Welcome!

Thank you for choosing Kitsap Podiatry for all your feel-better foot & ankle needs! We are honored by your choice and are looking forward to helping your feet feel healthy and able again. Below is a description of what you can expect when visiting our clinic.

YOUR APPOINTMENTS:

When you come to your appointment, please come prepared. It is important to always carry your insurance cards. We may not need to see them every visit, but if we do need to see them, you should have them with you. If you are not sure how much your co pay is, or if you even have one, please check with your insurance company prior to your appointment. When checking in, you will be expected to pay your co pay before services are rendered.

CANCELING OR RESCHEDULING APPOINTMENTS:

We require 24 hours notice for cancellations, and re-scheduling appointments. We understand that life happens, so, if you need to cancel or reschedule at the last minute, please call us immediately. However, if we notice any patient habitually canceling or rescheduling, we reserve the right to charge you for that appointment time, and it will be billed directly to you, not your insurance.

OUR SERVICES:

Kitsap Podiatry provides a wide variety of treatments in our office. Some of our treatments and over the counter can be billed to your insurance carrier, such as x-rays, and specialty boots/braces. However, you should also know that most insurance companies are very strict to the types of over-the-counter products that can be billed. Some items that the doctor may feel will improve your symptoms, simply do not come with codes to bill the insurance carrier. It is these items that you will be responsible for at the time of your appointment. The price of these items can range from $0.50-$550.00. You should come to each appointment with this in mind. For greater priced items, you may speak to the office manager about arranging a payment plan with a down payment. If you have any questions, do not hesitate to ask what any specific item may cost. Our staff is here to assist you in any way possible.

ADDITIONAL INFORMATION:

If at any time you have a question for a medical assistant, or about a prescription, feel free to leave them a voicemail message. They check their messages often and will return your call as soon as they are prepared to answer your questions. For prescriptions refills, please allow 24-48 hours.

Our billing department and office manager are also available by voicemail. Please be sure to leave as much information as possible, and they will call you as soon as they are able.

We welcome your word-of-mouth referrals! If you like our work, please tell your friends, family, and co-workers! We would love to help them enjoy the most out of life!

- Your Kitsap Podiatry Staff

Your Responsibilities

1. Arrive at your appointment on time.
2. To give 24 hours prior notice to cancel or reschedule an appointment.
3. To make sure you have your prior authorization in place before you come to your appointment.

Take an active part in your healthcare and understand that your lifestyle does affect your health.

- Provide accurate and complete information about present complaints, past illnesses, hospitalizations, living wills, durable power of attorney, and any other matters that relate to your healthcare.
- Provide a valid and active phone number and address, so we can reach you.
- Ask the doctor all the questions you want or need answered. If you do not fully understand what is being said, it is your right to ask them to explain it to you more clearly.
- Follow the agreed upon treatment plan. If for any reason you are unable to follow the plan, it is your responsibility to inform your doctor of this and to work with him/her to find a plan that will work.

Working with staff members

- *Treat our staff with Consideration, Respect and Dignity.*
- *Be patient and understanding while staff is assisting other patients.*
- *Be polite.* At no time is it acceptable for a patient, their friends, or family members to use foul language, make inappropriate comments or threats, or commit acts of violence against any staff member, either in the clinic or while speaking on the phone with them.

Observe facility safety rules and regulations for the consideration of all patients and staff:

- At no time should visitors be lying on the floor, climbing on the furniture, tearing up books and magazines, throwing items, taking up more than 1 chair per person, leaving a mess in the waiting room, or aggravating other patients.
- Out of consideration to the other patients, we ask that you keep your speaking voice to a normal talking level, and that there be no shouting or screaming by anyone. Remember that we cannot ensure your privacy in the waiting room area. We ask that you step out in the hall if you take a phone call.
- We gladly provide crayons, coloring pages, and a limited number of books to help keep children entertained.

Calling your Doctor's Assistant and/or getting Prescription refills.

- Non-emergent messages can be left on the appropriate voicemail box as directed by our phone system. Please make sure you give us an active phone number where you can be reached at any time of the day, and/or a number where we can leave a recorded message.
- Phone calls received from 8:00am to 3:30pm will be returned by the end of the same day. For calls received after 3:30pm every effort will be made to return your call on the same day ***if possible***, or by the next morning, on the following day of business.
- A minimum of 2 business days, **advanced notice** is required for prescription refills.

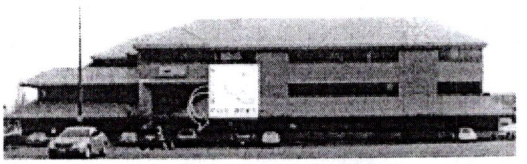
Insurance Information:

1. Provide a copy of your current insurance cards at the time of your appointment & notify the office of any changes.
2. Pay your co-pay at the time of your appointment and keep your receipts.
3. Know your insurance coverage and benefits and contact your insurance company if you disagree with their payment decisions. Promptly complete and return any forms your insurance company sends you.

We thank you for the time you took to read our policies and look forward to providing your care.

KITSA PODIATRY
Foot & Ankle Specialists

10049 Kitsap Mall Blvd SW Suite 109, Silverdale WA 98383| tel: (360) 698 - 2505



DRIVING SOUTH

1. Go South on HWY 3 to Silverdale
2. Take **EXIT 45 SILVERDALE/RTE 303/WAAGA WAY**
3. Continue West, then South on 303 as the road becomes Kitsap Mall Blvd NW
4. **Proceed 0.4 mile**
5. Turn **right at Hobby Lobby** and look for our building to your left

DRIVING NORTH

1. Go North on HWY 3 to Silverdale
2. Take **Exit 45A Clear Creek Road/Silverdale**
3. Turn **right** at the end of the exit ramp onto Kitsap Mall Blvd NW
4. **Proceed 0.4 mile**
5. Turn **right at Hobby Lobby** and look for our building to your left

DRIVING FROM EAST BREMERTON

1. Proceed **North on HWY 303**, several miles North of Bremerton HWY 303 shifts to a western direction, continue on HWY 303
2. Just after the intersection with HWY 3, **go left on Kitsap Mall Blvd NW**
3. **Proceed 0.4 mile**
4. Turn **right at Hobby Lobby** and look for our building to your left

KITSA PODIATRY
Foot & Ankle Specialists

Thuy Le, DPM
Geoffrey Linn, DPM
Gregory Hanks, DPM
Usman Khokhar, DPM

Silverdale Office: 360-698-2505
10049 Kitsap Mall Blvd, NW Ste 109
Silverdale, WA 98383
Sequim Office: 360-683-0164
543 Eureka Way
Sequim, WA 98382
Bremerton Office: 360-373-1772
710 Lebo Blvd
Bremerton, WA 98310

PATIENT DEMOGRAPHICS		
Today's Date:	Date of Birth:	Patient Age:
Last Name:	First Name:	MI:
Social Security Number: *This is especially important if you have Tricare or VA insurance, it is needed for billing*		
Preferred Name:	Sex: _____ Male ____ Female ____ Other	
Language:	Race:	Ethnic group: ___Hispanic ___non-Hispanic
Phone Number: ___Home ___Mobile	Alternate Phone Number: ___Home ___Mobile	
Mailing Address:		
Billing Address if different:		
Email Address:		
Employment status:	Employer and Phone #	
Emergency Contact Information: Name:	Phone Number:	
Advanced Care Directive: please provide a copy (ex: POLST, DNR, POA, Living Will, Legal Guardian) Location of documents:	Power of Attorney or surrogate decision maker: First name: Last Name: POA Phone #:	
***Are you currently in a Skilled Nursing Facility, Adult Family Home, Assisted Living or Hospice *** _____ Yes _____ No Facility Name:	Date of Admission:	

PRIMARY CARE DOCTOR AND REFERRING DOCTOR	
Who is your Primary Care Doctor?	
Were you referred to our office? _____Yes, _____No If yes, who is the referring Doctor?	
Preferred Pharmcy and City it is located:	
PRIMARY AND SECONDAY INSURANCE	
Do you have health insurance? _____Yes _____No	
Insurance Name:	
Policy Number:	
Are you the Policy holder? ____ Yes, _____No	
If not, patient's relationship to policy holder? _____Spouse ____Child ____Other	
Policy Holders First Name:	Last Name:
Policy Holders Date of Birth: *Social Security # is for Billing purposes*	Policy Holders Social Security Number:
SECONDARY INSURANCE	
Insurance Name:	
Policy Number:	
Are you the Policy holder? ____ Yes, _____No	
If not, patient's relationship to policy holder? _____Spouse ____Child ____Other	
Policy Holders First Name:	Last Name:
Policy Holders Date of Birth: *Social Security # is for Billing purposes*	Policy Holders Social Security Number:
People Authorized to receive health care information: (ex: spouse, children, parent)	**Relation to you**
Name and Phone Number:	
Name and Phone Number:	
Signature	Date

Medical History- Patient Information	
Today's Date:	
Patient Name:	Patient DOB:
ALLERGIES AND REACTION	**____ NO KNOWN DRUG ALLERGIES**

MEDICATIONS		
MEDICATION	DOSAGE	FREQUENCY

Are you on blood thinners? _____ Yes _____ No Type:

VITAMINS/HERBS/SUPPLEMENTS		
NAME	DOSAGE	FREQUENCY

MEDICAL HISTORY- CONTINUED (PLEASE CHECK ALL THAT APPLY)

☐ Anemia ☐ Atrial fibrillation ☐ Calf/ thigh pain when walking ☐ Heart Attack ☐ Heart trouble ☐ High blood pressure ☐ Poor circulation ☐ Swelling/Phlebitis ☐ Blood clots/DVT/PE ☐ Pacemaker ☐ Stroke ☐ Vein problems ☐ Chronic Obstructive lung disease ☐ Chronic Kidney Disease ☐ Epilepsy ☐ Gastroesophageal reflux disease ☐ Glaucoma ☐ Sleep Apnea ☐ Seizures ☐ Gout	☐ Anxiety Disorder ☐ Depression ☐ Edema ☐ Covid-19 ☐ Hearing loss ☐ Hemophilia ☐ Peripheral Vascular Disease ☐ HIV/Aids ☐ Hypercholesterolemia ☐ Hyperlipidemia ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Peripheral Neuropathy ☐ Leukemia ☐ Cancer ☐ Parkinsons Disease ☐ PTSD ☐ Rheumatoid Arthritis ☐ Arthritis ☐ Weight Loss/Gain

Additional Family History: (Immediate Family, i.e. Parents, Siblings)

Do you have Diabetes? ____ Yes ____No if yes, Last A1c: Date taken:
AM Glucose #:

PREVIOUS ILLNESS/INJURY/SURGERY/PROCEDURES THAT REQUIRED HOSPITAL CARE

ILLNESS/ SURGERY/ INJURY/ PROCEDURE	YEAR

SOCIAL HISTORY

Alcohol usage: ____Occasional _____ Daily _____History of abuse

Caffeine use: ___ Yes ____No If yes, how many cups per day? _____
(ex: Coffee, Tea, Soda, Energy drink)

Drug Dependency? _____ Cannabis Use? _____ THC? _____ CBD? _____

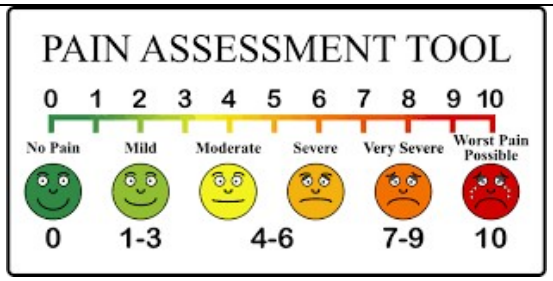
Tobacco Usage: _____ Currently _____ Previously _____ Never

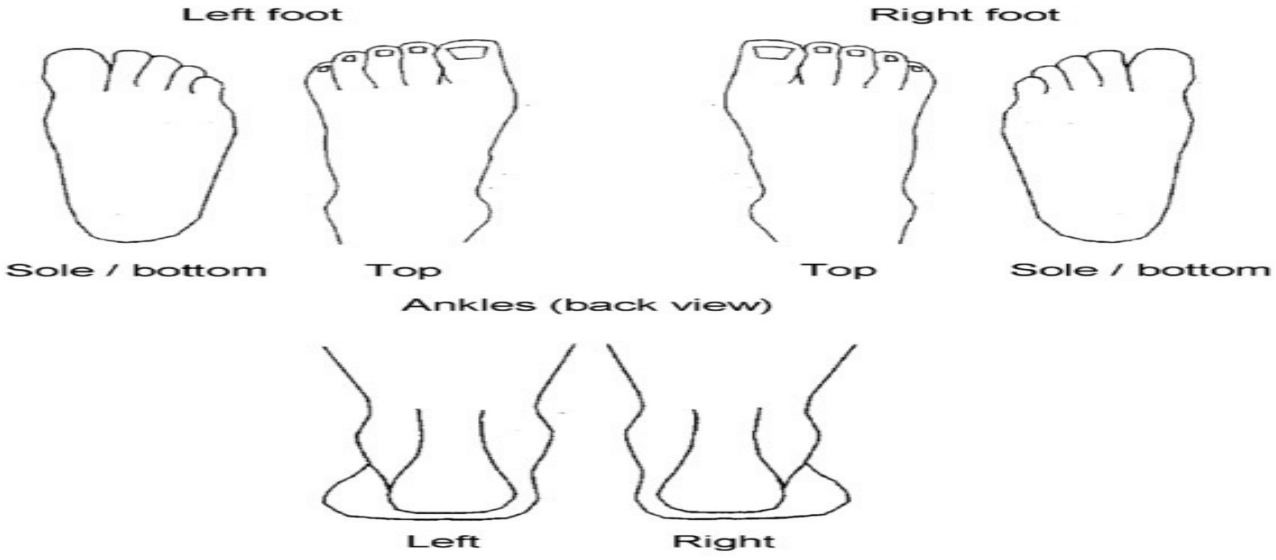
Vaping: _____Currently _____Previously _____ Never Smokeless Tabacco? _____ Yes _____No

Do you have pets? _____ Yes _____No If yes, what kind?

Have you had exposure to chemicals, toxins or heavy metals? _____Yes ____No

Do you feel safe at home? _____ Yes _____No

Do you live alone? _____ Yes _____ No		
Do you use: Cane _____ Walker _____ Wheelchair _____		
Have you fallen in the last year? _____ Yes _____No		
Do you feel unsteady on your feet? _____Yes _____ No		
Have you broken any bones as an adult? _____Yes _____No		
VACCINATIONS		
Flu Vaccine _____ Yes _____ No	Date:	
Covid Vaccine _____ Yes _____No	Date:	
Pneumonia Vaccine _____Yes _____No	Date:	
Height (Ft, In)	**Weight (lbs.)**	**Shoe Size:**
PLEASE DESCIBE FOOT PROBLEM	_____Left _____ Right _____ Both	
Current foot or ankle problem, and how long has it been hurting?		
What makes it better?		
What makes it worse?		
Previous Treatment? By whom and where? Using the Sale on the right, please indicate pain levels while weightbearing _____ and non-weightbearing _____		



Consent For Treatment and Financial Policy

Financial Policy:

- I Authorize Kitsap Podiatry to bill my insurance carrier(s). I acknowledge that I am responsible for all charges for services provided, including any amount not paid by my healthcare plan(s). I certify that the information I have provided regarding my insurance coverage is accurate to the best of my knowledge.
- I am not receiving DSHS medical assistance, and I agree to pay for the services rendered. If I later become eligible for DSHS medical assistance, I agree to notify the billing office.
- I am not participating in an HMO/Managed care plan and if I become retroactively covered, I acknowledge that an authorization for services may not be approved for services already received. I understand that if services are not covered, I am ultimately and financially responsible for billed charges.
- I authorize Kitsap Podiatry, the physicians, and the staff to release medical and other information to the necessary insurance companies, third party payers, and/or other healthcare entities required to participate in my care.
- I understand that it is my responsibility to provide Kitsap Podiatry with accurate and updated insurance information and provide copies of all insurance cards, as well as keep updated address and contact information current to ensure accurate receipt for statements.
- I will provide payment for all balances owed in a timely manner.
- I understand that copays are due at the time of service. I acknowledge that Kitsap Podiatry accepts major credit cards and checks. In the event of a NSF check, I will be charged a fee of $45.00.

Referrals/ Authorizations:

- Referrals and authorizations are not a guarantee of payment. I am responsible for any balances classified 'Patient Responsibility' by my insurance company. Any dispute with claim processing is between me and my insurance company.
- I understand that I am ultimately responsible for ensuring that my Primary Care Provider (PCP) has provided Kitsap Podiatry with a referral and/or prior authorization should one be needed.
- I authorize Kitsap Podiatry as a courtesy to obtain prior authorizations required by my insurance, for services that they provide.

Consent for Treatment:

- I hereby consent to treatment by Kitsap Podiatry.
- I understand that photographs, x-rays, and digital images will be used to document my care, and I consent to this. I understand that Kitsap Podiatry will retain ownership rights to these images, but I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time required by law. I understand that images identifying me will only be released and/or used outside Kitsap Podiatry only upon written authorization from me or my legal representative.
- I authorize Kitsap Podiatry personnel to communicate with me by phone, mail, answering machine message, and/or email according to the information that I have provided on my initial intake.
- I authorize Kitsap Podiatry to obtain my prescription history as needed to keep an accurate record of medications being taken.

By signing below, I acknowledge that I have a clear understanding of my financial responsibility, and I consent to be medically treated by Kitsap Podiatry.

_____ _____

Patient/ Guardian/ Legal Representative Signature **Date**

***A copy of Kitsap Podiatry's Notice of Privacy practices can be found in the lobby area.**