Patient Registration

Patient Information

Please use your full name as it appears on your insurance or Medicare card, no nicknames.

Last Name_____ First Name_____ MI_____

Address_____ City/State/Zip_____

Home Phone_____ Work Phone_____ Ext._____

Birth Date_____ Sex M/F Married/Single/Other Soc. Sec._____

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Unspecified

Race: □ American Indian or Alaskan Native □ Asian □ Black or African American

□ Native Hawaiian or Other Pacific Islander □White Preferred Language:_____

Employer_____ Spouse's Name _____

Emergency Contact name and Phone number_____

E-mail _____ Physician_____

Guarantor (Responsible for Account)

Last Name_____ First Name_____ MI_____

Address_____ City/State/Zip_____

Home Phone_____ Work Phone_____ Ext._____

Birth Date_____ Sex M/F Married/Single/Other Soc. Sec._____

Insurance Information (COPY CARD(S) FRONT & BACK)

Primary Insurance Company_____ Policy #_____

Group #_____ Relationship to Patient_____ Effective Date_____

Policy Holder's Last Name_____ First_____ MI_____

Sex M/F Birthdate_____ Home Phone_____ Work Phone_____

Employer_____ Co Pay $_____ Referral Needed? Y N

Secondary Insurance Company_____ Policy #_____

Group #_____ Relationship to Patient_____ Effective Date_____

Policy Holder's Last Name_____ First_____ MI_____

Sex M/F Birthdate_____ Home Phone_____ Work Phone_____

Employer_____ Co Pay $_____ Referral Needed? Y N

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I authorize my insurance benefits (including Medicare) to be paid directly to Cascade Foot and Ankle for services rendered. I also authorize Cascade Foot and Ankle to release any information requested by the insurance company with regard to payment of benefits.

_____

PATIENT'S SIGNATURE (OR LEGAL GUARDIAN) DATE

Welcome to our office

We are pleased to welcome you as a patient. The following is our financial policy. We feel that is it very important that our patients have a clear understanding of our expectations regarding your billing and payment for our services. Feel free to ask questions. After your initial appointment please advise a receptionist when you come in of any changes in your address, phone number, place of work, or insurance coverage since your last visit.

FEES

The fees for treatment are payable at the time of the visit unless you carry insurance that we bill. We accept cash, check, Visa or MasterCard. If other arrangements are needed, please talk to our billing staff prior to receiving service. If you do not have insurance, the initial visit is **estimated** at $150.00. **a $100 deposit will be due at the time of your visit**. We do offer a cash discount to private paying patients when paid in full the day of your service. Surgery patients will be required to pay applicable deductibles/co-pays prior to scheduled surgery. Past due accounts over 60 days will be charged a 3% interest fee. All accounts over 90 days will be sent to collection.

INSURANCE

We bill Medicare and insurance companies with which we are a contracted provider. Front office staff can tell you if your insurance is one of these. It is your responsibility to provide us with your insurance identification card showing proof of coverage on your visit. We also require an additional piece of identification.

CO-PAYS

Many insurance companies have a co-payment. **Our office requires that you pay your co-pay at the time of your appointment.** Please give your co-pay to our receptionist when you check in. If you do not have your co-pay at the time of appointment, you will be re-scheduled.

REFERRALS

If your insurance company requires a referral from your primary physician, it is your responsibility to make sure our office has a copy. You are responsible to keep track of visits allowed.

SUPPLIES

Most supplies (padding, pre-fabricated orthotics, heel cups, etc.) are not covered by insurance and payment will be due at time of dispensing. Medicare will not pay for post-operative shoes or custom insoles. The casting procedure is a separate fee from the orthotics themselves, and you may be responsible for this fee**. No refunds on DME (Durable Medical Equipment), night splint, walking cast, Darco shoes, etc.**

CANCELLED/NO SHOW APPOINTMENTS

If you are not able to keep a scheduled appointment, please notify our office within 24 hours so we can use that appointment time for another patient. **There is a strict NO SHOW FEE of $50 for office visits and $50 for procedures and surgeries**. If you miss or are late for multiple scheduled appointments without notice, our physicians reserve the right to release you from the practice.

When a child of divorced parents is seen, we will expect payment from whichever parent accompanies the child and that parent will ultimately be responsible for any unpaid balance. If you are having a financial difficulty, our patient account office will be happy to work with you. We do monitor our accounts regularly and nonpayment may jeopardize your ability to be seen by our physicians. Thank you for choosing Cascade Foot & Ankle.

I HAVE READ AND ACCEPT THE CASCADE FOOT & ANKLE FINACIAL POLICY

_____ _____

Signature of responsible party Date

_____

Please print name

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Cascade Foot and Ankle. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Cascade Foot and Ankle reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION		
In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)		
Spouse only	**☐ YES**	**☐ NO**
OR		
Any Member of my immediate family: (Spouse, Children, Children's Spouses)	**☐ YES**	**☐ NO**
Any Member of my extended family: (Parents, Grandchildren)	**☐ YES**	**☐ NO**
Other: _____	**☐ YES**	**☐ NO**
Name of patient (please print): _____		
Patient signature: _____		
Patient's personal representative: (Please Print): _____		
Personal Representative's signature: _____		
Representative's Telephone Number: _____ Date: _____		

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained			
Provided Prior to Treatment?	**☐ YES**	**☐ NO**	**Date Statement Provided: _____**
Reason for not obtaining patient signature	☐	**Needed more time to review Statement**	
	☐	**Wanted to consult another person before signing**	
	☐	**Physically unable to sign**	
	☐	**No reason offered**	
	☐	**Other:**	

Cascade Foot and Ankle
3919 Creekside Loop * Yakima, Washington * 98902 * 509-225-3668

Statement of Privacy Practices

Cascade Foot and Ankle

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. It is a requirement of this practice that every employee receive appropriate training and is dedicated to the principal concept that your health information shall never be compromised. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect our obligations and your rights.

Protecting your Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given or disclosed to anyone – even family members – without your consent or written authorization. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality, integrity, and access to your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Healthcare Information (PHI)

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of your Protected Healthcare Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing or fund-raising purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards unless you direct us otherwise. We will never use, disclose, sell, or otherwise allow access to your personal, protected information in exchange for or receipt of financial remuneration.

Any breach in the protection of your personal health information, including unauthorized acquisition, access, use, or disclosure, will be fully investigated, addressed, and mitigated as established by the HIPAA Privacy Breach Notification Rule. You have a right to and will be provided all information relating to any breach involving your personal PHI

Your Rights as our Patient

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

An expanded, and complete copy of our Statement of Privacy Practices, is available for your review.

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