OREGON FOOT CLINIC

**TODAY'S DATE:**_____

**PATIENT** First Name _____ Middle _____Last _____

**PREFFERED** Name_____ Birthdate (**DOB**) _____ Age _____ Sex _____

**Street** _____City _____State _____ **Zip** _____

Mailing if Different _____City _____State _____ Zip _____

**Cell** Phone _____ **Home** Phone *(if different from cell)*_____

*Can we leave a message identifying your name and our clinic at your home? Y / N*

**EMAIL** _____ (Provider sends email/text messages for appointment reminders)

Social Security # _____ (Circle: Spouse / Partner /Parent) _____

Employer (self) _____ Work Phone _____

Responsible Party _____ Billing Address _____

**REFERRED by** _____ ❒Google ❒Yelp ❒Instagram ❒Facebook ❒Other_____

In case of **Emergency / Next of Kin**, notify_____ Phone # (___)_____ Relationship _____

## PCP Primary Care Provider: _____

Phone #: _____Fax # (if known) _____ Last Visit Date: _____

## PHARMACY: (LOCATION) _____

Phone #: _____Fax # (if known) _____

**This office does not handle**
**Workers' compensation, Motor Vehicle Accidents or Third-party Liabilities**

## **INSURANCE** INFORMATION:

| **Primary :** | **Secondary:** |
|---|---|
| ID: | ID: |
| Subscriber (if different from patient): | Subscriber (if different from patient): |

### ❒ No Insurance

### Patient Consent for Authorization and Treatment:

I hereby authorize Oregon Foot Clinic to furnish information to insurance carriers concerning my illness and treatment and I hereby assign to Oregon Foot Clinic all payments for medical services rendered to myself or my dependents. I am aware that **it is my obligation to know my insurance company's policies,** whether I need a referral or authorization prior to treatment, if the company is in net-work, and that I am responsible for payment and for all non-covered services.

If requested, I will be provided a copy of the Notice of Privacy Practices and I have read or had the opportunity to read and I understand.

**Consent for Treatment:** I hereby request and voluntarily consent to such office care, including routine diagnostic procedures and medical treatment as may be deemed necessary by Oregon Foot Clinic, Inc. and its designees.

**Signature** _____**Print:**_____ **Date** _____

OREGON FOOT CLINIC

**TODAY'S DATE:_____**

## PATIENT HISTORY FORM

Patient Name: _____ Date of birth: _____ *Weight* _____ *Height* _____

*Foot-related problem you are here for today: Right/Left* _____

*Doctors who have seen you for this condition*_____

### Post Medical History and System Review

| | | | |
|---|---|---|---|
| **ALLERGIES. Please List…** | | Y | N |
| Have you been under the care of a physician during the past 6 months? For what condition? | | Y | N |
| **Foot Ailments, Please check off:** | | Y | N |
| ❒ athletes foot ❒ corns/calluses ❒ ingrown nails ❒ warts ❒ varicose veins ❒ ulcer | | Y | N |
| ❒ bunions ❒ fungus ❒ hammertoes ❒ ankle pain ❒ flat feet | | Y | N |
| Have you had any serious illnesses, operations, surgeries? Please list… | | Y | N |
| Do you smoke? How much? | | Y | N |
| Consume alcohol? How much? | | Y | N |
| Do you have regular moderate exercise? How much? | | Y | N |

### Do you have a family history of:

(**Mother**): ❒ Rheumatoid Arthritis ❒ Diabetes ❒ Heart Disease ❒ High Blood Pressure ❒ Coronary Artery Disease
❒ Thyroid Disease ❒ Cancer ❒ Stroke ❒ High Cholesterol ❒ Vascular Disease ❒ Other _____

(**Father**): ❒ Rheumatoid Arthritis ❒ Diabetes ❒ Heart Disease ❒ High Blood Pressure ❒ Coronary Artery Disease
❒ Thyroid Disease ❒ Cancer ❒ Stroke ❒ High Cholesterol ❒ Vascular Disease ❒ Other _____

(**Relative**): ❒ Rheumatoid Arthritis ❒ Diabetes ❒ Heart Disease ❒ High Blood Pressure ❒ Coronary Artery Disease
❒ Thyroid Disease ❒ Cancer ❒ Stroke ❒ High Cholesterol ❒ Vascular Disease ❒ Other _____

### Please check off if you had any problems with or are presently experiencing any of the following:

| | | | |
|---|---|---|---|
| ❒ High Blood Pressure | ❒ Asthma / Wheezing | ❒ Blood in Stool | ❒ Arthritis |
| ❒ Diabetes | ❒ Ulcers | ❒ Low Back Problems | ❒ Cancer |
| ❒ Pneumonia | ❒ GI Problems | ❒ Skin Diseases | ❒ Neuropathy or Tingling |
| ❒ Heart Disease / Heart Attack | ❒ Persistent Cough | ❒ HIV/AIDS | ❒ Blood Disorders/Clotting |
| ❒ Chest Pain / Tightness | ❒ Weight Gain/Loss | ❒ Anxiety / Racing Heart | ❒ Hay Fever |
| ❒ Palpitations | ❒ Depression | ❒ Shortness of Breath | ❒ Abdominal Discomfort |
| ❒ T.B. | ❒ Anemia | ❒ Swollen Ankles | ❒ Leg Cramps |
| ❒ Hepatitis or Jaundice | ❒ Alcohol or Drug Abuse | ❒ Neck or Back Pain | ❒ Nausea / Vomiting |
| ❒ Thyroid Disease | ❒ Stroke/TIA | ❒ Light-headedness / Fainting | ❒ Fever / Chills |
| ❒ Headache | ❒ Gout | ❒ Skin Rash | ❒ Constipation |
| ❒ Kidney Disease | ❒ Joint Pain | ❒ Blood Thinner | ❒ Kidney Stones |
| ❒ Vision Problems | ❒ Water pills | ❒ Liver Disease | ❒ Other _____ |

What **medications** are you presently taking? _____

_____

Any other information we need to know? _____

**MEDICATION HISTORY AUTHORIZATION**: By signing below, I authorize Oregon Foot Clinic to have access to my Medication History.

**Signature** _____**Print:**_____ **Date** _____

OREGON FOOT CLINIC

**TODAY'S DATE:_____**

## PATIENT AGREEMENT:

**The following is a statement of our Financial Policy which we ask that you read carefully and sign.**

AUTHORIZATION FOR TREATMENT & RELEASE OF MEDICAL INFORMATION: For any insurance plan that requires authorization from a primary care physician (e.g. HMO, PPO, OHP, etc.) it is your responsibility as the patient or guardian to be sure that this office receives all necessary referrals or authorizations PRIOR to treatment. Professional services are rendered and billed directly to your insurance carrier; however, you the patient or guardian are directly responsible for services rendered by the doctor. A health insurance policy is a contract between you, the patient or subscriber and your insurance carrier. If for any reason the insurance carrier denies charges, payment for any serves rendered will become the responsibility of the patient. We are not responsible for negotiating a settlement on a disputed claim or denial.

REFFERALS & DEDUCTIBLES/COPAYS: If your insurance requires a referral from your primary care physician, this needs to be completed prior to being seen. The responsibility for the referral is between you and your primary care physician. If for any reason your insurance and/or primary care physician does not authorize your visit, payment for services rendered by Oregon Foot Clinic will be your responsibility. If you have any doubt about your referral, please contact your primary care physician's office. You are responsible for payment to Oregon Foot Clinic all copays and deductibles.

MEDICARE PATIENTS: Oregon Foot Clinic is a participating Medicare provider. Medicare will be billed and upon receipt of payment, we will bill any secondary insurance, if the information is provided. If the secondary payment is not received in 60 days, a bill will be sent to you. Amounts that Medicare assigns as patient responsibility will be billed to you. If you receive payment from a secondary it is your responsibility to forward that payment to our office.

NON-COVERED SERVICES WAIVER/NOTICE OF FINANCIAL LIABILITY: I accept full financial liability for all items or services which are determined by my health care service plan not to be covered. Services not specified as being covered in the patient's contract, charges that occur because of missing referrals, deductibles, copays, coinsurance, or because the patient is considered out of network. I understand and agree that it is my responsibility and obligation to obtain a referral if required, and to follow up with my Primary Care Physician Referral Department to be sure my referral has been sent in a timely manner.

OUTSTANDING BALANCES: Again, it is your responsibility to follow up with the insurance company to ensure we receive payment timely. There is a **$35 fee for bounced, returned or cancelled checks**. Outstanding balances not paid within 61 days may result in further collections actions. If you have any question regarding your bill, please contact our Patient Accounts Office at (503) 255-8100. If any information regarding your account changes our office needs to be updated as soon as possible; this includes address changes, new insurance information, new PCP, etc.

By signing below, I authorize the release of any medical or other information necessary to process my insurance claim(s). I also authorize payment of my insurance and/or Government Benefits be made directly to Oregon Foot Clinic which include but not limited to Kevin Driscoll, D.P.M., Thomas Palmer, D.P.M. whom accept assignments for services rendered as outlined above.

**Signature** _____**Print:**_____ **Date** _____

**NEW & ESTABLISHED PATIENTS:** You are required to provide your insurance identification card (to include the billing address and phone number) at the time of your first visit. If you have an HMO or PPO insurance with a co-payment requirement, you will need to make the co-payment at the time of service before you are seen by the doctor. There is a **$25.00** fee if we have to send a bill for your co-pay. If you do not have proof of insurance, you will be required to pay at the time of service. When proof of insurance can be provided, you will be reimbursed. If you have a secondary insurance and would like us to bill this for you, we require all information to do this. Signature below authorizes the release of any medical or other information necessary to bill insurance and authorizes payment to Oregon Foot Clinic.

MISSED APPOINTMENTS / CANCELLATION AND NO SHOW POLICY: In the event that you are unable to keep your appointment at our office, we must be **notified 24 hours prior to your appointment**. If we do not receive notification of your cancelation, there will be a charge of **$50.00** for any missed appointment. You may not be rescheduled and dismissed from Oregon Foot Clinic. *If you are 15 minutes past your scheduled time, we reserve the right to reschedule your appointment.*

**Signature** _____**Print:**_____ **Date** _____

## NOTICE OF HEALTH PRIVACY PRACTICES:

**I acknowledge that I have been offered and understand Oregon Foot Clinic's NOTICE OF PRIVACY PRACTICES. This notice describes how we use/disclose your healthcare information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected information. I understand that this Notice of Privacy Practices is available should I wish to take one home with me.**

**Persons with authorization to have access to my medical records:**

_____

**Signature** _____**Print:**_____ **Date** _____

OREGON FOOT CLINIC

**TODAY'S DATE:_____**

**PLEASE READ CAREFULLY**

| **CDC FACILITIES COVID-19 SCREENING**<br>Accessible version available at https://www.cdc.gov/screening | | |
|---|---|---|
| **PLEASE READ ALL SYMPTOMS** | **PLEASE CIRCLE** | |
| Have you experienced any of the following symptoms in the past 48 hours:<br>• fever or chills<br>• cough<br>• shortness of breath or difficulty breathing<br>• fatigue<br>• muscle or body aches<br>• headache<br>• new loss of taste or smell<br>• sore throat<br>• congestion or runny nose<br>• nausea or vomiting<br>• diarrhea | **YES** | **NO** |
| Within the past 14 days, have you been in close physical contact (6 feet or closer for at least 15 minutes) with a person who is known to have laboratory-confirmed COVID-19 or with anyone who has any symptoms consistent with COVID-19? | **YES** | **NO** |
| Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19? | **YES** | **NO** |
| Are you currently waiting on the results of a COVID-19 test? | **YES** | **NO** |

**Signature** _____**Print:**_____ **Date** _____

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**FOR OFFICE USE ONLY**

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____

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