

## 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: \_\_\_\_\_

Race: (Please Circle) American Indian, Asian, African American, Native Hawaiian or Pacific Islander, Caucasian, Other, Patient Declined

Ethnicity: (Please Circle) Non-Hispanic, Hispanic, Patient Declined

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.**

**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  1<sup>st</sup> 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  Unsteady Walk  Sensitive to Sun  
 Chills  Breath

**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**

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**(208) 777-9794**

[www.inlandfoot.com](http://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.

- 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

**(continued on next page)**

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.

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Printed Name

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Date

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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:** \_\_\_\_\_

### 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