OREGON FOOT CLINIC

TODAY'S DATE: _____

PATIENT First Name _____ Middle _____Last _____

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

PREVIOUS Name(s)_____ Race/Ethnicity _____ Gender Identity _____

Language(s) *Primary*_____ *Secondary*_____ ***Interpreter requested for primary language? Y / N***

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, co-pays, deductibles, co-insurance,** 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*_____

Medical History Review _____ **Shoe Size:** _____

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

Fill out family history:

(**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 _____

Medications you presently taking (Name, Dosage (mg, ml, & # of times a day, for how long), Type (tablet, capsule, liquid)?
Please write on back of page if you need more space: _____

_____

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 which include but are not limited to and may be subject to deductibles, copays or patient responsibility amounts are: *Office visits (which are evaluations and examinations only), treatments, routine foot care, tests, injections, surgeries or procedures which may be considered surgical under your insurance policy, x-rays, labs, and Durable Medical Equipment (DME) or other services*, are all rendered and billed directly to your insurance carrier. You the patient or guardian, are directly responsible for services rendered by the doctor. *Any product or DME sold or given to patient is non-refundable, non-transferrable and cannot be returned.* 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 must be completed prior to being seen. The responsibility and obligation for the referral and follow up 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, including copays and deductibles, will be your responsibility. If you have any doubt about your referral, please contact your Primary Care Physician's office. ***MEDICARE PATIENTS:** We are a participating Medicare provider. Medicare will be billed and upon receipt of payment, we will bill any secondary insurance as 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, which are not limited to but may include 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. With no less than five (5) business days' notice, we will complete third-party forms that might be requested by your employer under the Oregon Family Leave Act (OFLA) and/or the federal Family and Medical Leave Act (FMLA) or by your disability insurance provider. **The charge is $25 per form set and $10 per form change.**

OUTSTANDING BALANCES: 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 Kevin Driscoll DPM, LLC dba Oregon Foot Clinic which include employed and contracted providers whom accept assignments at Oregon Foot Clinic for services rendered as outlined above.

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

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

NEW & ESTABLISHED PATIENTS: You must arrive no later than 15 minutes before your appointment and intake forms must be filled out by the time of your appointment or you will not be seen. 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 or tertiary insurance and would like us to bill this for you, we require all information prior to appointment. 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. *For established patients if you are 15 minutes past your scheduled time, we reserve the right to reschedule your appointment.*

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

OREGON FOOT CLINIC

TODAY'S 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 Name(s) & Phone #(s) if none write "none":**
  _____

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

(For Patient Reference/Copy can be provided)

Services that may or may not be non-covered by insurances.

This is a typical list and may not include all services and procedures that may or may not be rendered as covered services as classified by your insurance and specific insurance plan. These services may or may not be subject to deductibles or apply to deductibles, which typically restart at the beginning of the year.

- **At Risk Foot Care (Previously known as routine foot care)**
  - **Nail trimming, cutting, clipping or debridement of nails**
  - **Treatment of corns and callouses**
- **Cortisone injections**
- **Cyst drainage**
- **Bunion surgery**
- **Hammer toe surgery**
- **Plastic surgery**
- **Flat feet**
- **DME: Orthotics, shoes, boots**

You may wish to contact your insurance carrier prior to any treatment to understand your insurance's policies and coverage. This statement does not qualify for any waiver of patient responsibilities for services rendered not listed, albeit this is to help and create greater informed patients.