Rainier Foot & Ankle Associates
360.761.1285
853 Watson St. N. Suite 100
Enumclaw WA, 98022

What to Expect:

Welcome to Rainier Foot and Ankle Associates, we appreciate you choosing us for your foot and ankle needs. Your clear understanding of our office policies is important to our professional relationship.

We appreciate our patients showing up to their scheduled appointments on time with all required documents in hand (insurance card(s), valid identification and completed new patient paperwork. If you are more than 15 minutes late to an appointment you may be asked to reschedule.

Our office accepts most major commercial insurance plans as well as Medicare, Medicaid and L&I claims. It is your responsibility to know your insurance benefits. Please contact your insurance company with any questions that you may have regarding coverage.

Referrals – If your insurance requires that you obtain a referral from your PCP, it is your responsibility to ensure that our office receives the referral prior to your scheduled appointment.

Self-Pay – patients without insurance will be expected to pay for service at their scheduled appointment.

Patients with Insurance – We will bill your insurance as a courtesy to you. All paperwork must be filled out with all your current information as well as have a copy of your insurance card and signature on file.

Denied Claims – It is your responsibility to inform us of any changes to your insurance benefits. You will be responsible for any charges that are denied by your insurance company which result from your failure to provide our office with complete and current information in a timely manner.

Workers' Compensation – We accept L&I claims, it is your responsibility to ensure that we receive all the pertinent information from your employer's Workers' Compensation insurance as well as your health insurance. We reserve the right to bill you directly if payment is not received from these third parties within 90 days. If you have paperwork that needs to be filled out, please bring to your appointment, any paperwork not turned in during an appointment is subject to a $35 fee. Please allow at least 48 hours for such paperwork to be completed.

Prescriptions – If you require a medication refill, please be sure to give our office plenty of advanced notice. We will not refill prescriptions after 4pm or on weekends, unless it is an emergent situation. If you request a pain medication refill, that does require a physical prescription, we will need at least 48 hours advance notice.

_____

Patient or Legal Guardian Signature

_____/_____/_____

Witness (Staff Member) **Date**

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Patient Name:

_____
(First) (MI) (Last)

Physical Address:

_____
(Street Address)

_____
(City) (State) (Zip)

DOB:____/____/_____ **AGE:**_____ **Male** ☐ **Female** ■ **SSN:** _____-_____-_____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Mobile Phone #: (_____)_____-_____ **Home Phone:** (_____)_____-_____

Preferred Number: **Mobile** ☐ **Home** ☐

Consent to receive text messages on mobile device: **Yes** ☐ **No** ☐

(Text messaging would be used for appointment reminders and other practice features like 'Text to Pay' Message and data rates may apply)

Email: _____

Do you wish to receive emails from RFAA? Yes ☐ No ☐

(Emails may include appointment confirmations, practice updates, offers, and feedback opportunities.)

How did you hear about us?

Google Search ☐ Google Ad ☐ RFAA Website ☐ Social Media ☐

Friend/Family Recommendation ☐ Referral from Doctor ☐ Other ☐_____

PCP: _____ **Date of last visit:** ____/____/_____

Race: Caucasian ☐ American Indian/Alaskan Native ☐ Asian ☐

Black/African American ☐ Hawaiian/Pacific Islander ☐

Ethnicity: Hispanic or Latino ☐ Not Hispanic or Latino ☐

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Financially Responsible Party Information (if different than patient):

_____

(Name) (Relationship)

_____

(Address)

_____(_____)_____-_____

(DOB) (Phone)

Is this a work-related injury?

Yes ☐ No ☐ Date of injury: _____/_____/_____

Auto Accident?

Yes ☐ NO ☐ Body part:_____

Date of injury: _____/_____/_____

3RD Party Accident?

Yes ☐ No ☐ How did injury occur:_____

Date of injury: _____/_____/_____

Workers Comp/AA Information:

_____(_____)_____-_____

(Insurance Co) (Phone)

_____

(Address)

_____

(Claim #) (Claims MNGR)

Claim Open: Yes ☐ NO ☐

If NO, date claim closed: _____/_____/_____

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Name: _____ **HT:**_____**WT**:_____lbs. **Shoe Size**_____

Please explain the reason for your visit today:

_____

_____

Choose all that apply: Foot ☐ Ankle ☐ Toes ☐ Left ☐ Right ☐ Both ☐

How long have you been in pain? _____

Have you had prior treatment? YES ☐ NO ☐

If yes, what treatments have you tried: _____

Do you wear arch supports: Yes ☐ No ☐

Store Bought: Yes ☐ No ☐

Custom Orthotics: Yes ☐ No ☐

MEDICAL HISTORY:

Do you currently or have you ever had any of the following, please check all that apply:

☐ Anemia ☐ Cancer ☐ Epilepsy ☐ Hepatitis ☐ Pneumonia
☐ Anxiety ☐ Congestive heart failure ☐ Fall Risk ☐ High Cholesterol
☐ Stroke ☐ Arthritis ☐ COPD ☐ GERD Hypertension
☐ Asthma ☐ Dementia ☐ Glaucoma ☐ Kidney Disease ☐ Gout
☐ TB ☐ Thyroid Disease ☐ Back Problems ☐ Depression
☐ MI (heart attack) ☐ Ulcer GI ☐ Blood Clots/DVT ☐ Dermatitis
☐ HIV/AIDS ☐ MRSA ☐ Headaches ☐ Coronary Artery Disease
☐ Diabetes ☐ Other _____

LIST SURGERIES, SERIOUS INJURIES, AND ILLNESS:

_____

_____

SOCIAL HISTORY:

Do you smoke: No ☐ YES ☐ Pks/day:_____ Former Smoker ☐

Recreational Drugs: No ☐ YES ☐

Alcohol Use: None ☐ Social/Light ☐ Occasional ☐ Heavy ☐

Occupation: _____

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I CERTIFIY THAT THE PROVIDED INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOT HOLD MY PHYSICIAN OR ANY MEMBERS OF HIS/HER STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I HAVE MADE IN THE COMPLETION OF THIS FORM.

_____

(Printed Name)

_____ / / _____

(Signature) (Date)

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CURRENT MEDICATIONS AND ALLERGIES

In our efforts to improve patient care and safety, it is required that you complete this list with any current medications you are taking including the dosage, how often those medications are taken and the reason for taking them. Please include any known allergies to medications, latex, iodine, food, or metals.

Printed Name: _____Date of Birth: _____/_____/_____

CURRENT MEDICATIONS: **Primary Care Physician: _____**

Medication Name	Dosage	How often	Reason

OVER THE COUNTER MEDICATIONS: INCLUDE HERBAL AND DIETARY SUPPLEMENTS:

Supplement Name	Dosage	How Often	Reason

Allergies:

_____

_____/_____/_____
(Signature) (Date)

_____(_____)_____-_____
(Pharmacy Location) (Pharmacy Phone)

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HIPAA PRIVACY NOTICE CONSENT FORM

I agree to information provided in Rainier Foot & Ankle Associate's Notice of Privacy Practices that provides a complete description of information uses and disclosures. Rainier Foot & Ankle reserves the right to make changes to their Privacy Notice and revised copies are available. By signing this form I acknowledge that I have been afforded the opportunity to consider Rainier Foot & Ankle's Notice of Privacy Practices prior to signing this consent and making healthcare decisions. I also understand and agree to have my digital photo taken for identification as part of my electronic health record.

HIPAA AUTHORIZATION TO DISCUSS YOUR MEDICAL INFORMATION

Indicated below are names of any Person(s) to whom I would like Rainier Foot & Ankle to allow disclosure of Protected Health Information (PHI). (Please specify the type of information that may be disclosed, such as lab test, appointment information, prescription information, bill information, etc. You may indicate "ALL" if appropriate). I understand that I am not required to list anyone, and I may change this list at any time in writing.

Name	Relationship	Phone number	Type of information

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY):

_____ (Home Phone)	_____ (Cell Phone)
☐ Leave message name & number ONLY ☐ Okay to leave detailed message ☐ Leave no message at all	☐ Leave message name & number ONLY ☐ Okay to leave detailed message ☐ Leave no message at all

EMERGENCY CONTACT: Medical information is not released to this person. (However this person can be the same as your HIPAA Authorized Contact).

_____(_____)_____-_____
(Emergency Contact Name) (Relationship) (Phone Number)

I acknowledge the information outlined in Rainier Foot & Ankle Associates' Notice of Privacy Practices, otherwise known as HIPAA. (To review a copy of the document, please ask our front desk)

_____/_____/_____
(Patient Printed Name) Date of Birth

_____/_____/_____
(Signature of Patient) (Date)

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Financial Agreement

Please review the following financial agreement and sign below:

Payment for services is due at your scheduled appointments.
Self-pay patients must pay in full.

Insurance: Co-payments, co-insurance and deductibles, where applicable, will be collected at the time of service. As a courtesy, Rainier Foot and Ankle will bill your insurance company for services provided. If you have a secondary insurance, we will bill them one time. If the secondary does not pay the balance within 45 days, the balance will be billed to you and due at that time. If for any reason the required payment cannot be made at the time of service, Rainier Foot and Ankle Associates reserves the right to refuse treatment.

Balances/Collection Fees: A statement will be sent to the mailing address you provide notifying you of any outstanding balances. If balances are not paid within 30 days of receipt, a $10 re-billing fee will be added each month. If you are unable to pay the balance in full, it is your responsibility to contact our billing department to discuss a possible payment plan. If you then fail to make payments, your account may be referred to a professional collection agency and/or attorney and will be subject to a 35% fee.

Non-Covered Charges: Under some circumstances, there may be some charges for our services which your insurance company considers non-covered and may be excluded from your policy. In these cases, you the patient, will be responsible for these charges.

Durable Medical Equipment: When necessary our office will assist in authorizing coverage for Durable Medical Equipment. All services, procedures, treatments and care will be billed to you and your insurance. There is no guarantee of payment by your insurance company and any item not covered will be patient responsibility.

Cancellation/No Show Policy: A 24-hour notice is required for all cancellations of appointments. If you fail to give 24-hours' notice or no show to a scheduled appointment, you will be charged a $50 no show fee. We will do our best to accommodate you in rescheduling your appointment as soon as possible. Multiple no shows may require a deposit prior to scheduling a future appointment.

Forms: There is a $30 charge for form completion. Please allow up to 7 business days for completion of forms.

Payment Methods: We accept all major credit cards, (Visa, Mastercard, American Express, Discover) as well as personal checks, money order, cash and Care Credit on purchases/services over $200.

_____

(Printed Name) (Signature)

_____/_____/_____

(Witness - staff member) (Date)

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No Show Fee and Late Arrival Policy

Our goal is to provide quality care in a timely manner. Rainier Foot & Ankle Associates schedule appointments in order to provide each patient with the individual attention you deserve.

Late Arrivals:

If a patient presents to the office 10 minutes or later for a scheduled appointment, the patient will be asked to reschedule their appointment.

When a patient arrives late, the time spent with the patient is minimized and does not allow for a full assessment. It also disrupts the schedule for Dr. Bock and other patients.

Cancellation of an Appointment:

We urge you to keep your scheduled appointments whenever possible. In the event you need to cancel, please contact the clinic by phone and provide at least 24 hour notice. Your early cancellation allows us to offer your appointment to another patient needing medical care.

No Show Policy:

A "no show" is someone who misses an appointment without cancelling it in advance. We may charge a $50 fee to patients who do not arrive for their scheduled appointment. Patients who no show 3 times in a 12-month period may be dismissed from the clinic, or may require a deposited prior to scheduling future appointment

No Show Fee/Late Arrival Policy Acknowledgement

By signing below, I acknowledge that I have reviewed the No Show Fee Policy. I agree to pay Rainier Foot & Ankle Associates a fee of $50 in the event I am unable to make an appointment and do not notify the clinic in advance.

_____

(Printed Name)

_____ / / _____

(Signature) (Date)

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NARCOTIC PAIN MEDICATION POLICY

Thank you for choosing Dr. Christopher Bock for your foot and ankle care needs. We will supply appropriate narcotic pain medication for certain acute injuries and postoperative care. Narcotics are considered safe when used appropriately, but side effects may occur, as well as a potential risk of an addictive disorder developing. Side effects for these medications can be, but are not limited to drowsiness, urinary retention, constipation, itching, nausea, confusion and may hurt the body's ability to control pain. We weigh the risks versus the benefits before utilizing these medications. Once we have decided to utilize these medications for pain management, the following conditions MUST be met:

1. Narcotic pain medications will ONLY be prescribed for post-operative pain, or after acute trauma*. For those patients, the narcotic pain medication will be closely monitored and discontinued after 60 days or less.

2. If you feel that you require additional narcotic pain medication after three months you will be referred to a pain management physician, or a physician specially trained in the treatment of chronic pain.

3. You understand that prescriptions that are lost, stolen, accidentally disposed of, or consumed before the appropriate date will not be refilled.

4. We are unable to dispense narcotic drugs after office hours, weekends or the days Dr. Bock is in surgery.

5. If you receive controlled medications from another health care professional, you agree to inform us of the medications prescribed and by whom.

* Please note: Pain medications are meant to manage pain, NOT eliminate pain.

We reserve the right to discontinue care should you not comply with the above conditions.

I HAVE READ THE ABOVE CONDITIONS AND WILL ABIDE BY THEM.

_____
(Printed Name)

_____/_____/_____
(Signature) DATE

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Please turn over page