OREGON FOOT CLINIC

Patient Intake Forms & Financial Policy Agreement

TODAY'S DATE: _____

DEMOGRAPHIC INFORMATION: **Read carefully and Sign** **(Please fill out all three 3 pages)**

***Legal First Name**	***Middle Name**	***Last Name**

PREFFERED Name	Age	Sex

*Birthdate (**DOB**)	Social Security #	Gender Identity

Race/Ethnicity	**PREFERRED Language**	**Interpreter requested? Y / N**

Address	**City**	**State**	**Zip**

Emergency / Next of Kin Name	**Emergency Phone**	**Relationship**

Home #	**Work #**	***Cell #**

Preferred Phone #? _____ ***Can we leave a message with your name and our clinic at home/cell? Y / N***

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

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

If patient is a minor, Responsible Party Name	**Relationship to Patient**	**Phone #**

Primary Care Provider Name)PCP)	**Phone #**	**Fax #**	**Last Visit Date**
PHARMACY Name	**Location:**	**Phone #**	**Fax #**

INSURANCE INFORMATION: ❒ **No Insurance**

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

The information above is true to the best of my knowledge acknowledged by signing below:

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

OREGON FOOT CLINIC

TODAY'S DATE: _____

Patient First/Last Name: _____ **Date of birth:** _____ ***Weight*** _____ ***Height*** _____

PATIENT HISTORY FORM

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

FAMILY history: (**Relative Please Specify Who"**) _____

❒ 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 INITIALLING, I authorize Oregon Foot Clinic access to my Medication History.

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** _____

Please Read carefully and Sign.

TODAY'S DATE: _____

PATIENT CONSENT & AUTHORIZATION FOR TREATMENT

Initial _____ 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. If you have more than one (1) insurance policy, you must notify us of your designated PRIMARY policy.

Initial _____ 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.** A deposit may be required for surgical procedures at your preo-operative appointment or before services rendered. 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 date of services rendered, we will bill secondary insurance as provided, if payment is not received from insurance within 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 payment to our office.

Initial _____ NON-COVERED SERVICES WAIVER & NOTICE OF FINANCIAL LIABILITY: **I am aware that it is my obligation to know if I am in network with a provider and my insurance company's policies, co-pays, deductibles, co-insurance and payment to Oregon Foot Clinic and 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; you may have out of network rates that you will be billed at.

Initial _____ THIRD-PARTY FORMS: 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 or PLO) 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.**

Initial _____ 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 paid over 61 days may result in collections actions and incur a billing **fee of 25%** which will be added to the balance. Account balances **over $500** agree to keep a credit card/debit card on file for payment or approved payment plans. If you have questions 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 or within 48 hours prior to appointment; this includes medical information, address changes, new insurance information, new PCP, etc.**

Initial _____ NEW & ESTABLISHED PATIENTS: **You must arrive 15 minutes before your appointment, insurance card(s) and photo identification as well as Intake Forms must be filled out prior to the time of your appointment or you will not be seen.** Please have photo identification available and provide your insurance identification card (including billing address and phone number) at the time of your first check-in. 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 co-pay has to be billed. If you do not have proof of insurance, you will be required to pay at the time of service. When proof of insurance is verified, 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. Demographic information is required to be updated at the beginning of every year.

Initial _____ MISSED APPOINTMENTS / CANCELLATION & NO SHOW POLICY: Please be on time, tardiness or missing appointments hurts your care and takes away from other patients' available time. If you are unable to keep your appointment, we must be **notified 24 HRS 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 be dismissed from Oregon Foot Clinic for repeat cancels/no shows, not maintaining a "Good Faith" status, or non-compliance and we will transfer of care to another practice. *For established patients if you are 10 minutes past your scheduled time, we reserve the right to reschedule your appointment.*

* **By signing below**, **I voluntarily consent to such care described above as deemed necessary by Oregon Foot Clinic and its designees.** I hereby authorize the release and furnishing of any medical services, my illnesses and medical treatment or other information necessary to process my insurance claim(s) to my insurance carriers. 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 to myself or my dependents.

Initial _____ *** Patient requested and received financial policy copy ☐ Y / ☐ N.**

- **Print Patient First/Last Name: _____**

- **Signature Patient/Guardian: _____ 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.