ALDERWOOD
3500 188th Street SW, Suite 110
Lynnwood, Washington 98037
(425) 778-5666

ALDERWOOD ANKLE & FOOT CLINIC, P.S.

ankleandfootclinic.org

LAKE STEVENS
515 State Route 9 NE, Suite 103
Lake Stevens, Washington 98258
(425) 397-7401

Patient Information

DATE _____ **ACCT #**_____

NAME _____
First Middle Last

ADDRESS _____
Street City State Zip

TELEPHONE (Home) _____ (Work) _____

(Cell Phone)_____ (E-Mail Address) _____

PREFERRED CONTACT # HOME ☐ MOBILE ☐ WORK ☐ PREFERRED PHARMACY _____

BIRTHDATE _____ AGE_____ SEX _____ HEIGHT ____ WEIGHT _____ SHOE SIZE _____

SOCIAL SECURITY NUMBER _____-_____-_____ REFERRED BY_____

MARITAL STATUS Single _____ Married _____ Widowed _____ Divorced _____

RACE (Please check all that apply) Black/African American ☐ Asian ☐ Native American/Native Alaskan ☐
Native Hawaiian/Pacific Islander ☐ White ☐ Prefer Not to Specify ☐

ETHNICITY Hispanic ☐ Non-Hispanic ☐ Prefer Not to Specify ☐ PREFERRED LANGUAGE _____

EMPLOYER _____ OCCUPATION _____

EMERGENCY CONTACT (Name)_____ (Phone) _____

(Relation)_____

IN YOUR OWN WORDS DESCRIBE YOUR FOOT AND/OR ANKLE PROBLEM _____

_____

_____

FAMILY PHYSICIAN _____ PREVIOUS PODIATRIST_____

PARENT/GUARDIAN INFORMATION (IF PATIENT IS A MINOR)

NAME _____ SS# _____
First Middle Last Social Security Number

ADDRESS _____
Street City State Zip

TELEPHONE (Home)_____ (Work) _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:_____

MEMBER ID #_____ GROUP #_____

SUBSCRIBERS NAME_____ SUBSCRIBERS DATE OF BIRTH_____

SECONDARY INSURANCE COMPANY:_____

MEMBER ID #_____ GROUP #_____

SUBSCRIBERS NAME_____ SUBSCRIBERS DATE OF BIRTH_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I read (or had the opportunity to read if I so choose) and understand the notice.

SIGNATURE _____ **DATE** _____

If applicable
PARENT/AUTHORIZED REPRENTATIVE _____ **DATE** _____

RELEASE OF INFORMATION

I authorize Alderwood Ankle and Foot Clinic, P.S. to release information to _____ and understand I can revoke this decision at any time.

Regarding: Scheduling Appointments ☐ Discuss Billing and Payments ☐ Patient Notes ☐ Lab Results ☐

SIGNATURE _____ **DATE** _____

RELEASE OF BENEFITS AND INFORMATION

I authorize my insurance benefits to be paid directly to the doctor. I am financially responsible for any balance due. I authorize the doctor or any insurance company to release information required for this claim.

SIGNATURE _____ **DATE** _____

OFFICE POLICY

While this office makes every attempt to maintain up-to-date information about your health plan coverage, we require our patients to make inquiry about covered services directly from their health plan's customer service department to avoid any misinterpretations or updates. Please refer to your identification card for the correct phone number.

Please note that any services done determined medically necessary for your condition are done so by your attending physician in his professional judgment. These services may, however, be deemed "non-covered" by your health plan. Our practice administrator will be happy to arrange mutually agreeable self-payment arrangements for these services upon your request.

We will gladly bill your primary and secondary insurance companies. After hearing from primary/secondary insurance, you will be billed with your patient balance. At that time, a payment in full or the amount agreed upon in your payment plan is due.

I HAVE READ AND AGREE WITH THE ABOVE OFFICE POLICY.

SIGNATURE _____ **DATE** _____