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_____

Cell Phone_____ Home Phone_____ WorkPhone_____

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

Ethnicity: □ Hispanic or Latino □ Asian □ Other_____ How did you hear about us:

Race: □ American Indian or Alaskan Native □ Walk-in □ Friend □ Internet □ Facebook

□ White □ Black or African American □ Yellow Pages □ Ad □ Referring Provider

Employer_____ □ Other_____

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

Cascade Foot and Ankle PLLC

Yakima, Washington

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**
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 (if 18 years old or older) _____		
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 of Privacy Practices**
	☐	**Wanted to consult another person before signing**
	☐	**Physically unable to sign**
	☐	**No reason offered**
	☐	**Other:**

CASCADE FOOT & ANKLE

2400 Racquet Lane, Yakima, WA 98902
611 S. Chestnut, Suite C, Ellensburg, WA 98926
Phone: 509-225-3668

Pain medication policy for CFA patients

Pain medications and muscle relaxants can be prescribed to post surgical patients. If you are not a surgical patient, pain medications must be obtained through your primary care physician or a pain management clinic.

If you need to refill your pain medication, please call your pharmacy to request a prescription refill at least 48 hours prior to your last dose. Do not wait until the day your medication runs out. Our staff needs sufficient notice to review your request for a refill and to process it appropriately. In order to obtain prescription refills prior to the weekend you must call your pharmacy with your request by 5 PM on Thursday. We will not provide refills after 5 PM on Thursday through 8 AM on Monday.

Many pain prescriptions cannot be refilled by phone or fax. Use only one pharmacy to refill your pain medication. Using the same pharmacy assures that the pharmacy will stock your medication for refills and the pharmacy will know that you have a legitimate need for pain medication. You must notify our office if you change pharmacies.

You are responsible for the safekeeping of your medication. Do not sell, trade, or give it away. If your medication is lost, stolen, or damaged, you must notify us right away. All stolen medications require a police report.

Chronic pain management should be managed by your primary care physician or a chronic pain management clinic. All chronic pain management medications should be refilled through them. Please let us know at any time another doctor prescribes pain medication for you. Our physicians reserve the right to request random urine or blood drug screens. Failure to comply with these policies will result in discharge from our clinic. If you are using medical marijuana that prescriber must provide all your medications.

Remember when taking narcotics or other pain medications that they can cause drowsiness, dizziness, or impair motor function. Do not drive, operate machinery, or perform any task that may put your life or someone else's life in danger. Do not abuse alcohol or other medically unauthorized substances.

This policy applies to the following drug types:

1. Narcotics (ie Vicodin, Percocet)
2. Nonsteroidal anti-inflammatory's (ie motrin, naprosyn)
3. Other pain meds (ie tramadol)
4. Muscle relaxants (ie flexeril)

if you have questions about this agreement please ask one of our medical staff.

I acknowledge that I have read, understand, and will comply with CFA's policy on prescription pain medication.

_____ _____

Patient Signature Date