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.
- We may 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:

Front Office Manager

360.754.3338 Fax: 360.753.4861

1610 Bishop Rd SW Suite 101 Tumwater, WA 98512

Acknowledgment or Receipt of Notice of Privacy Practices

I acknowledge that I was provided with a copy of the Notice of Privacy Practices.

____ _____________________
Patient Name (please print) Date

____
Signature

1. Cancellation/No Show policy for Doctor Appointments

At Foot & Ankle Surgical Associates your scheduled appointment is very important. We have a policy for patients who do not show up for their appointments, or who fail to give **24 hours' notice** of canceling or rescheduling their scheduled appointment. **There is a $30.00 charge for failure to follow this policy.**

2. Scheduled Appointments

We understand that delays can happen. However, we must try to keep the other patients and doctors on time. **If a patient is 15 minutes past their scheduled time, we will have to reschedule the appointment.**

3. Cancellation/No Show Policy for Surgery

Due to the large block of time needed for surgery, late cancellations cause problems and added expenses to the office. **If the surgery is not cancelled at least 10 days in advance, you will be charged a $200 fee. This will not be covered by your insurance company.**

I have read and acknowledge the above policy.

____ _____________________
Patient Name (please print) Date

____
Signature

Consent to Treatment, Insurance Authorization and Assignment

I authorize medical care for ________________________. I hereby authorize my insurance benefits to be paid directly to the physician. I am financially responsible for all services according to the Foot & Ankle Surgical Associates (FASA) policy, regardless of pending insurance claims.

I understand that my express consent is required for the medical provider to release any information regarding diagnosis and/or treatment of HIV (AIDS Virus), sexually transmitted disease, drug or alcohol abuse, psychiatric treatment or mental illness. If I have been treated or diagnosed in connection to HIV (AIDS Virus), sexually transmitted disease, drug or alcohol abuse, psychiatric treatment or mental illness, you are specifically authorized to release to the insurance company in my medical file all information or medical records relating to the diagnosis or treatment.

Assignment of Benefits

I attest that the information I have provided to FASA is correct and true to the best of my knowledge. I hereby assign any medical and/or surgical benefits to FASA. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges, whether or not paid by said insurance. I further authorize FASA to release all information to secure payment.

Assignment to Release Information

I hereby authorize any physician, hospital, pharmacy or medical facility to provide all information regarding my medical or pharmaceutical history and treatment to FASA. I further will allow my pharmacy to supply verification of benefits. I also authorize FASA to release my medical information to other physicians as needed to facilitate treatment.

Text/Email Consent Form

I have read and acknowledged the text/email consent policy.

Patient Signature: ____ Date: ________________

If a minor: Parent or Legal Guardian: ____ Date: ________________

*If the patient has reached his/her 14th birthday, ONLY the patient may authorize disclosure relating to sexually transmitted disease.

Medicare Authorization and Assignment

I authorize any holder of medical or other information about me to release to the Social Security Administration and Healthcare Financing Administration or its intermediaries or carriers any information necessary for this or related Medicare claim/other insurance claim. I permit copy of this authorization to be used in the place of the original, and request payment of medical insurance benefits to the party who accepts the assignment. Regulation pertaining to Medicare assignment of benefits applies. I understand it is mandatory to notify the health care provider of any party who may be responsible for my treatment. (Section 128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.)

Patient Signature: ____ Date: ________________

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: ________________

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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: __________________

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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: ____

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Do I Need a Test for PAD?

Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain, or kidneys, become narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, difficult to control blood pressure, or symptoms of stroke. People with PAD are at significantly increased risk for stroke and heart attack. Answers to these questions will determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Name: ______________________________ Date: ____________

Circle "Yes" or "No"			Test for PAD
Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is relieved by rest?	Yes	No	☐
Do you experience any pain at rest in your lower leg(s) or feet?	Yes	No	☐
Do you experience toe or foot pain that often disturbs your sleep?	Yes	No	☐
Are your toes or feet pale, discolored, or bluish?	Yes	No	☐
Do you have skin wounds or ulcers on your feet or toes that are slow to heal (8-12 weeks)?	Yes	No	☐
Has your doctor ever told you that you have diminished or absent pedal (foot) pulses?	Yes	No	☐
Have you suffered a severe injury to the leg(s) or feet?	Yes	No	☐
Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)?	Yes	No	☐

Patient Signature: ______________________________

Physician Signature: ______________________________ Date: ____________