R. Tyson Scott, DPM, FACFAS
1128 NE 2nd St. | Corvallis, OR 97330
Phone: (541)757-7100
Fax: (541)304-2277

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: _____ DOB: _____ Age: _____

Preferred Name: _____ **Circle:** Male/Female/Prefer not to answer

Address: _____ City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____

Emergency Contact: _____ Relationship: _____ Phone:_____

Guarantor/Relationship to Patient (person responsible for payment): _____

What do you do for work? _____

Do you have a family history of your current condition: **Circle: Yes or No**

Continuity of Care

Please include first and last names

Primary Care Physician: _____

Clinic Name:_____ Fax Number: _____

Specialty Care Physician: _____ Reason: _____

Clinic Name:_____ Fax Number: _____

Preferred Pharmacy: _____ Phone: _____

Medical Questionnaire

Do you have an Advance Directive? **Circle:** Yes or No

Are you a diabetic? **Circle:** Yes or No → **If yes, please circle:** Type 1 or Type 2
Most Recent A1C:_____ Most Recent Fasting Blood Sugar:_____

Do you smoke? **Circle:** Yes or No → Are you a previous smoker? **Circle:** Yes or No
If you are a current smoker, how many cigarettes per day? _____

Do you drink? **Circle:** Yes or No → **If yes, how often? Circle:** Rarely/Moderate/Daily

Have you fallen within the last year? **Circle:** Yes or No → **If yes, circle:** Once or More than once
Were you injured in the fall(s)? **Circle:** Yes or No

Please circle your daily activity level (0 = no activity, 10 = very active): 1 2 3 4 5 6 7 8 9 10

Please circle how often you are on your feet (0 = not at all, 10 = all day): 1 2 3 4 5 6 7 8 9 10

Do you have any serious health/medical conditions? **Circle:** Yes or No
If yes, please list:

_____
_____

Have you had any major surgeries? **Circle:** Yes or No
If yes, please list (please include MM/YYYY):

_____
_____

Do you have any allergies? **Circle:** Yes or No
If yes, please list:

_____
_____

Please list any medications you are currently taking (name of medication only):

_____ _____ _____
_____ _____ _____
_____ _____ _____

Have you had any recent changes in your overall health? **Circle:** Yes or No
If yes, please list:

_____

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.

**** By initialing next to each statement, it tells us that you simply read the information. For example, EVEN IF YOU HAVE INSURANCE, please initial by the "No Insurance" line to indicate you read the statement. ****

_____(initial) 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.

_____(initial) 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.

_____(initial) 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.

_____(initial) Co-payments & Deductibles: Please be prepared to call our Salem office billing department to pay your co-payment at the time of your visit. 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.

_____ (initial) Orthotics: Orthotics can be a non-covered service by some insurance plans. Please note that any attempt to verify benefits by our office is not a guarantee of benefits and we do not accept financial responsibility.

_____ (initial) Surgery: A $100 surgery deposit is required and due at the time of pre-op appointment if the patient is not double covered. 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 a patient decides to cancel surgery, we reserve the right to keep the deposit.

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 (Guarantor if patient is a minor):_____ Date: _____

Acknowledgment of Receipt of Notice of Privacy Practices

_____(initial) 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.

Release of Benefits and Information

_____(initial) Release of Benefits and Information: I understand and agree that health and accident insurance policies are an arrangement between an 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 costs.

HIPAA Consent

_____(initial) 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:_____

Print Patient Name: _____ Date:_____

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

Communication

Below are ways we can communicate with you about your medical care. Please read the statements carefully and initial where indicated <u>only if you are providing permission.</u>

_____ **(initial)** I give Coastline Foot & Ankle Center - Corvallis permission to leave confidential medical information on my ***voicemail.***

_____ **(initial)** I give Coastline Foot & Ankle Center - Corvallis permission to leave confidential medical information and communicate with me about my medical care ***via email.***

Please provide email address:_____

_____ **(initial)** I give Coastline Foot & Ankle Center - Corvallis permission to leave confidential medical information and communicate with me about my medical care ***via text.***

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