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800 Liberty St SE | Salem, OR 97302
Phone: (503) 370-8784
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Thank you for choosing our office for your podiatric care. In order to serve you properly, please fill out the following information as legibly as possible. All information is confidential.

Personal Information

Patient Name: _____ **Male/Female** **DOB**: _____ **Age**: _____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Cell Phone: _____ **Home Phone**: _____ **SSN**: _____

Marital Status (Circle One): Single Married Widowed Divorced

Employer: _____ **City**: _____ **State**: _____

Emergency Contact: _____ **Relationship**: _____ **Phone**: _____

***Name of Person Financially Responsible:** _____ DOB: _____ **Phone**:_____

***IS THIS A WORK-RELATED INJURY?** **Yes**☐ **No**☐ ***IS THIS RELATED TO A MOTOR VEHICLE ACCIDENT?** **Yes**☐ **No**☐

Insurance Information

(* INDICATES REQUIRED FIELD, ALONG WITH COPY OF INSURANCE CARD)

***Primary Insurance**: _____ ***Member ID Number**: _____

***Subscriber Name**: _____ ***DOB**: _____

***Secondary Insurance**: _____ ***Member ID Number**: _____

***Subscriber Name**: _____ ***DOB**: _____

Other Information

For access to electronic medical records please enter your email: _____

Preferred Pharmacy (include specific location): _____

Release of Benefits and Information: I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. I understand that I am requesting services that may not be a covered benefit with my insurance carrier and I agree to pay for these services personally if necessary. I agree to any co-pays due at the time service is rendered. I authorize the doctor or insurance company to release any information required to assist in the collection of monies due, and I authorize payment to be paid directly to this office. If it becomes necessary to seek third party services for collection of monies owed, I agree to pay for all costs and expenses, including reasonable attorney fees and court cost.

***Patient Signature (Guardian if patient is a minor):** _____ **Date:** _____

Financial Policy

Thank you for choosing Coastline Foot and Ankle Center. 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 accepted. **There will be a $50.00 charge for returned checks**. Delinquent accounts **over 90 days** will be turned over to collections with an additional **collection fee of $100**.

Co-payments: Please be prepared to pay your co-payment at the time of your visit.

Deductibles: If you have an annual deductible that has not yet been met by the time of your visit, any charges incurred up to that amount will be your responsibility.

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** if you fail to call or not show up for your initial appointment. If you cancel less than 24 hours**, we reserve the right to charge a $25 fee.** 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. **Full deposit of $150 or full payment is due** when the orthotics are ordered or made.

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.

Surgery: Surgery deposits are **required and due** at the time of pre-op appointment if the patient is **not** double covered. We will collect about 20% of what we bill insurance as a deposit. After billing insurance, if they cover 100%, we will refund the surgery deposit back. If insurance says there is a payment due from the patient, we will take it from the surgery deposit. If the payment due from the patient is more than the surgery deposit, we will send out a statement**. If patient decides to cancel surgery, we reserve the right to charge a $100 fee.**

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

*Terms and policies are subject to change without notice

***Patient Signature:** _____ **Date:** _____

Acknowledgment of Notice of Privacy Practices

We keep records of the health care services we provide for you. You may ask to see and copy that record. If you would like to obtain a copy of your medical records our office has up to 30 days to respond to the request. A report of your visit today will be sent to your primary care doctor or referring doctor unless requested otherwise by you.

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

Patient Name (Please print): _____

Parent/Guardian (if applicable): _____

*__Patient Signature:__ _____ __Date:__ _____

This form will be retained in your medical record.

HEALTH HISTORY

PAST MEDICAL HISTORY

Please list any serious illnesses, surgeries, or hospitalizations including the dates they occurred:

_____
_____
_____
_____
_____
_____
_____
_____

Allergies

Do you have allergies to any of the following?

□ PENICILLIN □ ASPIRIN □ IODINE □ LATEX □ Other (List): _____
_____

□ SULFA □ LOCAL ANESTHETICS □ ADHESIVE TAPE

Medications: Please list all current medications (please write as legibly as possible)

Name of Medication:	Dose/Frequency:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Age: _____ Height: _____ Shoe Size: _____ Weight: _____

What is your foot/ankle problem? When did it begin? _____

_____

Have you tried anything for relief? _____

Is this your first time seeing a podiatrist? □ YES □ NO

FAMILY HISTORY

HAVE ANY OF YOUR BLOOD RELATIVES HAD ANY OF THE FOLLOWING DISEASES/CONDITIONS?

	Relationship		Relationship
Diabetes	☐ YES _____	Cancer/Tumor	☐ YES _____
High Blood Pressure	☐ YES _____	Heart Trouble	☐ YES _____
Arthritis	☐ YES _____	Birth Abnormalities	☐ YES _____
Foot Problems	☐ YES _____	Stroke	☐ YES _____

ALL QUESTIONS MUST BE ANSWERED FOR INSURANCE PURPOSES

Do you smoke tobacco? □ YES □ NO How many cigarettes per day? _____

Are you a previous smoker? □ YES □ NO Do you chew tobacco? □ YES □ NO

Do you have an Advanced Directive? □ YES □ NO

Are you diabetic? □ YES □ NO □ Type I □ Type II

Do you drink? □ YES □ NO If yes, how often? □ Rarely □ Moderately □ Daily □ Quit

Have you fallen within the last year? □ YES □ NO

If yes, how many times? □ Once □ More than once

Were you injured from the fall or falls? □ Yes □ No

FAMILY (PRIMARY CARE) PHYSICIAN INFORMATION

FACILITY NAME: _____ PHONE: _____

DOCTORS NAME: _____

Were you referred by your Primary care doctor? □ YES □NO

Are you currently seeing a specialist for any reason? □YES □NO

Explain: _____

Did a specialist refer you to us? □YES □ NO

REVIEW OF SYSTEMS

Please check-mark any conditions you are currently experiencing:

General

- ☐ Fever
- ☐ Significant weight change
- ☐ Fatigue
- ☐ Weakness

Skin

- ☐ Rash
- ☐ Change in skin pigmentation
- ☐ Dryness
- ☐ Itching

Head/Eyes/Ears/Nose/Throat

- ☐ Headache
- ☐ Dizziness
- ☐ Recent head injury
- ☐ Corrective lenses
- ☐ Blurry vision
- ☐ Glaucoma
- ☐ Ringing in ears
- ☐ Hearing loss
- ☐ Frequent ear infection
- ☐ Sinusitis
- ☐ Nose bleeding
- ☐ Postnasal discharge
- ☐ Nasal obstruction

Pulmonary

- ☐ Difficulty breathing
- ☐ Wheezing
- ☐ Cough
- ☐ Chest pain

Cardiovascular

- ☐ Chest pain/pressure
- ☐ Palpitation
- ☐ Hypertension
- ☐ Recent heart attack
- ☐ Murmur
- ☐ Stroke/Mini stroke

Gastrointestinal

- ☐ Hernia
- ☐ Blood in stool
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Nausea/Vomiting
- ☐ Diarrhea
- ☐ Gastric ulcers
- ☐ Crohn's disease

Genitourinary

- ☐ Painful urination
- ☐ Frequent urination
- ☐ Hepatitis: Type _____

Peripheral vascular

- ☐ Varicose veins
- ☐ Lower extremity swelling
- ☐ Anemia
- ☐ Thrombosis
- ☐ Tendency to bleed

Endocrine/Immune

- ☐ Diabetes: Type I Type II
  - **A1C:**
  - **Fasting Blood Sugar:**
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ HIV/AIDS

Musculoskeletal:

- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Fibromyalgia

Neurological:

- ☐ Gait/coordination problems
- ☐ Numbness/tingling in limbs
- ☐ Paralysis

Psychological

- ☐ Memory Loss
- ☐ Depression
- ☐ Anxiety
- ☐ Drug/alcohol abuse

HIPAA CONSENT

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides privacy protections to your medical records. Our benefits office (or other third party designated by our office) may sometimes need to disclose medical information or payment information protected by HIPAA in relation to our group health plans to your family members or close friends involved in your health care. For example, your spouse may need to contact us if you are in the hospital to determine whether a particular procedure is covered under our group health plan or may need assistance filing a claim for medical services. Under HIPAA, unless you specifically object, we are allowed to use our professional judgment in deciding whether to discuss your medical and payment information with your family members or close friends. However, we would like to provide you with the opportunity to tell us with whom we may discuss your medical or payment information under our group health plans. You may communicate with the following individual(s) relating to my medical or payment information:

Name:_____ Relation: _____
Name:_____ Relation: _____
Name:_____ Relation: _____

Print Patient Name: _____

_____ _____
*__Patient Signature__: (Or legal Guardian if patient is under 18) Date:

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