# Willamette Foot Center Robert C. Stevens DPM John Sessions DPM, PhD Podiatric Physicians & Surgeons 4305 River Road N, Keizer, OR 97303

Phone: (503) 363-0763 Fax: (503) 363-8154

Dear	±	
Thank you for making an appointment with Wil opportunity to welcome you to our clinic. We are in a compassionate and caring environment. You	e committed to pr	roviding excellent medical care
	At	_(Check in 10 minutes before)
For your convenience, and to minimize waiting completed prior to your visit.	time in our office	we have enclosed forms to be

## 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 <u>new patients arrive 10 minutes prior to the first appointment with your paperwork completely filled out</u>. 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			
	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 Primary Language			
Latino/Hispanic Non-Latino/Non-HispanicUnknown/Refused			
	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:			
Socia  Do you smoke? Do you drink a  Yes No Former Yes No			
Allergies: Circ	ele: yes or NONE		
* *	odeine Demerol Iodine Latex cillin Seafood Sulfa No Allergies		
Other:			
Surgical History			
Appendectomy Gall Bladder Hysterec Heart Eye Thyroidectomy Tonsillec	•		

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:	
the following:  Tingling/Numbness in: Leg  Pain radiation into: Leg  Weakness of the: Leg I  Difficulty with: Stan Bend  How long ago did this problem Is this condition affecting your	r are you suffering from any of  R/L Ankle R/L Feet R/L  R/L Ankle R/L Feet R/L  R/L Ankle R/L Feet R/L  ding Walking Sitting ling Lifting Kneeling	Medication (Doses) Please provide a list of medications if over 5  1	
How would you describe your On a scale of 1-10 (10 being the What makes your pain or problem Have you seen a Podiatrist before What treatment did you received Have you used over the counter Anti-Inflammatory/NSAIDS (Imaging, X-Rays, MRI, etc (fee Have you received injections (fee	pain?_ e worst) how would you rate your pain em feel worse?_ ore? Yes No If yes, who?	?	

Diet Controlled?

Oral Medications?

## 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

payment, scheduling of procedures, of	any other entity deemed nece	ssary for my care.
randomly to any third party. I am be housing authorities or any other third	ing made aware that there may party may request a copy of n e, supplies, special report, etc	not sell my PHI (protected health information) be times that an attorney, disability insurance, my PHI and Willamette Foot Center may request c. I give Willamette Foot Center permission to or this information.
Signature	Date Relat	ionship (if other than Patient)
Due to the recent implementation of authorization for our office to leav machines regarding the following  Confirm or Change Appoint Results of testing ordered	e messages at your home wi	HPAA), it is necessary to obtain ith family members and/or on answering
□ I AUTHORIZE	X	Date
COI I give Willamette Foot Center permiss	NSENT AND ACKNOWL sion to release medical information	ation to the following persons:
None		
Father (only)	Mother (only	)
Guardian	Other	
requests for protected health information	tion to the minimum necessar	onsible steps to limit the use of disclosure of and ry to accomplish the intended purpose. These athorization requested by the individual.
Healthcare entities must keep records completed properly, will constitute an		on disclosures. Information provided below, if
practice for purposes of treatment, pay	ment, health care operations,	about me by my physician and my physician's protection of others and disclosure required by

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Ιc pra 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 W	Villamette Foot Centers.	Notice of Privacy	Practices
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Signature of Patient or Personal Representative.	Date
Relationship of Personal Representative to the Patient	Print personal Representative's Name

# Willamette Foot Center Robert C. Stevens DPM John Sessions DPM, PhD Podiatric Physicians & Surgeons 4305 River Road N, Keizer, OR 97303

### 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.
- 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.
- 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: 07/28/2020