## **Š**KAGIT FOOT & ANKLE CLINIC

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## NEW PATIENT REGISTRATION

Date:

Name (Last, First, MI):				
Preferred Name: DOB:				
Gender: Marital Status: SSN:				
Address:				
Phone: (Home) (Cell)				
E-mail:				
Emergency Contact Name & Phone:				
Primary Care Provider: Referred by:				
Preferred Pharmacy & City:				
Reason for Visit (Right/Left/Both):				
Duration and Characteristic of Condition:				
Pain Scale: No Pain – 0 / 1 / 2 / 3 / 4 / 5 / 6 / 7 / 8 / 9 / 10 – Severe Pain				
If someone other than patient is responsible for payment, then please complete the following:				
Responsible Party:				
Relationship: Phone:				

Past Medical History:			
Anemia	Cancer	Liver Disease	
Asthma	Diabetes	Lung Disease	
Arthritis	Gout	Kidney Disease	
Back Problems	Neuropathy	Heart/Vascular Disease	
Any Other Illness:			
Family Medical History:			
Past Surgical History:			
Medications:			
Allergies (Circle): Adhe	sive Penicillin Sulfa Iodi	ne Novocain Other:	
Height:	Weight:	Shoe Size:	Men/Women
Current Smoker? Y / N	Packs Per Day:	Number of Years	
Former Smoker? Y / N	Packs Per Day:	From	_ То
Alcohol? Y / N How Much & How Often? Recreational Drug? Y / N			

We strive to provide you with the highest standard of medical care. You are consenting to the treatment provided by Skagit Foot and Ankle Clinic, LLC and its employees. You are consenting to follow the treatment and post-procedure protocols advised to you by our provider. No guarantees will be made as the therapeutic results that may be achieved could vary. You have the right to refuse any treatment at any given time, and you must notify the doctor if you wish to decline or refuse any treatment. We are contracted with various insurance companies and will bill them directly. Any remaining balance will be billed to you. Please present your insurance card to each visit to ensure we bill your insurance correctly. For HMO, you are responsible for referral or full payment. It is your responsibility to follow-up with your insurance company and pay the bill in a timely manner. The insurance companies that we are contracted with may change from time to time. If you are considering a new insurance plan, then please call our clinic to check if we are contracted with that plan. If you are injured in a motor vehicle accident and have personal injury protection through auto insurance, then your healthcare insurance will not cover the cost of the treatment. You are responsible for the charges at the time of the visit. When a patient turns 18 years old, they become the guarantors of their account. They will be asked to review their own financial agreements for their first visit after turning 18. We request payment at time of service for copays, coinsurance, and private pay. Copays not paid at the time of your visit may be subject to additional charges to your account. If you are having financial difficulty, then please contact our office to establish a payment plan. Repeated failure to pay may result in dismissal from Skagit Foot and Ankle Clinic, LLC and assignment of your account to a collection agency in the event of nonpayment. A rebilling fee may be applied to any overdue balance, authorized by Washington State Law. If your check is returned for insufficient funds, then we may add a service charge to your account; you will be responsible to pay the full amount, draft fees, plus a service charge of \$40 within 10 days, and failure to comply may result in assignment to a collection agency. Some insurance plans do not cover certain procedures, such as custom orthotics or elective procedures; in the event that insurance does not cover the fees, you will be responsible to pay the full amount. Please call your insurance company to determine coverage for the particular procedure that is being considered. Occasional updates and changes to these policies may occur without notice. Thank you for choosing Skagit Foot and Ankle Clinic, LLC to provide your foot and ankle care.

I certify all information provided is true and factual to the best of my knowledge, and I have read and agreed with all the terms listed above.

Patient/Representative Signature: \_\_\_\_\_ Date: