NORTHWEST EXTREMITY
SPECIALISTS

Cedar Mill

Name: _____ Date of Birth: _____
First Middle Initial Last

Age: _____ Social Security #: _____What is your assigned gender? Male/Female

What is your preferred Gender? Male/Female/Other: _____

Mailing Address: _____ City: _____

State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____Work Phone: _____

Email: _____ Contact by email? Yes/No

**Marital Status**(circle one): Single Married Domestic Partner Widowed Legally Separated Divorced

**Race**(circle all that apply): White Black/African American Asian Hispanic Native American Native Hawaiian/Pacific Islander Declined

**Ethnicity**(circle one): Not Hispanic/Latino Hispanic/Latino Declined

**Preferred Contact** (circle one): Phone- home/mobile/work Email Text

Employer: _____ Occupation: _____Phone:_____

Spouse/Parent/Guardian: _____Phone:_____Employer: _____

Emergency Contact Name: _____Relationship: _____Phone:_____

Primary Care Physician: _____ Phone: _____
Date Last Seen: _____

**Whom may we thank for referring you:**
Physician/Clinic Name: _____(first & last name, clinic name)
Another Patient:_____
(circle) Internet Insurance Hospital Family/Friend Other: _____

**********

**ASSIGNMENT AND RELEASE:**

I give permission to Northwest Extremity Specialists, LLC to administer treatment and to perform such procedures as may be necessary in my diagnosis and/or treatment. I also give my permission to electronically check my medication history.

Patient Name (please print) Patient/Guardian Signature Date

NORTHWEST EXTREMITY SPECIALISTS

Patient Name: _____ Date of Birth: _____

## REASON FOR TODAY'S VISIT

**Injured Body Part (foot, leg, ankle):**_____

(circle all that apply)

**Date of Onset/Injury: _____Pain Level:** None 1 2 3 4 5 6 7 8 9 10 (worst) **Location:** R / L / Both

**Type of Pain:** Sharp Burning Dull Aching Intermittent Constant Throbbing Shooting

**Onset**: Slow Sudden Traumatic **Is Pain Getting:** Worse Better No Change

**Prior Treatments:** _____

**What makes it worse:** Walking Running Standing Shoes Other: _____

**Is this a work related or Motor vehicle injury?** Yes/No **Is this a second opinion?** Yes/No

**Previous Physician Treating Injury:** _____

**Vein Screening Questionnaire:**

Are your legs heavy, tight, tired, dull or achy? Yes/No

Do you have swelling in the legs and/or ankles and/or varicose veins? Yes/No

Is the skin just above the ankle brownish-red or discolored? Does it feel leathery, hard, or itchy? Yes/No

## MEDICAL HISTORY

**Height: _____ Weight: _____ Shoe Size: _____ BP: _____ Pulse: _____**

| Medications | Allergies |
|---|---|
| Include Prescriptions, over-the-counter medications and vitamins (please provide a list or attach an additional page if necessary):<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____<br>Pharmacy Name(s): _____<br>Pharmacy Phone(s): _____<br>Do you take oral contraceptives? Yes ___ No___ | (circle all that apply)<br><br>NO ALLERGIES<br>Adhesive/Tape<br>Local Anesthetics<br>Anticoagulant Therapy<br>Novocaine<br>Aspirin<br>Penicillin<br>Codeine<br>Seafood<br>Demerol<br>Sulfa<br>Iodine<br>Latex<br>Metal/Nickel<br>Other _____ |

**SOCIAL HISTORY**: Alcohol use/frequency: _____ Drug Use/Frequency: _____

**SMOKING STATUS** (circle one): Current Everyday/Current Someday/Former Smoker/Never Smoked/Unknown

**Hospitalizations/Surgeries** (last 10 years): _____

_____

**FAMILY HISTORY** (circle all that apply): Heart Disease Early Deaths Bleeding High Blood Pressure Asthma COPD High Cholesterol Thyroid Disorder Osteoporosis Diabetes Stroke Cancer (other)_____

NORTHWEST EXTREMITY SPECIALISTS

**Patient Name: _____ Date of Birth: _____**

**Active Medical Problems**

**(**circle all that apply)

AIDS/HIV Anesthesia Problems Artificial Heart Valves Artificial Joints Bipolar Disease Bleeding Problems Cancer Circulatory Problems Hepatitis Hiatal Hernia High Blood Pressure High Cholesterol Infections Neuropathy Pacemaker Prostate Problems Seizures Sexually Transmitted Disease Sleep Apnea Snoring Thyroid Problems TMJ Tuberculosis

**Are You Currently Experiencing Any of the Following Symptoms?**

**General**: Fatigue Fever Chills Sweating Heavily at Night Recent Weight Loss Recent Weight Gain

**Head**: Headache Sinus pain

**Eye**: Worsening vision Floaters Double vision Blurry Vision Pain w/Eye Movement Red Eyes Sensitivity to Light Glasses Contacts Glaucoma Dry Eye Loss of Vision

**ENT**: Hearing Loss Earache Draining from Ear or Nose Ringing in Ear(s) Sneezing Nasal Itching Sore Throat Mouth Sores Dry Mouth Difficulty Swallowing

**Cardiovascular**: Chest Pain Crushing Chest Pain Heart Palpitations Leg Pain w/Exercise Heart Attack Heart Disease Angina Congestive Heart Failure

**Pulmonary**: Difficulty Breathing Shortness of Breath Wheezing Orthopnea Cough Loose Cough Dry Cough Coughing up Blood Asthma

**GI**: Decreased Appetite Anorexia Heartburn Nausea Vomiting Abdominal Pain Jaundice Diarrhea Constipation Ulcers

**GU**: Blood in Urine Urine odor abnormal Painful Urination Change in Urine Frequency Frequent or Excessive Nighttime Urination Incontinence Urinary Urgency Kidney Problems Liver Disease Blood in Urine/Stool Dialysis

**Endocrine**: Diabetes Mellitus Excessive Thirst Heat Intolerance Cold Intolerance Excessive Sweating Feelings of Weakness

**Musculoskeletal**: Back pain Muscle Aches Muscle Cramps Joint Pain Joint Swelling Joint Stiffness Arthritis

**Neurologic**: Dizziness/Vertigo Fainting Confusion Memory Loss Speech Disturbance Limb Weakness Paralysis Tingling Involuntary Movements Balance Problems Numbness □Stroke

**Psychological**: Anxiety Depression

**Skin**: Dry Skin Itching Peeling of Skin Skin Scaling Rash Skin Discoloration

NORTHWEST EXTREMITY SPECIALISTS

Podiatric Physicians and Surgeons

Jason Surratt, DPM
Thomas Melillo, DPM
Michael Gentile, DPM
Yama Dehqanzada, DPM
Todd Galle, DPM
Mia Horvath, DPM

Clifford Mah, DPM
Denny Le, DPM
Manny Moy, DPM
Patricia Cain, DPM
Amy Theppote, DPM

## RECORDS RELEASE AUTHORIZATION

To:_____
(Name of Doctor releasing records, such as a primary care physician)

Patient's Name: _____
LAST FIRST MI

Patient's DOB: _____

I hereby authorize and request your office to release the following:

[ ] All Medical Records including X-Rays

[ ] Medical Records Only

[ ] X-Rays Only

[ ] Lab Test

[ ] Other:_____

To Be Faxed To: _____
Name of Medical Facility/Medical Office/Doctor/Insurance/Other

To Be Mailed To: _____
Name of Facility/ Street Number/ Suite Number/ City/ State/ Zip Code

To Be Picked Up: _____
Name of patient or relative picking up information to be hand carried to Westside Podiatry Clinic

Patient's Signature:_____ Date: _____

Please state relationship to the patient if not signed by patient: _____

Podiatric Physicians and Surgeons

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# Notice of Privacy Practices Patient Acknowledgement

I have received this practices' Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices upon request.

Signature: _____ Relationship to patient: _____ Date: _____

Please indicate below the name(s) of any person(s) you allow Northwest Extremities Specialists, LLC to disclose personal/medical information to.

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

Podiatric Physicians and Surgeons

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Amy Theppote, DPM

## FINANCIAL POLICY

Patient Name: _____ Date of Birth: _____

Welcome to Northwest Extremity Specialists, LLC. Thank you for choosing us as your podiatric physician. We are committed to your treatment being successful, as you, the patient, are our first and foremost concern. The following is a statement of our Financial Policy which we request you read, initial and sign prior to any treatment. To avoid any misunderstandings, please contact us should you have any questions about our policies.

**INSURANCE:** Your insurance policy is a contract between you and your insurance company, therefore you are responsible whether or not your insurance pays. If we are participating with your insurance plan, we will submit the claim to your insurance. In order to do this, we will need complete and accurate insurance information including social security number, home address, phone number, insurance claim mailing address, insurance phone number, subscriber ID number and/or group number. (This may be obtained by providing a copy of the front and back of your insurance card). This should be provided for each insurance plan you are currently effective with. **_____initials**

**NON-INSURED:** If you do not have insurance or the doctor is not a participating provider with your insurance plan, full payment is due at the time of each visit. **_____ initials**

**PAYMENT:** Payments for any co-pays, deductibles, balance due, etc., is due at the time of service. You will receive a statement showing itemized charges and payments monthly. A $35 charge will be applied to your account for any returned checks. **_____ initials**

**MINOR PATIENTS:** The adult or the parent (custodial guardian) accompanying a minor is responsible for payment of services. For unaccompanied minors, non-emergency treatment will be denied unless prior authorization from the parent or guardian has been made for the charges and treatment. Young adults (age 18 & over) are legally responsible for their accounts unless a parent accompanies them to the initial appointment and signs this financial agreement, regardless of insurance coverage. **_____ initials**

**MISSED APPOINTMENTS:** Please help us serve you better by keeping scheduled appointments. If it is necessary to cancel, please call our office 24 hours in advance. This allows us to accommodate our other patients. A $35 charge may be assessed for missed appointments. **_____ initials**

**REFERRALS:** It is your responsibility to obtain any required referral from your insurance company. Failure to do so may reduce the amount of benefits paid by your insurance, in turn increasing the patient responsibility. Please be aware that if you choose to be seen before you have received a valid referral, your insurance may not pay for services rendered. **_____ initials**

**COLLECTIONS:** Account balances 60 days old are considered past-due. Account balances 90 days old are considered delinquent. Account balances 120 days or older will be referred to a third party collection agency. However, we do reserve the right to send any account to collections, regardless of the amount of days past due. Payment plans can be arranged with our business office if you are not able to pay the balance in full. **_____ initials**

**SUPPLIES:** For your convenience we make some supplies available for purchase in the office. If you choose to purchase these items, payment is due at the time of purchase. **_____ initials.**

By signing below, I understand the above information pertaining to the financial policy at Northwest Extremity Specialists, LLC and agree to adhere to the patient responsibility requirements.

_____

Patient Name (please print) Patient/Guardian Signature Date

NORTHWEST EXTREMITY SPECIALISTS

This Joint Notice of Privacy Practices (Notice) describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The Notice is being provided to you on behalf of Northwest Extremity Specialists, its medical staff and other providers (collectively referred to herein as "we" or "our").

**Northwest Extremity Specialists is committed to protecting the confidentiality of your health information.**
We are required by law to maintain the privacy of your protected health information (commonly called PHI or health information), including PHI in electronic format. We are also required to notify you of our legal duties and privacy practices regarding your health information and abide by the practices of this Notice, unless more stringent laws or regulations apply. The Notice applies to all Northwest Extremity Specialists facilities, services and programs that provide health care to you.

**Application of this Notice**
The information privacy practices described in this Notice will be followed by:

- Any health care professional that treats you at any of our locations.
- All facilities, departments and units, clinics and other affiliates.
- All workforce members such as employees, medical staff, trainees, students, volunteers and other persons under our direct control whether or not they are paid by us.
- Other health care providers that have agreed to abide by this Notice of Privacy Practices.

This Notice provides detailed information about how we may use and disclose your health information with or without authorization as well as more information about your specific rights with respect to your health information.

**Uses and disclosures of your health information that we may make without your authorization**
**To contact you:** Your information may be used to contact you to remind you about appointments, provide test results, inform you about treatment options or advise you about other health-related benefits and services.
**Treatment:** Your information may be shared with any health care provider who is providing you with health care services. This includes coordinating your care with other health care providers and providing referrals to other health care providers. Examples of health care providers who may need your information to treat you include your doctor, pharmacist, nurse and other providers such as physical therapists, home health providers, and X-ray technicians. We may share your information electronically with your health care providers in order to make sure they have your information as quickly as possible to treat you. We may share your health information with any family member or friend who is assisting with your health care. We will only do this if you agree or do not object, and will only share with them the information they need in order to help you. If you are unable to either agree or object to such a disclosure, we may disclose your health care information as necessary if we determine that it is in your best interest based on our professional judgment.
We may disclose health information to a family member, relative or another person who was involved in your health care or payment for health care when you are deceased if not inconsistent with your prior expressed preferences.

**Payment:** In order to obtain payment for your health care services, we may have to provide your health information to the party responsible for paying. This may include Medicare, Medicaid (state health plan) or your insurance company. Your insurance company or health plan may need your information for activities such as determining your eligibility for coverage, reviewing the medical necessity of the health care services provided to you or providing approval for hospital services or stays.
**Health care operations:** Your health information may be used in order to support our business activities and to assure that quality health care services are being provided. Some of these activities include quality assessments, peer or employee review, training of medical personnel, licensure and accreditation, data aggregation and audits by regulatory agencies.
We may share you PHI with third parties who perform services such as transcription or billing. In those cases, we have written agreements with the third parties that they will not use or disclose your health information except if permitted by law.
**You have the right to opt out of receiving such communication.** If you do not want to receive these materials, please contact our office and request that these materials not be sent to you.
**Other uses and disclosures that we may make without your authorization**
There are a number of ways that your health information may be used or disclosed without your authorization. Generally, these uses and disclosures are either required by law or for public health and safety purposes.
**When required by law:** We may use or disclose your health information when required by law. If this happens, we will comply with the law and will only disclose the information necessary.
**Public health:** We may disclose your health information to a public health authority for public health activities. Public health activities include preventing or controlling disease, injury, disability, and responding to reports of abuse, neglect or domestic violence. We may disclose your health information to a person or agency required to report adverse events, product defects or problems, biologic product deviations or for product recalls, repairs or replacements. Any disclosures of this nature will be made consistent with state and federal law.
**Health oversight:** We may disclose your health information to health oversight agencies for oversight activities authorized by law, such as audits, investigations, and inspections. Health oversight agencies include government agencies that oversee the Health care system, government benefit programs, government regulatory programs and civil rights.
**Legal proceedings:** We may use or disclose your health information in response to a court or administrative order in an administrative or judicial proceeding, or in response to a subpoena, discovery request or other legal process.

**Law enforcement:** We may use or disclose your health information for law enforcement purposes. Examples include (1) responding to legal processes; (2) providing limited information to identify or locate a suspect; (3) providing information about crime victims; (4) reporting suspicion that death has occurred as a result of criminal conduct; (5) reporting a crime which occurred on our premises; and (6) for medical emergencies, reporting where it appears likely a crime occurred.
**Preventing a serious threat:** We may use or disclose your health information if we believe in good faith that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or of the public. Disclosure may only be made to a person reasonably able to prevent or lessen the threat.
**Military activity and national security:** We may disclose the health information of Armed Forces personnel: (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits; or (3) to a foreign military authority if you are a member of that foreign military service. We may also disclose your health information to authorized federal officials to conduct national security and intelligence activities, including the provision of protective services to the President or others legally authorized to receive information.
**Inmates/arrestees:** We may use or disclose your health information as necessary to comply with worker's compensation laws and other similar legally established programs.

**Your Rights**
**Right to request restrictions:** You have the right to ask us to place restrictions on the way we use or disclose your health information for treatment, payment or health care operations. We will consider your request but are not required to agree to the restriction (except as described below). If we agree to a restriction, we will not use or disclose your health information in violation of that restriction unless it is needed for an emergency. If a restriction is no longer feasible, we will notify you.
**Right to restrict disclosure to health plans:** You may request in writing, at the time of service that we not disclose information to health plans where you have paid for items or services out of pocket in full. We must agree not to disclose this information to your health plan if certain conditions are met.
**Confidential communications:** We will accommodate reasonable requests to communicate with you about your health information by different methods or alternative locations. For example, if you are covered on a health plan but are not the subscriber, and would like your health information sent to a different address than the subscriber, we can usually do that for you.
**Breach notification:** You have the right to receive notification of breaches of your health information as required by law.
**Access to your health information:** You have the right to receive a copy of your health information that we maintain, with some limited expectations. You may request access to your information in writing, and you may request a copy of your information in electronic format. We reserve the right to charge a reasonable fee for the cost of producing and providing your health information. You have the right to request that your health information be sent to any person or entity, such as another doctor, caregiver or online personal health record.
**Amendment of your health information:** You have the right to ask us to amend any of your health information. You need to request this amendment in writing and submit it to the facility's medical records department. We may deny your request in certain situations, such as when the health information in your records was created by another provider or if we determine your information is accurate and complete. Any denials will be in writing. You have the right to appeal our denial by filling a written statement of disagreement.
**Accounting of certain disclosures:** You have a right to a listing of the disclosures we make of your health information, except for those disclosures made for treatment, payment, or health care operations, or those disclosures made pursuant to your authorization. The type of disclosures typically contained in a listing would be disclosures made for mandatory public health purposes, law enforcement, legal proceedings, or for other required reporting such as birth and death certificates.
**Exercising your rights:** To exercise any of the above rights or if you need to share your health information with someone for purposes other than those listed here, contact the appropriate medical records department.

**Questions and complaints**
If you have questions or are concerned that any of your privacy rights have been violated please contact our Privacy Officer:
Jennifer Diaz at (503)-245-2420
You also have the right to complain to the Secretary of Health and Human Services at:

Office of Civil Rights – AK, WA, OR, MT
U.S. Department of Health and Human Services
2201 Sixth Avenue- M/S: RX-11
Seattle, WA 98121-1831

Office of Civil Rights- CA
U.S. Department of Health and Human Services
90 Seventh Street, Suite 4-100
San Francisco, CA 94103

You will not be retaliated against for filing a complaint.
**Changes to Joint Notice of Privacy Policy**
We reserve the right to change the terms of our Notice at any time. New Notice provisions will be effective for all protected health information that we maintain. You may request a current copy from the medical records department, privacy officer, or registration staff at any time.