Willamette Foot Center
Robert C. Stevens, DPM
Podiatric Physician & Surgeon
4305 River Road N, Keizer, OR 97303
Phone: (503) 363-0763 Fax: (503) 363-8154

Dear _____

Thank you for making an appointment with Willamette Foot Center. We would like to take this opportunity to welcome you to our clinic. We are committed to providing excellent medical care in a compassionate and caring environment. You are scheduled to see:

Dr. Robert C. Stevens on:

_____ At _____ (Check in 10 minutes before)

For your convenience, and to minimize waiting time in our office we have enclosed forms to be completed prior to your visit.

Please bring the following with you to your appointment:

- Enclosed forms completed
- Photo ID and Insurance cards
- Co-pay or Co-Insurance
- **All medications and doses including any over-the-counter** supplements (use separate sheet of paper, if needed).

During your visit, please feel free to ask questions or share any concerns you may have. Your healthcare is a partnership and we are counting on you to take an active role. This includes freely discussing symptoms as well as leading a healthy lifestyle.

Willamette Foot Center requests that new patients arrive 10 minutes prior to the first appointment with your paperwork completely filled out. If you miss your new patient appointment without any notice, we will be unable to establish your care at our clinic.

Once you are an established patient, if you miss 3 appointments in a consecutive 12 month period without notice, you may be discharged from the clinic. We require at least 24 hours advanced notice if you find you are unable to keep your scheduled appointment

If you have any questions, please do not hesitate to call our office.

Sincerely,

Willamette Foot Center

Patient Name:	**Responsible Party Name:**
Mailing Address (Street)	Mailing Address (Street, City, Zip Code)
City Zip code	
Home Phone Number Email	Employer
SSN DOB Gender	SSN DOB Gender
Primary Insurance:	**Secondary Insurance:**
Card Holder Name DOB	Card Holder Name DOB
Subscriber I.D. # Group #	Subscriber I.D. # Group #
Patient Relationship to Card Holder	Patient Relationship to Card Holder

Emergency Contact Name:_____ Contact Number:_____
Relationship:_____

Marital Status

Married Single Divorced Widowed Partnered Minor

Height___ '__'' Weight_____lbs_ Shoe size____ Last FLU shot_____/Pneumonia _____

Primary Doctor:_____ Last Visit:_____
Address/ clinic name:_____

Race

Asian Black/African American Caucasian Hispanic Native American
Alaskan Native Native Hawaiian/Pacific Islander Unknown/Refused Multi-Racial

Ethnicity

Latino/Hispanic Non-Latino/Non-Hispanic
Unknown/Refused

Primary Language

_____

Family Medical History

Please check if anyone in your family has had any of the following: Diabetes Heart Disease Gout
Bleeding Disorder Rheumatoid Arthritis Peripheral Vascular Disease (PVD)

Other:_____

Social History

Do you smoke?	Do you drink alcohol?	Do you use recreational drugs?
Yes No Former	Yes No	Yes No

Allergies: Circle: yes or NONE

Adhesive Tape Aspirin Codeine Demerol Iodine Latex
Local Anesthetics Lortab Penicillin Seafood Sulfa No Allergies

Other:_____

Surgical History

Appendectomy Gall Bladder Hysterectomy Foot/Ankle Surgery C-Section
Heart Eye Thyroidectomy Tonsillectomy Knee Back Other_____

Past Medical History

Major Disease
- ***Diabetes***
- High Blood Pressure
- Heart Disease
- Heart Attack
- Arrhythmia
- Heart Murmur
- Mitral Valve Prolapse
- Stroke
- High Cholesterol

Neurological
- Headaches
- Glaucoma
- Hearing Problems

Respirator
- Asthma
- Tuberculosis
- Emphysema

Arthritis
- Osteoarthritis
- Rheumatoid
- Gout

Vascular
- Anemia
- Prolonged Bleeding
- Pacemaker
- Poor Circulation
- Leg Pain When Walking
- Varicose Veins
- Blood Clots

Psychological
- Anxiety
- Depression
- Psychiatric Care
- Drug Dependence
- Alcohol Dependence

Gastrointestinal
- Ulcers
- Acid Reflux (GERD)
- Stomach Problems
- Hiatal Hernia
- GI or Rectal Bleeding
- Bowel Disorders

Miscellaneous
- Epilepsy/Seizures
- Thyroid Disease
- Muscle Disease/Polio
- Kidney Problems
- Bladder Problems
- Prostate Problems
- HIV
- Hepatitis/Liver Disease
- Cancer (Type:_____)

Other Medical Problems:

_____

Is this condition causing or are you suffering from any of the following:

Tingling/Numbness in: Leg R/L Ankle R/L Feet R/L

Pain radiation into: Leg R/L Ankle R/L Feet R/L

Weakness of the: Leg R/L Ankle R/L Feet R/L

Difficulty with: Standing Walking Sitting Bending Lifting Kneeling

How long ago did this problem first start?_____D/M/Y
Is this condition affecting your ability to perform daily tasks? Y/N
Did your pain or problem begin: □ all of a sudden □ gradually develop over time?

Medication (Doses)
Please provide a list of medications if over 5

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

Preferred **Pharmacy** Location:

Podiatric History

What is your chief complaint for which you came to our office?_____
_____
How would you describe your pain?_____
On a scale of 1-10 (10 being the worst) how would you rate your pain?_____
What makes your pain or problem feel worse?_____

Have you seen a Podiatrist before? Yes No If yes, who? _____
What treatment did you receive?_____
Have you used over the counter Orthotics/Supports?...Yes No
Anti-Inflammatory/NSAIDS (feet or leg pain)?.....Yes No
Imaging, X-Rays, MRI, etc (feet)?.....Yes No
Have you received injections (feet)? .....Yes No

DIABETIC Y / N Circle: Type 1 Type 2 How Long? _____ **Insulin?** _____
Oral Medications?_____ **Diet Controlled?**_____

ASSIGNMENT OF INSURANCE BENEFITS
AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize direct payment of surgical/medical benefits to Willamette Foot Center for service rendered. I understand that **I am financially responsible for any balance not covered by my insurance** and for payment regardless of insurance pending. I hereby authorize Willamette Foot Center to release any medical or incidental information that may be necessary for either medical care or processing application for financial benefit.

I understand that Willamette Foot Center will do their best with regard to the release of "minimum necessary" information under the HITECH Act related to my PHI (protected health information). I understand that there will be times that the release of my name, date of birth, address, phone number(s), fax number, email, social security number, medical record number, health plan beneficiary number or account number may have to be disclosed to my insurance company, primary care physician or any other entity that Willamette Foot Center deems necessary for payment, scheduling of procedures, or any other entity deemed necessary for my care.

Willamette Foot Center is also making me aware that they will not sell my PHI (protected health information) randomly to any third party. I am being made aware that there may be times that an attorney, disability insurance, housing authorities or any other third party may request a copy of my PHI and Willamette Foot Center may request an exchange of monies for their time, supplies, special report, etc. I give Willamette Foot Center permission to release this information and to receive payment for the third party for this information.

Signature_____ **Date**_____
Relationship (if other than Patient)_____

MESSAGES LEFT AT YOUR HOME/ANSWERING MACHINE

Due to the recent implementation of the patient Privacy Act (**HIPAA**), it is necessary to obtain authorization for our office to leave messages at your home with family members and/or on answering machines regarding the following

- Confirm or Change Appointment
- Results of testing ordered by the physician
- And/or any pertinent information that may be relative to your care

☐ I DO NOT AUTHORIZE

☐ I AUTHORIZE **X**_____ **Date**_____

PERMISSION TO DISCLOSE MEDICAL RECORDS, PER ORS 192.525
CONSENT AND ACKNOWLDEGMENT

I give Willamette Foot Center permission to release medical information to the following persons:

None Spouse_____

Father (only)_____ Mother (only)_____

Guardian_____ Other_____

The Privacy Act generally requires healthcare providers to take responsible steps to limit the use of disclosure of and requests for protected health information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.
Healthcare entities must keep records of protected health information disclosures. Information provided below, if completed properly, will constitute an adequate record.

CONSENT:
I consent to the use and disclosure of protected health information about me by my physician and my physician's practice for purposes of treatment, payment, health care operations, protection of others and disclosure required by law, including information about notifiable diseases, sexual transmitted diseases, acquired immunodeficiency syndrome (AIDS), and human immunodeficiency virus (HIV).
NOTE: Uses and disclosures for protected health information may be permitted without consent in an emergency.
ACKNOWLEDGEMENTS:
I acknowledge that I have received Willamette Foot Centers, Notice of Privacy Practices.

_____ _____
Signature of Patient or Personal Representative **Date**

_____ _____
Relationship of Personal Representative to the Patient **Print personal Representative's Name**

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FINANCIAL POLICY

Our desire is to serve you and to provide quality, professional, courteous care for you and your family's medical needs. The following items are to assist you in knowing your financial responsibilities prior to treatment. Please remember that your insurance coverage is a contract between you and/or your employer and the insurance company. We will bill your insurance as a courtesy, but you, the patient or responsible party, are the one who is ultimately responsible for payment.

1. Co-payments are the responsibility of the patient and are due at the time of service.

2. Your insurance company is billed as a courtesy and payment is usually received within 30 days. If your primary insurance does not cross your balance over to the secondary payer, we will bill the secondary payer one time as a courtesy.

3. All insurances are not the same and do not cover the same services. In the event you health plan determines a service to be "not covered", or you do not have authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

4. You MUST inform the office of all insurance changed and authorization/referral requirements. In the event the office in not informed, you will be responsible for any charges denied.

5. After receiving payment from the insurance company, any balance owed will come to the patient on a remainder balance statement. We will not send any statements unless a balance is due from the patient or responsible party. We offer payment plan options that enable you to pay off the balance within three months. We accept all debit/credit cards, cash, checks, money orders and care credit.

6. If no payment has been received for the balance owed, a second statement will be mailed. If the balance is still not received, we will place a phone call to the responsible party to discuss payment arrangements.

7. If the patient/responsible party does not have insurance, private pay accounts must be paid in full at the time of service.

8. If the balance cannot be paid in full at the time of service, your appointment will be canceled or you may apply for care credit prior to your appointment.

9. A $20.00 fee will be applied for each returned check. Cash or money order must be presented to cover the returned check plus the $20.00, before the patient will be seen again in the clinic.

10. Out of state Medicaid insurance will not be billed or accepted. Cash payment for services will be expected.

11. There will be a $15 charge for any missed appointments or appointments canceled less than 24 hours in advance. This allows us to fill the spot with other patients who are waiting to get in with us.

I hereby certify that I have read and agree to the terms of this financial policy. Willamette Foot Center will not accept any changes made to this form.

_____ _____

Signature of Patient or Personal Representative **Date**

Updated: 05/01/2015