EUGENE
FOOT & ANKLE
PODIATRIC PHYSICIANS & SURGEONS

Patient Information

Date_____
Name_____
Address_____
City_____State_____Zip_____
Home Phone_____
Cell Phone_____
Work Phone_____
E-Mail_____
Male/ Female/transgender Age_____DOB_____
Employer_____
Occupation_____
Family Doctor_____
Pharmacy_____

☐ Married ☐ Widow ☐ Single
☐ Separated ☐ Divorced ☐ Partner

In Case of Emergency, Contact:
Name_____
Relationship_____
Phone Number_____

How did you hear about Eugene Foot and Ankle?

☐ Eugenefootandankle.com ☐ 3 Best Rated
☐ Google Search ☐ Newspaper
☐ Facebook ☐ Yellow pages
☐ Referral from:_____ ☐ Other:_____
☐ Yelp

Treatment Consent

I hereby consent and give permission to the Doctor (and Doctor's assistant or designated replacement) to evaluate me as the Doctor deems necessary.

_____
Signature of Beneficiary, Guardian, Or Representative

_____
Print name

_____
Date

Primary Insurance

Subscriber's Name_____
Subscriber's DOB_____
Relationship to patient_____
Insurance Co._____

Secondary Insurance

Subscriber's Name_____
Subscriber's DOB_____
Relationship to patient_____
Insurance Co._____

Insurance Assignment and Release

I certify that I have insurance coverage and assign Eugene Foot and Ankle all insurance benefits if any otherwise payable to me for the services provided. I understand that I am financially responsible for all charges including the cost of Collection Agency fees, whether my insurance company pays or not.

I hereby authorize Eugene Foot and Ankle to release all necessary information to secure payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____
Signature of Beneficiary, Guardian, Or Representative

Medicare/Medigap Authorization

I request that payment of authorized Medicare-Medigap benefits, be made either to me on my behalf to Eugene Foot and Ankle for any services furnished to me by the provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers of Medicare and Medicaid services my Medigap Insurer, and their agents any information needed to determine these benefits or benefits for related services

_____
Signature of Beneficiary, Guardian, Or Representative

What is the chief complaint for which you came to be treated? (include foot, ankle, knee, thigh and hip complaints)

_____

_____

Athletic Activities in which you participate:
What?_____
How often?_____

Podiatric History

Please indicate which foot problems you have:

- ☐ Ankle pain
- ☐ Athlete's foot
- ☐ Bunions
- ☐ Corns/calluses
- ☐ Fungal nails
- ☐ Numbness in feet/legs
- ☐ Flat feet
- ☐ Foot or leg cramps
- ☐ Heel pain
- ☐ Ingrown toenails
- ☐ Plantar warts
- ☐ Swelling in feet/ankles
- ☐ Tired feet

Height _____Weight_____
Do you take birth control? Yes / No
Have you ever been to podiatrist before? YES / NO
If yes please list:
Name_____
Last visit_____
If you are Diabetic, what was your last:
AM Blood Sugar_____HgA1c_____

Review of Systems, Please **circle** all that apply:

1) heart burn, hepatitis nausea/vomiting, blood in stool, liver disease
2) Thyroid disease , Heat or cold intolerance
3) Weight loss , Loss of appetite
4) Blurred Vision, Double vision or Vision Loss
5) Hearing loss, hoarseness, trouble swallowing
6) Chest pain, Palpitations
7) Chronic cough, Shortness of breath
8) Painful urination, blood in urine, Kidney problems, Dialysis
9) Frequent rashes, Skin ulcers, psoriasis, lumps
10) headaches, dizziness, seizures
11) Sleep disorder, depression, drug/alcohol addiction
12) Easy bleeding, easy bruising, anemia

☐ **NONE OF THE ABOVE**

HIV positive? YES / NO HEPATITIS C positive? YES / NO
MRSA history past or current YES / NO Year_____

Your Past Medical History, Please **circle** all that apply:

Anemia
Gout
Cancer:_____
Diabetes
Seizures
Stroke
AIDS
Rheumatoid Arthritis
Stomach Ulcers
Osteoarthritis
High Blood Pressure
High Cholesterol
Other:_____
_____

Dementia/Alzheimer's
Autism/On Spectrum
Fibromyalgia
Chronic Back Pain
Bleeding Disorder
Heart Condition:_____
Irregular Heart Beat
Heart Attack
Asthma/Emphysema
Blood Clots
Pulmonary Embolism
Sleep Apnea
Kidney Disease/transplant
Thyroid disease

List any surgical procedures with year surgery was performed starting with most recent_____

_____

Have you ever had any issues with anesthesia? YES / NO If yes, please explain_____

Do you smoke tobacco? Current / Former / Never
If yes, how much?_____
For how long?_____
Do you use drugs recreational or other? YES/ NO if yes,
What Drug?_____
How often?_____
Do you drink alcohol? YES / NO
How often?_____
Do you use any of the following (circle)?
CANE / WALKER / WHEELCHAIR / BRACE

Is there any Family History of:

- ☐ DVT/ Blood clot
  WHO?_____
- ☐ Diabetes
- ☐ Cancer
- ☐ High Blood Pressure
- ☐ CAD
- ☐ Heart Attack
- ☐ Stroke
- ☐ Other_____
  _____

Allergies? YES / NO Please List:_____

_____

Current Medications: Please provide a medication list from your primary care provider.

1._____ 2._____ 3._____ 4._____

Are you currently taking any anticoagulants? YES / NO (circle)

Warfarin Coumadin Xarelto Aspirin Eliquis Heparin Plavix Pradaxa

Are you on a Pain Contract? YES / NO Pain Doctor:_____

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Electronic Consent Form

Declaration

I consent to the practice contacting me by text message or email for the purpose for appointment reminders.

I acknowledge that appointment reminders by text or email are a courtesy and that the responsibility of attending or canceling appointments still rests with me. I can cancel the text, automated calls and email reminders at any time.

Texts, automated calls and emails are generated using a secure facility. I understand that they are transmitting over a public network onto a personal device that may not be secure. However the practice will not transmit any information that would enable an individual patient to be identified. I would like to receive:

- ☐ Text messages to_____
- ☐ Email messages to _____
- ☐ Automated reminder call to _____

I agree to advise the practice if my mobile number or email changes or if it is no longer in my possession.

Patient Name: (please print) _____

Signature: _____

Starting February 1st 2020 ALL reminders will be done through text, email or automated call.

Eugene Foot and Ankle
1680 Chambers St. Suite 201 Eugene, OR 97402
(541) 683-3351 office (541) 683-6440 fax

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Release of Information and HIPAA Privacy Policy

Release of information: I authorize the following persons or entities to communicate with Eugene Foot and Ankle Health Center regarding my medical records (Lab results, imaging results, care, billing information, etc). If only authorizing particular categories of medical information to be released, please specify below.

Patient Name:_____ DOB:_____

Name (person to release info to)	Type of information to be released
SELF	ALL
_____	_____
_____	_____
_____	_____
_____	_____

Patient/Guardian Signature	Date
_____	_____

If fifteen or older, patient must authorize access to the above mentioned information.

HIPAA Privacy Policy:

I acknowledge that I was notified of the Notice of Privacy Practices and that I have had the opportunity to read it, if I choose, or be provided a copy of it.

Patient/Responsible Party: _____ Date: _____

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Financial Policy

Thank you for choosing our clinic. We are committed to your treatment being successful, as you, the patient, are our first and foremost concern. As part of our services, we try to contain the cost of health care. In an effort to do this, we have implemented a financial policy. The following is a statement of said policy which we request you read and sign prior to any treatment to avoid any misunderstandings. Please contact us if you have any questions about our policies.

Insurance: We are contracted providers for most of the major insurance plans. On your behalf we will bill your insurance company to determine insurance vs. patient responsibility. Providing accurate billing information including the presence of your insurance card will be needed at time of care and will Insure more timely claims submission. Being a provider for your insurance does not mean that your insurance will pay for the services provided. It is imperative that any necessary referral authorization paperwork is provided to us by your primary care physician if a referral or prior authorization is required by your insurance.
No insurance: If you are uninsured or the doctor is not a participating provider with your insurance *plan,* please be prepared to fully cover the fees for each visit at the time of treatment,
Payment: Payments for co-payments, and non-covered services are due at the time of the visit with all forms of payments including cash, checks, Visa or MasterCard accepted. There will be a $50.00 charge for returned checks. Delinquent accounts will be turned over to collections at the discretion of the billing administrator.
Co-payments: Please be prepared to **pay your co-payment at the time of your visit**. Copay amount: $_____
Deductibles: If you have an annual deductible which has not yet been paid in full by the time of your visit, then any charges incurred up to that amount will be your responsibility. What is your deductible if known? $_____
Minor patients: The adult or the parent (custodial guardian) accompanying a minor is responsible for payment of services. Unaccompanied minors will be denied unless prior authorization from the parent or guardian has been made for the charges and treatment. Young adults (age 18 & over) are legally responsible for their accounts unless a parent accompanies them to the initial appointment and signs this financial agreement, regardless of insurance coverage.
Missed Appointments: If it is necessary to cancel, please call our office 24 hours in advance. This allows us to accommodate for our other patients. **We reserve the right to charge a $50.00 fee for missed appointments or late cancellations if you fail to call or not show up for your initial appointment** If you call 24 hours before your appointment, you will be given the opportunity to reschedule. Failure to appear without prior cancellation for three consecutive visits will result in discharge from our practice.
Orthotics: Orthotics can be a non-covered service by some insurance plans. Please check with your insurance company prior to the scanning for orthotics to determine your orthotic benefits. A $125 deposit is due at the time of casting whether insurance will be billed or paying cash pay for the service. Cash pay patient balances will be due at pick up.
Supplies: For your convenience we make some supplies available for purchase in the office. If you chose to purchase these items, payment is due upon purchase. We are unable to bill for these items. We will be happy to provide receipts for any items that are purchased in the office for your record keeping.

I have read and agree to the terms set forth in the above financial policy. I am financially responsible for any balance due.

Signature: _____ Date:_____

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