Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Foot & Ankle Surgical Associates respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. Your protected health information may include your symptoms, test results, diagnoses and treatment, health information from other providers, and billing and payment information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Examples of use and disclosures of protected health information for treatment, payment and health operations:

For Treatment:

- Information obtained by a nurse, physician, or other member of our healthcare team will be recorded in your medical record and used to help decide what care might be right for you.
- Wemay also provide information to others providing you care. This will help them stay informed about your care.

For Payment:

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to your health plans may include your diagnoses, procedures performed, or recommended care.

For Health Care Operations:

- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health related benefits and services.
- We may use and disclose your information to conduct or arrange for services, including:
    - Medical quality review by your health plan.
    - Accounting, legal, risk management, and insurance services.
    - Audit functions, including fraud and abuse detection and compliance programs.

Your Health Information:

The health and billing records we create and store are the property of FASA Family Wellness, PLLC. The Health information in it, however, generally belongs to you. You have the right to:

- Receive, read, and ask questions about this notice.
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. While we are not required to grant the request, we will comply with any request granted.
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information.
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.
- Have us review a denial-of-access to your health information – except in certain circumstances.

- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record and included in the release of your records.
- Upon your request, we will provide a list of disclosures of your health information. The list will not include disclosures to third-party payers. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in a 12 month period.
- Ask that your health information be given to you by other means or at another location. Please sign, date, and give us this request in writing.
- Cancel prior authorizations to use or disclose your health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action we have taken before we have it. Sometimes you cannot cancel an authorization if its purpose was to obtain insurance.

Our responsibilities:

We are required to:

- Keep your protected health information private.
- Give you this notice.
- Follow the terms of this notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this notice. You may receive the newest copy of this notice by calling and asking for it or by visiting one of our clinics to pick one up.

To ask for help or report a problem:

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact us:

Office Manager

P:360.754.3338 Fax:360.753.4861

1610 Bishop Rd SW Suite 101 Tumwater, WA 98512

Patient Last Name:______________________________First Name:________________________________MI:___________

Mailing Address: ____

City:_________________________________State:__________Zip: ______________ Male ☐ Female ☐

Home Phone:______________________________________Cell Phone: ____

Employer:____Employer Phone: ____________________________________

Employer Address: ____

Date of Birth:_____________________Social Security:________________________Marital Status: ______________________

Email Address: ____

If Minor: Responsible Party's Name:____Date of Birth: __________________

Referring Physician:____Phone:__________________________

Emergency Contact:____Relation:____________________________

Emergency Contact's Phone: ____

How did you hear about us? ____

Insurance Policy Information: Please Complete All Information

Primary Plan:____Group Number: _____________________________

Insurance ID Number:_____________________Subscriber's Name: ____

Date of Birth:_____________________________Employer:____

Secondary Plan:____Group Number: _____________________________

Insurance ID Number:_____________________________Subscriber's Name: ______________________________________

Date of Birth:_________________________Employer:____

If this is a work related injury: Industrial Insurance Carrier: ____

Phone:_______________________Date of Injury:_______________________Claim Number: _________________________

Medical and Podiatric Information

Family Physician:___________________________________City:________________________Last Visit: _________________

Pharmacy of Choice:____Phone:_________________________________

Former Podiatrist Name:____Last Visit: _________________

Medical History Form

Patient Name:______________________________________Referring Doctor: ______________________________________

Your answers on this form will help your clinician understand your medical concerns and conditions better. If you are uncomfortable with any of the questions, do not answer them. Best estimates are fine if you cannot remember specific details.

Symptom Area (left/right leg/foot/toes/ankle): ____

When did you first notice symptoms (date): ____

Describe how your symptoms began: ____

Treatment (if any) to date:____Has it helped? ____________

Medications: Prescription and non-prescription medicines, vitamins/supplements, home remedies, birth control pills, herbs

	MEDICATION	DOSE		MEDICATION	DOSE
1			6		
2			7		
3			8		
4			9		
5			10		

Allergies or Reactions to Medications:

MEDICATION	REACTION/SIDE EFFECT

Surgical History:

	OPERATION	DATE		OPERATION	DATE
1			5		
2			6		
3			7		
4			8		

Social History:

Occupation: ____

Height:_________ft._________in. Shoe Size: ___________________ Weight:___________________lbs.

Women: Possibility of pregnancy? Yes / No

Tobacco use? Yes / No Number of packs/cans per day: ____

Alcohol use? Yes / No How much/often: ____

Street drug use? Yes / No Drug names:_____________________________________Last use: __________________

Foot & Ankle SURGICAL ASSOCIATES

Personal Medical History: Please indicate with a ✓ whether you have had any of the following medical problems.

MEDICAL CONDITION		MEDICAL CONDITION		MEDICAL CONDITION	
Heart Problems		Ulcers		Thyroid/Glandular Problems	
Heart Attack		Stroke		Cancer-Where:	
Angina/Chest Pain		Diabetes Type I / II		Arthritis-Where:	
Kidney Problems		Stomach Problems		Paralysis/Weakness	
Breathing Problems		High Blood Pressure		Problems With Surgery	
Lung Disease		Psychiatric/Emotional Problems		Osteoporosis	
Bleeding Problems		Other:		Other:	

Family History: Please indicate with a ✓ family members who have had any of the following medical problems.

MEDICAL CONDITION	MOM	DAD	SISTER	BROTHER	DAUGHTER	SON	OTHER
Alcoholism							
Anemia							
Anesthesia Problems							
Arthritis							
Asthma							
Bleeding Problems							
Cancer-Type:							
Depression							
Diabetes Type I							
Diabetes Type II (Adult Onset)							
Eczema							
Heart Attack (Coronary Artery Disease)							
High Blood Pressure							
High Cholesterol							
Kidney Disease							
Lupus							
Migraines/Headaches							
Mitral Valve Prolapse							
Osteoarthritis							
Osteoporosis							
Rheumatoid Arthritis							
Stroke							
Thyroid Disorders							
Tuberculosis							
Epilepsy (Seizures)							
Other:							

Form completed by: ____

Consent for Treatment

I consent to evaluation and treatment of the condition for which I, or my child or dependent, have come to FASA Family Wellness PLLC dba Foo t& Ankle Surgical Associates (FASA) and authorize the physicians and other health care providers affiliated with FASA to provide such evaluation and treatment. I understand that the practice of medicine is not an exact science, and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, treatment, diagnosis, or test performed at or by FASA. I authorize FASA to examine, use, store and dispose of all tissue, fluids, or specimens removed from my body. I acknowledge and agree that this consent will be applicable to all visits or episodes of evaluation and treatment at FASA.

Payment Policy

Thank you for choosing FASA as your foot care provider. We are committed to providing you with quality and affordable health care. Please read the following office payment policy and feel free to ask us any questions that you may have. Once you accept this policy, kindly sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments, deductibles and co-insurance. All co-payments, deductibles and co-insurance must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some - and perhaps all - of the services you receive may be uncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. If required, obtaining the proper referral from your Primary Care Physician is your responsibility. Patients presenting to our office without a valid referral will be asked to pay in full. This payment will be held for 48 hours and will become non refundable if the proper referral is not obtained by then.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

7. Nonpayment. Invoices are sent out every 30 days. Your prompt payment will assist us in keeping the cost of healthcare down. If your account is over 60 days past due, you will receive a letter requesting immediate payment. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative podiatric care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments. Our policy is to charge $50.00 for missed appointments not canceled within a reasonable amount of time (24 HOURS) or for an understandable reason. Our policy is to charge $200.00 for a cancellation within 10 days of a scheduled surgery. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our fees are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines: