PATIENT CONTACT INFORMATION

PLEASE PRINT LEGIBLY

PATIENT LAST NAME _____ PATIENT FIRST NAME _____ MI _____ BIRTHDATE _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ SOC SEC NUMBER _____ ☐ M ☐ F ☐ X

H W C_____ PRIMARY PHONE NUMBER H W C_____ SECONDARY PHONE NUMBER _____ EMAIL ADDRESS

MAY WE TEXT YOU APPOINTMENT REMINDERS/NOTIFICATIONS? ☐ YES ☐ NO

REFERRING PHYSICIAN (WHO THE PRESCRIPTION CAME FROM) _____

PRIMARY CARE PHYSICIAN (YOUR GENERAL DOCTOR) _____

PRIMARY INSURANCE _____

SECONDARY INSURANCE _____

EMERGENCY CONTACT NAME _____ PHONE NUMBER _____ RELATIONSHIP _____

ARE YOU AFFECTED BY DIABETES? ☐ NO ☐ YES (If yes, please fill out the diabetes questionnaire)

I understand that any insurance quoted by Althea's Footwear Solutions, Inc. is not a guarantee of benefits. It is my obligation to know my insurance or to contact my insurance company for any questions.

Although my insurance company will be billed, I understand that the **FINAL BALANCE** is my responsibility and is due within 90 days from the time of delivery. If custom products are required, I will make a 50% down payment at time of order. **CUSTOM ITEMS, SPECIAL ORDER ITEMS, AND STOCKINGS ARE NON-REFUNDABLE.**

I hereby authorize **ALTHEA'S FOOTWEAR SOLUTIONS, INC.,** to bill my insurance carrier for services, which I have received, and assign payment for those services to **ALTHEA'S FOOTWEAR SOLUTIONS, INC.,** and to release information to my insurance company regarding my diagnosis and any services rendered.

SIGNATURE _____ DATE _____

LABOR AND INDUSTRIES ONLY

CLAIM # _____ DATE OF INJURY _____

EMPLOYER _____

CLAIMS ADJUSTER _____ TELEPHONE NUMBER _____

Everett
1932 Broadway
Everett WA 98201
P: 425-303-0108 F: 425-303-2539

Althea's FOOTWEAR SOLUTIONS

Lakewood
7501 Custer Road West
Lakewood WA 98499
P: 253-473-4311 F: 253-473-4408

OFFICE POLICY

Patient Name**:** _____ Date: _____

INSURANCE:

Any insurance quoted is not a guarantee of benefits. It is the patient's obligation to know their insurance or to contact their insurance company for any questions. Insurance coverage for Pedorthic devices and compression garments vary widely. We encourage you to contact your insurance carrier to determine what type of coverage is provided for your prescription. Keep in mind that your insurance policy may use certain fee schedules or allowances which may not coincide with our fees. *Therefore, while you may be able to receive Pedorthic products at little or no costs, deductibles and co-pays may apply.* At Althea's Footwear Solutions, Inc., all amounts charged are usual and customary for the products and services we offer.

Althea's Footwear Solutions, Inc., accepts assignment only for Medicare, Medicaid, Worker's Compensation and other contracted insurance company claims. Any exceptions will require pre-authorization from the third party to be billed. If you are unsure if we are contracted with your insurance company, please ask.

FEES AND PAYMENTS:

Our goal is to provide the best Pedorthic care and services we can. We make every effort to keep our fees reasonable and to avoid unfairly passing on to all our patients the cost of unnecessary collection procedures. Therefore, all fees are due and payable at the time the services and/or devices are provided. In addition, payment is required on all special order items, custom shoes, and foot orthotics. We accept Visa, Mastercard, Discover, American Express, Apple Pay, Checks and Cash.

If it becomes apparent that a client does not intend to satisfy a financial obligation to Althea's Footwear Solutions, Inc., a collection agency or legal remedy may be employed to resolve the debt.

RETURNS:

New, unaltered shoes or other items may be returned within seven days from the date of purchase for refund or exchange. Shoes billed to insurance may not be returned once billing has been submitted, even if that is within 7 days. All returns must be in their ORIGINAL packaging. Custom, special order, or altered items may not be returned or exchanged.

Due to health regulations, compression garments are not returnable and may only be exchanged if we made a mistake on measuring.

ADJUSTMENTS:

There will be two adjustments at no charge within 60 days after purchase or shoes and orthotics. Beginning with the third adjustment or adjustments after 60 days, there will be a $10.00 office fee per each 15-minute adjustment.

By signing this form, I indicate that I have read this form or that it has been read to me. Any questions have been satisfactorily addressed. I understand these policies.

Signature:_____ Date:_____

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PATIENT AGREEMENT AND REQUEST FOR PROVISION OF SERVICE

Patient Name: _____ Date: _____

I understand that by signing this agreement, I indicate my wish to purchase health care products or services or both from ALTHEA'S FOOTWEAR SOLUTIONS, INC.

INDICATIONS OF MEDICAL RESPONSIBILITY

I understand that I am under the supervision and control of my attending physician. I also understand that my physician has prescribed this treatment. I understand that the services at ALTHEA'S FOOTWEAR SOLUTIONS, INC., do not include diagnostic, prescriptive or other functions typically performed by licensed physicians, and that my physician is solely responsible for diagnosing and prescribing drugs and or therapy for my condition and otherwise supervising and controlling my medical care.

EXTENDED MEDICAL ASSIGNMENT

I certify that the information given for payment under Medicare (title XVIII of the Social Security Act) or other medical insurance is correct.

1. The patient, if physically and mentally competent, must sign on his/her own behalf. If the patient cannot sign for him/herself, a representative payee as designated by the Social Security Administration, or a legally appointed guardian may sign. The source of the signatory's authority should be the state: e.g., Social Security Appointed representative payee, court appointed guardian, etc.
2. This form is issued in lieu of the patient's signature on the "request for payment" form HCFA-1500 (i-84) and is, therefore, an extension of that form. Anyone who misrepresents or falsifies essential information in making Medicare claims may, upon conviction, be subjected to fine and imprisonment under Federal Law. Furthermore, in signing, the beneficiary authorizes any holder of medical or other information needed to process related medical claims. He/she further permits a copy of the authorization to be used in place of the original.
3. On assigned claims, the provider agrees to accept the Medicare Carrier's allowable amount as the full charge for covered services. The patient is responsible for the deductible, co-insurance, and non-covered services. This authorization may be canceled by mutual agreement of the provider and customer at any time by written notice to the Medicare Carrier.

I request payment under the Medical Insurance Part of Medicare be made directly to ALTHEA'S FOOTWEAR SOLUTIONS, INC., for services furnished to me during the effective period of the authorization. I have read and I agree to release information as specified in paragraph two above.

The undersigned certifies that he/she has read the foregoing and received a copy, as well as a copy of the Bill of Rights and patient responsibilities documented on the attached form. The undersigned also certifies that he/she is the patient or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

This consent signed by _____ Dated _____
(Signature)

If the signer is not the patient and is instead the patient's representative, please print signer's name here:

_____

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PATIENT CONSENT FORM

Patient Name: _____ Date: _____

NOTICE OF PRIVACY PRACTICE - HIPAA

Our Notice of Privacy Practice provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and healthcare operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices, and that the patient has the opportunity to review this notice.
- The Practice reserves this right to change the Notice of Privacy Policies.
- The patient has the right to restrict the use of their information, but the Practice does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this consent.

This consent signed by _____ Date _____
(Signature)

In addition to my doctor's offices and my insurance companies, I give permission for Althea's Footwear to discuss my account with the following people:

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

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PATIENT ACKNOWLEDGMENT FORM

Patient Name: _____ Date: _____

The products and or services provided to you by Althea's Footwear Solutions Inc. are subject to the supplier standards contained in Code 42 of Federal Regulations Section 424.57 (c). These standards concern business, professional and operational matters (e.g. honoring warranties and hours of operations). The full text of these standards can be obtained at http://www.ecfr.gov. Upon request we will provide a written copy of the standards.

My initials below acknowledge receipt of:

_____Althea's Footwear Solutions, Inc. Office Policy

_____Althea's Footwear Solutions, Patient Agreement

_____Althea's Footwear Solutions, Patient Consent form/HIPPA Notice of Privacy Practices

_____Medical Supplier Standards

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DIABETES QUESTIONNAIRE

Patient Name: _____ Date: _____

1.) Do you have Diabetes? YES or NO If you answered NO, **STOP**, do not continue

2.) How long ago did the doctor tell you that you have Diabetes? _____

3.) Are you insulin dependent? YES or NO

4.) What are your daily activities? _____

5.) Do you have foot pain? YES or NO

If yes, please explain: _____

6.) Do you currently have or in the past have you had?

Callus YES or NO

Ulcers YES or NO

Toe Amputations YES or NO

7.) Do you have or has your doctor told you that you have any loss of feeling in your feet?

YES or NO If yes, how long? _____

8.) Do you or has your doctor told you that you have circulation problems?

YES or NO If yes, how long? _____

9.) Have you ever worn foot orthotics or received diabetic shoes in the past? YES or NO

10.) If you answered yes on the last question, have you ever had an allergic reaction to any materials used? YES or NO

If YES, please explain in detail what materials were used and what reaction you had:

_____

_____

11.) What are your goals and expectations for us? _____

_____

_____

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