NORTHWEST PODIATRY CENTER

G.C. BRYNICZKA, DPM A.W. BRYNICZKA, DPM D.W. O'BRIAN, DPM B.ALI, DPM S. PESENKO, DPM S. J. LUU, DPM

WELCOME: Thank you for choosing Northwest Podiatry Center for your foot care needs. Below are questions to help us get better acquainted and provide information vital to your health. Please feel free to discuss matters of a private nature with the doctor. This information will be kept confidential.

Please fill out both sides of this form in its entirety.

PATIENT INFORMATION

Name: Last _____ First _____ M.I. _____

Address:_____ City:_____ ST:_____ Zip:_____-_____

Birthdate: _____ Age:_____ SSN#:_____ *Please check* ✓ □ MALE □ FEMALE

Home Phone _____ Cell Phone _____ May We Text Information to You? *Please check* ✓ □ YES □ NO

Email Address: _____ May We Email Information to You? *Please check* ✓ □ YES □ NO

WOULD YOU LIKE TO BE ADDED TO THE PATIENT PORTAL? □ YES □ NO (VALID EMAIL ADDRESS REQUIRED)**

Race:_____ Ethnicity:_____ Decline to Specify □ Height:_____ Weight:_____ Shoe Size :_____

Marital Status: □ Single □ Married □ Widowed □ Separated □ Divorced

Employer:_____ Employer's Address:_____ Employer's Phone Number: _____

Is there another person you would like us to release medical information to: Name: Last _____First_ _____

Relationship to Patient:_____ Cell Phone _____

IF THE PATIENT IS A MINOR, PLEASE FILL THIS BOX OUT

Father's Name: Last_____ First _____ M.I. _____ Mother's Name: Last _____First _____M.I_____

Father's DOB: _____ Cell _____ Mother's DOB: _____

Fathers Address:_____ Mother's Address: _____

City:_____ ST:_____ Zip:_____ City:_____ ST:_____ Zip:_____

Fathers Employer Information: _____
Employer Name, Address and Phone Number

Mother's Employer Information: _____
Employer Name, Address and Phone Number

INSURANCE INFORMATION

In order to file your claim, we need the insurance information below filled out.

Is this a Work-Related Incident? *Please check* ✓ □ YES □ NO (Please see our Worker's Compensation Form)

Your Primary Insurance Company : _____ ID #_____ GROUP #_____

Name of Insured _____ Relationship to Patient _____

Policy Holders Date of Birth _____ Policy Holders SSN _____ CO-PAY: *Please check* ✓ □ YES □ NO Amount:$ _____

Do you have a Secondary Insurance Company *Please check* ✓ □ YES □ NO

Name of Secondary Insurance Company:_____ ID #_____ GROUP #_____

Name of Secondary Insurance Policy Holder_____ Relationship to Patient _____

Secondary Insurance Policy Holders Date of Birth _____ Policy Holders SSN _____

OFFICE VISIT INFORMATION

What Brings you to the office today? _____

How Long has it bothered you? *Please check* ✓ □ Days □ Weeks □ Months □ Years Other:_____

Any problems in the past with your ankles or feet? *Please check* ✓ □ Yes □ No Please Describe: _____

How did you hear about us? □ Facebook □ Google □ Insurance □ Patient □ Doctor (please list below) □ Relative _____ □ Other:_____

MEDICAL INFORMATION **Please fill out both sides of this form in its entirety**

Primary Care Physician Information ****ALL Medicare or Medicare Advantage patients are required to fill out your PCP information****

Primary Doctor Name: Last _____ First_____ Date of Your Last Visit: _____

Address: _____ Phone # _____ Fax # _____

Would you like your medical notes sent to your primary care physician? *Please check* ✓ □ YES □ NO

Pharmacy Information

Pharmacy Name: _____ Address:_____ Phone: _____

Emergency Contact Information:

Name: _____ Phone : _____

Medications:

Are you taking any medications? *Please check* ✓ □ YES □ NO *If yes, please fill in below or provide a list of medications. Extra paper is available if needed.*

Name of Medication(s)	Dosage	Name of Medication(s)	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies

Do you have any allergies? *Please check* ✓ □ No Known Drug Allergies □ YES (If yes, please list) Allergies: _____

Allergies cont.: _____

Medical History:

Do you have, or have you had any of the following: (*please check* ✓*if yes*)

Angina □	Emphysema □	Osteoporosis □	Sleep Apnea □
Anemia □	Fibromyalgia □	Peripheral Vascular Disease □	Thyroid Disease □
Asthma □	Heart Issues □	Pneumonia □	Tuberculosis □
Back Problems □	Hernia □	Polio □	Liver Disease □
Bronchitis □	HIV/Aids □	Recent Cold or Flu □	Jaundice □
Cancer □ _____	Irregular Heartbeat □	Rheumatic Fever □	GERD □
Cardiac Disease □	Kidney Disease □	Rheumatoid Arthritis □	Other □ (please list below)
COPD □	Obesity □	Stroke □	_____
Diabetes □	Osteoarthritis □		_____

Surgical History:

Please list any surgical procedures you have had below: *Extra paper available if needed**

Procedure: _____ Date: _____
Procedure: _____ Date: _____
Procedure: _____ Date: _____
Procedure: _____ Date: _____

Do you have any artificial joints? *Please check* ✓ □ YES □ NO Do you have a heart valve implant? *Please check* ✓ □ YES □ NO

Family History

Father: _____
Mother: _____
Brother(s):_____
Sister(s): _____

Social History

Do you currently smoke? YES NO (*please circle*) If YES, how much? (*Please check* ✓) ½ Pack Per Day _____ 1 Pack Per Day _____ Other _____

Are you a former smoker? YES NO (*please circle*) If YES, when did you quit smoking? _____

Alcohol Consumption: *Please check* ✓ None_____ Socially _____ 1 Drink per day_____ 2 or more drinks per day _____

Do you use recreational drugs? YES NO (*please circle)*

PATIENT SIGNATURE:_____ **DATE:**_____

GUARDIAN SIGNATURE:_____ **RELATIONSHIP: □ MOTHER □ FATHER □ OTHER** _____

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Patient Consent for Text Message Communication (Including Limited PHI)

Purpose of This Consent

Northwest Podiatry Center offers the option to communicate with you via text message (SMS) to enhance convenience and efficiency in managing your care. These messages may include limited protected health information (PHI). By signing this form, you authorize Northwest Podiatry Center to send you text messages for purposes including, but not limited to:

- Appointment confirmations, reminders, or schedule changes
- Billing and insurance communications, including balance notifications
- General office updates or requests to contact our office
- Limited care coordination messages (e.g., "Your lab results are ready — please call the office")

Important Information and Acknowledgments

1. **Privacy and Security Risks:** I understand that text messaging is not a fully secure form of communication. Messages may not be encrypted and could be intercepted, misdirected, or read by unauthorized persons. I accept these risks and consent to receive text messages that may contain limited PHI.
2. **Content Limitations:** Northwest Podiatry Center will not send detailed medical information, diagnostic results, or sensitive health data (e.g., mental health, substance use, sexual health, or genetic information) by text.
3. **Revocation of Consent:** I may withdraw this consent at any time by replying "STOP" to any text message or notifying the office in writing. Revocation will not affect communications sent before the revocation was received.
4. **Carrier Charges:** Standard message and data rates may apply depending on my mobile service plan.
5. **Record Keeping:** Text messages related to my care may be retained as part of my medical record in accordance with HIPAA regulations.
6. **Alternate Communication:** I understand I am **not** required to consent to text messaging to receive care. Alternate communication options (such as phone calls or patient portal messages) are available upon request.

Patient Authorization

By signing below, I acknowledge that I have read and understand the information above. I consent to receive text messages from Northwest Podiatry Center and authorize the use of limited PHI in these messages as described.

Patient Name: _____

Date of Birth: _____

Mobile Number: _____

Signature: _____ Date: _____

Staff Initials: _____| Date Entered: _____

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Credit Card on File Agreement

I authorize, Northwest Podiatry Center, to keep my credit/debit card safely encrypted on file and to charge my card for any outstanding balances that my healthcare plan has identified as my financial responsibility. This authorization relates to all charges not covered by my insurance for services provided to me by Northwest Podiatry Center. This authorization will remain in effect for one year. I understand I have the right to revoke this authorization at any time. If the provided credit/debit card on file has changed, expired or denied for any reason, I agree to immediately give Northwest Podiatry Center a new, valid credit/debit card which I will allow to be charged over the phone. I agree that the new card will be used with the same authorization as the original card I presented.

Patient's name:_____
DOB:_____

□ Please keep my credit card on file and charge my account to pay for charges not paid by my insurance plan.

Charge limits: Balances exceeding $1000.00 require verbal authorization from me. Charges under this amount require no further authorization.

Patient/Guardian signature:_____
Date:_____

Credit Card Information

Card Type: Amex Visa Mastercard Discover

Is this a Flexible Spending/Health Savings card? Yes No

Card number ending in (last 4 digits): _____ Expires: _____

Cardholder Name:
_____

Card's bill to address:
_____

City: _____ State: _____ Zip:
_____

Phone Number: _____

Transaction Type: AUTHORIZATION

Email receipt to: _____@_____ or □ Mail Receipt

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Credit Card on File Policy

Northwest Podiatry Center is implementing a credit card on file policy to streamline our billing and payment system and to provide a seamless, convenient way for patients to pay their bills. Recent changes in healthcare markets and payment processes have altered insurance coverages to shift more of the cost of care to our patients. The credit card on file policy is a convenient method to pay for your portion of services that are deemed the patient's responsibility, such as but not limited to, co-payments, deductible and/or co-insurance. Please note, co-payments are still due at the time of your visit.

Frequently Asked Questions about the Credit Card on File Agreement

How does this work? At check-in, you will be asked to sign a credit card on file agreement. As part of the agreement, you will be able to set a maximum to be charged to your card. Charges that exceed this maximum require verbal authorization from the card holder prior to processing payments. At check-out fees due at the time of service will be paid using the card on file unless you elect to pay by an alternative method.

What are the benefits to me? You can use your credit card on file to pay co-payments, co-insurance and deductibles at future visits. It will make the check-in and checkout process easier, faster and more efficient.

How much and when will money be taken from my account? Once your insurance company has processed your claim, we will send you a statement(s) noting the patient or guarantor's responsibility. You will have 30 days to send an alternative form of payment if you prefer. If no alternative payment is received after 60 days, the patient's financial responsibility amount will be processed.

What if there is a payment discrepancy or I have other payment questions? Please contact our billing department directly to settle payment discrepancies or for other payment questions. This policy in no way compromises your ability to dispute a charge or question your insurance company's explanation of benefits.

Will I still receive a paper statement by mail (or electronically if I prefer)? Yes. You will receive statements in the mail (or electronically if preferred).

What if I cannot pay the balance in full? Please contact the billing department immediately to discuss your balance.