. Repeated cancelling of appointments without notice or two "no-shows" will likely result in our inability to further schedule you.

**The following are our office policies. These policies may or may not apply to you, but we still need both pages signed**. The financial cost of services rendered is the responsibility of the patient and /or guarantor regardless of insurance coverage. We will bill all health insurance companies as long as you provide the correct billing information to us. Please bring your insurance cards to your appointment. Also, please bring any physician referral documentation that may be necessary for billing purposes or is required by your insurance company. If you are unsure of what your insurance requirements are, please contact your customer service member department. You will usually find this toll free number on the back of your insurance card. If you receive a billing statement that you do not understand, please call our billing department at (208) 667-3152.

Idaho and Washington workman's compensation insurance are the only workman's compensation insurance accepted, in general. You must provide our office with the following information at the time of your first appointment. (continued on next page)

________________________________________ ____________________

Printed Name Date

____________________________________________________________

Signature of Patient/Guardian

- Name and address of your employer's Workman's Compensation Center
- Exact date of your injury with a brief description
- Workman's Compensation claim number
- Case workers name & phone number

This information is the only way that we can bill the workman's compensation insurance. Your employer can assist you in obtaining this information. You may otherwise need to be rescheduled or be required to self-pay until such information is received.

If you were in a motor vehicle accident, payment is required at the time of your visit. We can bill the insurance if you provide us with all of the information.

Liability action and/or litigation against a third party are not acceptable reason for delay in payment for services rendered. Litigation may go on for an extended period of time. Prompt payment is required.

Narcotic medications and other prescriptions will be provided by our office in the immediate post-operative period only (usually for no more than 6 weeks after surgery). Chronic pain requiring a more protracted course of narcotics is best managed by a specialist trained to deal with chronic pain, or by your primary care physician. It is very important to note that prescriptions will only be provided or refilled during normal office hours (not nights, weekends or holidays). **Please contact your pharmacy for refill requests.** Refills take 24 to 48 hours to process. We do not refill prescriptions after 3:00 pm on weekdays and after 12pm on Fridays. Please plan ahead. We do not replace lost or stolen prescriptions so please keep these in a safe place.

Every effort is made to arrange your surgery in an expeditious manner. If an emergency arises which forces you to cancel or reschedule your surgery, please try to allow 72-hour notice as the available days and times for surgery are limited. A cancellation without acceptable reason within less than 72-hours notice will delay the scheduling of your next surgery by up to 30 days. Two such short notice cancellations will preclude further scheduling of surgery, unfortunately.

______________________________________ ______________________

Printed Name Date

____________________________________________________________

Signature of Patient/Guardian

# *Inland Northwest Foot & Ankle*

Bryan Thompson, D.P.M.

## FINANCIAL POLICY

**Patient Name:**____________________________________________________

- All payments are due when services are rendered. For cash only patients, a 20% discount applies.
- For insurance patients, all copayments are due on the day of service and once insurance has paid its portion, full payment is due.
- If a payment plan is needed, you must speak with our billing service and be placed on an Extended Payment Plan Agreement.
- For the Extended Payment Plan, the maximum payment extension is 25% down, 25% within 30 days, 25% more within 60 days, and the balance in 90 days.
- Any concerns or disputes that cannot be resolved will need to be discussed with Dr. Thompson during a follow up visit.

**I understand and agree to the terms of this financial policy.**

**Patient/Guardian Signature:** __________________________________**Date:**_______________________

Inland Northwest
Foot and Ankle

Bryan T. Thompson, D.P.M

## Notice of Privacy Practices – Acknowledgement

We keep a record of the health care services we provide you. You may ask to see and receive a copy of the record. We have up to 5 business days to provide this information to you. 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 authorizes or compels us to do so. You may see your record or get more information about it by contacting our office.

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 I have been provided or had the opportunity to read the Notice of Privacy Practices.**

____________________________________ __________________

Printed Name of Patient Date

______________________________________________________

Signature of Patient or Legal Guardian

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