Thank you for selecting our clinic to provide for your foot and ankle medical needs. In order to make your first appointment as comfortable and convenient as possible for you, *PLEASE READ PRIOR TO YOUR FIRST APPOINTMENT.*

Please bring the following to the office with you at the time of your appointment:

- Insurance card
- Photo Identification
- Names of your other doctors
- Completed patient history packet
- Signed Financial Policy
- Recent medical records or x-rays will be helpful and may save you time and charges if you are seeking a second opinion or transferring your care.
- Co-pays, if applicable, are due at time of service.

When to arrive: If you have not completed your paperwork, please arrive 15 minutes prior to your appointment to complete any forms. We strive to stay on schedule. New patients may require as much as much as 60 minutes for their initial evaluation, depending on their condition.

DUE TO THE NATURE OF THIS SURGICAL PRACTICE, YOU MAY EXPERIENCE DELAYS DUE TO EMERGENT SITUATIONS THAT ARE BEYOND OUR CONTROL.

IF YOU HAVE TIME CONSTRAINTS YOU MAY WANT TO CALL AHEAD TO CHECK TO SEE IF YOU MAY HAVE A DELAY:

Broadway Foot Clinic (503)-282-8777
Hillsboro Foot Clinic (503) 648-2200

FINANCIAL POLICY

We Accept Visa and Mastercard

Welcome To Our Office

Thank you for choosing our physicians and staff to provide for your foot and ankle needs. We are committed to your treatment being successful, as you, the patient, are our first and foremost concern. As part of our service, 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 our **FINANCIAL POLICY** which we request you read and sign prior to any treatment. To avoid any misunderstandings, please contact us should you have any questions about our policies, services or fees.

INSURANCE: If your doctor is a participating provider with your insurance plan, we will submit the claim to your insurance company for you. To do this we must have *complete and accurate* insurance information and a copy of your insurance card or claim form. Your insurance policy is a contract between you and your insurance company; therefore you are responsible for payment whether or not your insurance company pays. **It is your responsibility to contact your insurance company regarding *participating provider status, pre-authorizations, obtaining required referrals, second opinions, etc*.** Failure to do so may reduce the amount of benefits paid by your insurance, and the balance will then become your responsibility to pay. All co-payments must be paid at the time of service. In order to prevent insurance fraud, we request a copy of your photo identification. If you will not allow us to copy your photo ID, please be prepared to show your identification at every visit.

NO INSURANCE: If you do not have insurance or if 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 the balance due and co-payments are due at the time of service and may be made by *cash, check or credit card* (Visa, MasterCard). There will be a $25.00 charge for *returned checks. Delinquent accounts* will be assigned to a collection agency and will incur a $50.00 collection charge. Please call our office immediately if you are unable to pay your balance in full.

CO-PAYMENTS: Please be prepared to pay all co-payments at the time of service. Co-Payments are the amount an insured person is expected to pay for a medical expense at the time of the visit. Co-payments are a personal responsibility and have been determined by your contract with your insurance company.

DEDUCTIBLES: Many insurance companies have annual deductibles. A deductible is the amount you must pay toward a claim before your insurance begins to pay. The amount is a contract between you and your insurance company. It is your responsibility to pay for services that have been applied to the deductible. We encouraged you to contact your insurance company prior to your visit to determine the amount remaining to satisfy your deductible expense.

MINOR PATIENTS: The adult or the parent (custodial guardian) accompanying a minor is responsible for payment of services. For unaccompanied minors, non-emergency treatment 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: Please help us serve you better by keeping scheduled appointments. If it is necessary to cancel, please call our office 24 hours in advance. This allows us to provide treatment to our other patients. We reserve the right to charge $35.00 for missed appointments.

ORTHOTICS: Orthotics are a non-covered service by some insurance plans. Please check with your insurance company *prior* to the examination and casting for orthotics to determine your orthotic benefits. A deposit of $125.00 is requested at the time of the examination and casting and full payment is due when the orthotics are dispensed.

SUPPLIES: For your convenience we make some supplies available for purchase in the office. If you choose to purchase these items, payment is due at the time of purchase. We cannot bill for these items.

Please complete the following items:

What is your co-payment per visit: $________
What is your insurance annual deductible: $ ________ How much of the deductible is current (not yet paid): $_________
(if you are not sure what your current (not yet paid) deductible is, please call your insurance company prior to your visit.)

Please be prepared to pay your co-payment at the time of your visit

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

SIGNED____ **DATE**_______________________

PATIENT REGISTRATION

Patient Information

Patient Name: Last | First | M.I. | □ M □ F

By what name to you preferred to be addressed? | Single Married Widowed Other

Patient's Address:

City | State | Zip

Home Phone: | Daytime Contact Phone: | Cell phone:

Social Security #: | DOB: | Age:

Employer: | Occupation:

Emergency Contact: | Phone#:

Insurance

Name of insured (if other than self) | Member Number:

Name of insured's employer: | Insured's work phone number:

Patient is: □ Subscriber □ Spouse □ Partner □ Dependent

We request a copy of your photo identification to protect our patients and our clinic from insurance fraud.
We are required to have a copy of your insurance card(s) on file in order to bill your insurance for you.
If we do not have this information on file, you will be billed directly and are solely responsible for all charges.
Payment is due at the time of service.

Workers Compensation

Date of Injury: | Type of Injury: □Work □ Auto □ Other

Has a claim been filed? □ Yes □ No Claim#: | Where was claim filed?

Cause of injury:

Referral

Referred By:

Primary Care Physician and Clinic Name | Phone #:

If you were not referred how did you find out about our office? □ Yellow Pages □ Web Page □ Other:

Signature

Release of Benefits Information :

I authorize my insurance benefits to be paid directly to the doctor. I understand that the doctors office will bill my insurance as a courtesy and that I am responsible for all co-payments, deductibles and non-covered services. I authorize the release of information required to process my claims. (If not signed payment in full is due at time of service)

ALL CO-PAYMENTS DUE ON DAY OF SERVICE.

Patient Signature: ____Date:________________

Medical History - Confidential Information

Lower Extremity Medical History

What is the chief complaint(s) which brings you to our office for medical treatment ?
(Include foot, ankle, leg, knee and hip complaints)

____
____
____
____

Former foot and ankle physician:
Name:______________________________________

Last visit:__________________________________

Any previous injuries or problems to the feet, ankles or legs?

____

Symptoms

Which Side: ☐Right ☐Left ☐Both

Type of Pain: ☐Dull ☐Achy ☐Throbbing
☐Burning ☐Sharp ☐Shooting

Area of Pain:__________________________________

Onset: ☐ Slow ☐ Sudden ☐ Traumatic

Duration:_____________________________________

Has pain gotten: ☐Better ☐Worse ☐Stayed the Same

What aggravates condition? ☐ walking ☐ running
☐ standing ☐shoes

What have you tried to help the pain? ☐ Changing shoes
☐anti-inflammatories ☐ decrease activities
Other:____

How long does pain last?________________________

Have you ever had a similar pain? (describe, including treatments received)

____

Runners Only

How long have you been running?

____

Mileage:_______miles per ☐ wk ☐ month

Allergies and Drug Intolerance

☐ Adhesive/Tape ☐ Aspirin
☐ Codeine ☐ Iodine
☐ Local Anesthetics ☐ Penicillin
☐ Seafoods ☐ Sulfa
☐ No known drug allergies ☐ ________________

Medications

List all medications you are taking:

____
____
____
____
____
____
____
____
____

General

What is your weight:_______________

What is your height: _______________

What is your shoe size:______________

Mental / Emotional

☐ yes ☐ no Eating Disorder
☐ yes ☐ no Anxiety
☐ yes ☐ no Depression
☐ yes ☐ no Psychiatric
☐ yes ☐ no Alcoholism

Surgeries, Injuries, Illnesses

List surgeries, serious injuries, and illnesses not previously listed:

____
____
____
____
____

Social History

Do you smoke? ☐ yes ☐ no

Are you a past smoker? ☐ yes ☐ no

How Much?____packs/ _____.
Years Smoked:_________

Drink Alcohol?: ☐ yes ☐ no
How Much:___________

Recreational Drugs? ☐ yes ☐ no
What:____________

Pregnant or possibly pregnant? ☐ yes ☐ no

Athletic Activities in which you participate:

____

General Medical History

Mark “yes” or “no” to indicate if you or a family member have any of the following:

Personal		Condition	Family Member
☐ yes	☐ no	Anemia	
☐ yes	☐ no	Arthritis: Type:_________	☐ yes
☐ yes	☐ no	Artificial Heart Valve or Joints	
☐ yes	☐ no	Asthma	☐ yes
☐ yes	☐ no	Back Problems	☐ yes
☐ yes	☐ no	Bleed easily	☐ yes
☐ yes	☐ no	Cancer	☐ yes
☐ yes	☐ no	Chemical Dependency	☐ yes
☐ yes	☐ no	Chest Pain	☐ yes
☐ yes	☐ no	Circulatory Problems	☐ yes
☐ yes	☐ no	Diabetes	☐ yes
☐ yes	☐ no	Epilepsy	☐ yes
☐ yes	☐ no	Fibromyalgia	☐ yes
☐ yes	☐ no	Gout	☐ yes
☐ yes	☐ no	Heart Disease	☐ yes
☐ yes	☐ no	Hemophilia	☐ yes
☐ yes	☐ no	Hepatitis	
☐ yes	☐ no	High Blood Pressure	☐ yes
☐ yes	☐ no	HIV Positive	
☐ yes	☐ no	Kidney Problems	☐ yes
☐ yes	☐ no	Leg Cramps	
☐ yes	☐ no	Liver Disease	☐ yes
☐ yes	☐ no	Lung/Respiratory	☐ yes
☐ yes	☐ no	Menopause	
☐ yes	☐ no	Mental Illness	☐ yes
☐ yes	☐ no	Phlebitis / Clots	☐ yes
☐ yes	☐ no	Psoraisis	☐ yes
☐ yes	☐ no	Rheumatic Fever	
☐ yes	☐ no	Stroke	☐ yes
☐ yes	☐ no	Thyroid Problems	
☐ yes	☐ no	Tuberculosis	
☐ yes	☐ no	Ulcers—Stomach	
☐ yes	☐ no	Venereal Disease	
☐ yes	☐ no	Weight Change, Recent. _____lbs	

Hillsboro Foot and Ankle Clinic
862 SE Oak St, Suite 1A
Hillsboro, OR, 97123

Broadway Foot & Ankle Clinic
3508 NE Broadway St.
Portland, OR 97232

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

We keep a record of the health care services we provide you in your medical record. If you would like to obtain a copy of your medical records, a fee of $0.50 per page will be charged and is due upon receipt. Our office has up to 30 days to respond to the request.

A report of your visit today will be sent to your referring physician unless you requested otherwise.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or have been given the opportunity to read if I so chose) and understood the Notice.

______________________________________ ________________________
Patient Name (please print) Date

____
Parent or Authorized Representative (if applicable)

____
Signature

This form will be retained in your medical record.