# Welcome to Northwest Foot & Ankle

** The information on this form is necessary for our office to obtain prior to your initial office visit. If this form is not competed in its entirety, you will be delayed in seeing the doctor until the form is complete. Please write on the back if more room is needed. Thank you for your cooperation.

## PATIENT INFORMATION: Please complete ALL of the following entries!

Today's Date:_____ Patient Name:_____

Date of Birth:_____ Age:_____ ☐ Male ☐ Female ☐ Other

Home Phone:_____ Cell/Mobile Phone:_____ Email Address:_____

Address:_____ City, State, Zip:_____

Insurance Provider:_____

- Patients insured under Medicare will NOT be reimbursed for visits.
- We cannot see patients who are insured by Oregon Health Plan (OHP), CareOregon, Healthshare Oregon, FamilyShare, Tricare, Medicaid or those who have Auto Accident coverage.

Employer:_____ Occupation:_____ Work Phone:_____

Emergency Contact:_____

Relationship:_____ Emergency Contact Phone:_____

Primary Care Physician:_____ Phone:_____

Address:_____ Date last seen by PCP:_____

Pharmacy:_____ Pharmacy Phone:_____

How did you find out about us/Who may we thank for referring you to our office?_____

May we contact you via email for feedback, updates and newsletters? ☐ Yes ☐ No

## PATIENT COMPLAINTS: Check ALL that apply

☐ Headaches ☐ Right foot ☐ Left foot ☐ Corns ☐ Flat feet ☐ Calluses ☐ Pain in heels

☐ Soft corns ☐ Back aches ☐ Thick nails ☐ Warts ☐ Knee pain ☐ Ankle sprains ☐ Bunions

☐ Ingrown toe nail ☐ Leg cramping ☐ Feet cramping ☐ Other _____

Please explain your current foot or ankle problem:_____

When did the problem start?_____

What has been done to treat the problem?_____

Is this injury work related? How?_____

Do we have your permission to send imaging results to your PCP or referring medical provider?_____

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## PA TIENT HEALTH INFORMATION:

Weight: _____ Height: _____

Shoe Size: _____ Width: _____

How is your general health? Good ☐ Fair ☐ Poor ☐

| | Yes | No |
|---|---|---|
| Do you have a history of low back pain? | ☐ | ☐ |
| Are you regularly tired and exhausted? | ☐ | ☐ |
| At work, do you spend more than 30% of your time on your feet? | ☐ | ☐ |
| Did anyon e in your family (mother, father, grandparents) have similar foot problems? | ☐ | ☐ |
| Have you been treated by a doctor in the past 2 years? | ☐ | ☐ |
| Are you subject to prolonged bleeding? | ☐ | ☐ |
| Is there a family history of diabetes? | ☐ | ☐ |
| Do you smoke cigarettes? | ☐ | ☐ |
| If yes, how many per day? _____ | | |
| Have you ever fainted in a doctor's or dentist's office? | ☐ | ☐ |
| Have you had previous care by a podiatrist? | ☐ | ☐ |
| Date last seen: _____ | | |
| Dr's Name: _____ | | |
| Is your current pain/injury keeping you from regular activities? | ☐ | ☐ |

Have you ever been treated for any of the following?

☐ Epilepsy/Seizures ☐ Gout ☐ Heart Disease
☐ Stomach ulcer ☐ Stroke or Heart Attack
☐ Phlebitis ☐ Diabetes ☐ Anemia
☐ Kidney Bladder ☐ Difficulty in healing
☐ Liver Disease ☐ Rheumatic fever
☐ Thyroid Disease ☐ Tuberculosis
☐ Shortness of breath ☐ High/low blood pressure
☐ Depression or Anxiety ☐ Accident/Injury
☐ Vascular/Circulatory Disease ☐ Cancer
☐ Immune Disease (HIV, AIDS, Hepatitis ☐A, ☐B, ☐C)

Have you experienced any ill effects from any of the following?

☐ Penicillin ☐ Aspirin ☐ Cortisone
☐ Sulfa Drugs ☐ Novacain ☐ Tape
☐ Codeine ☐ Any antibiotics
☐ Latex ☐ Peanuts

Others, please list: _____

Are you allergic to any medications?

If yes, please list ALL: _____

SERIOUS ILLNESSES:

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

SURGERIES and HOSPITALIZATIONS:

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

MEDICATIONS/Vitamins, Supplements, and over-the-counter products such as Advil, Tylenol, etc. (include dosage of each):

This section is important…Please do not skip!! *If a list is available, please give to the receptionist in order for us to make a copy for your records.

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____
7. _____ 8. _____ 9. _____

For Office Use ONLY

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# Office Policy

**We do not bill Insurance Companies or 3rd Party Injuries. We will not be bound by what Insurance Companies may request.

## BILLING POLICY:

-The fees charged are standardized and based on a relative value scale that takes into account the time, skills and professional component required for each visit and procedure. They are comparable to fees charged in this and neighboring communities by other competent physicians. An estimate for the charge of any procedure will be given when requested.

-We accept **Visa, MasterCard, AMEX, Debit, Check, or Cash.**
-PATIENTS ARE REQUIRED TO PAY IN FULL AT THE TIME OF SERVICE
-If you have insurance that pays out-of-network, we will provide you with the needed information (superbill) so that you can send it into your insurance company so they can reimburse you.
-A $25.00 fee plus any bank fee charges will be charged to your account for all returned checks.
-A fee of $15.00 will be collected from the patient prior to doctor filling out any forms.
(example: disability, Private forms, Time Loss, etc.)
-If for some reason you have an amount due on your account it is considered delinquent 30 days from the date of service. At the discretion of the office manager, all accounts 60 days are delinquent and will be referred to an outside collection agency. A $50.00 fee will be charged if the account is placed with an outside agency.
We will be unable to see you until the account is paid in full.

## APPOINTMENTS:

-We do not call to remind patients of their appointment. Please be sure to mark your calendar to remind yourself of your appointment. (see cancellation policy below)

## CANCELLATION POLICY:

-You **must** notify the office **24 business hours prior** to your scheduled appointment if you need to cancel or reschedule. **Failure to do so will result in forfeiture of your deposit.**

**Deposit amounts: $150 for new patients, $75 for a returns visit, and $60 for a remote consultation.**

**Please note we are a sports medicine teaching clinic and may have medical students, medical residents, and doctors observing our doctors in the patient room.**

## RETURN POLICY:

- Unless otherwise noted, products can be returned or exchanged within 30 days of purchase (in original condition and original packaging).
- Charges for patient services, procedures, custom-made orthotics and other custom-made accessories are non-refundable and non-exchangeable.

I understand and agree that I am responsible for payments to Northwest Foot & Ankle for charges to my account. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, I agree to pay for all costs and expenses including reasonable attorney fees.

_____ _____

**Signature** **Date**

Effective 09/20/18

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# Acknowledgment of Receipt

I, _____ ,have been notified of the Notice of Use of Private Health Information from Northwest Foot & Ankle, posted in the office and offered a copy for my records, in accordance with The Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule") established by The U.S. Department of Health and Human Services to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I have also been given the opportunity to have any questions regarding this notice answered by my health care provider or staff, as well as the appropriate contact information to the Office of Civil Rights.

_____ _____

Signature of Recipient Date

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