



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

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

PREFERRED 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: \_\_\_\_\_

Patient First/Last Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

#### 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: \_\_\_\_\_



**TODAY'S DATE:** \_\_\_\_\_

**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:** \_\_\_\_\_

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

**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:**

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

Initial \_\_\_\_\_ **MEDICATION HISTORY AUTHORIZATION:** By INITIALLING, I authorize Oregon Foot Clinic access to my Medication History.

**PATIENT CONSENT & AUTHORIZATION OF HEALTH INFORMATION DOCUMENTATION**

Initial \_\_\_\_\_ **Charting Scribe / AI / Dictation Consent:** Oregon Foot Clinic uses a scribe, AI technology, and/or voice recording tools during patient visits to help with charting and documentation. These tools are used securely and follow privacy laws.

Initial \_\_\_\_\_ **Photo/Video Consent:** I authorize Oregon Foot Clinic to take photos/videos of my lower extremities during evaluation, treatment, or surgery for documentation and marketing or educational use. My name, face, or any identifiable marks (such as tattoos or scars) will be removed or obscured. I may revoke this permission in writing at any time.



**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 services 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  *I understand that a diagnostic evaluation or office exam is separate from treatments, laboratory testing, or imaging. If treatment is recommended during my visit, it will be explained to me and performed with my consent. Insurance coverage varies by plan, and I may be responsible for applicable copays, deductibles, or coinsurance for services provided. Because treatment needs are often determined after the exam, advance benefit verification or cost estimates are not required for routine same-day, in-office procedures and treatments under the No Surprises Act.*

Initial  **REFERRED, 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 or cancellation fee of at least \$350 may be required for surgical procedures at your pre-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 **notify us 24 HRS prior to your appointment. If we do not receive notification of your cancellation, you will incur a charge of \$50.00 for office appointments & \$100 for In-office or Outpatient surgeries.** 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.**



**TODAY'S DATE:** \_\_\_\_\_

\* **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: \_\_\_\_\_

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(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.