Account #: _____

R. Tyson Scott, DPM, FACFAS
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800 Liberty St SE | Salem, OR 97302
Phone: (503) 370-8784
Fax: (503) 362-4017

Personal Information

Patient's Full Name: _____ **DOB:** _____ **Age:** ____

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

Mailing Address: _____

Ph #: _____**Cell / Home** **Alternative Ph #:** _____ **Cell / Home**

Email Address: _____

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

Emergency Contact: _____ **Relationship:** _____ **Ph #:** _____

****Please mark ONE person financially responsible for any account balance AFTER insurance is billed:**

- Patient – Name & DOB: _____
- Parent/Guardian - Name & DOB: _____ Ph #: _____
- Spouse – Name & DOB: _____ Ph #: _____
- Other – Relation to Patient: _____ Name & DOB: _____
  Ph #: _____

Insurance Information

**** Insurance information is REQUIRED to be completely filled out. Insurance and ID cards must be present at time of appointment. Our receptionist will take copies of all cards that are presented. ****

*Name of **Primary** Insurance: _____ *Member ID #: _____

*Name & DOB of Subscriber: _____ *Relation to Subscriber: _____

*Name of **Secondary** Insurance: _____*Member ID #: _____

*Name & DOB of Subscriber: _____ *Relation to Subscriber: _____

Name of **Tertiary** Insurance: _____ Member ID #: _____

Name & DOB of Subscriber: _____ Relation to Subscriber: _____

**SSN (for Medicare & VA patients): _____

Continuity of Care

Please provide first and last names

Primary Care Physician: _____ **Clinic Name:** _____

Preferred Pharmacy (including location): _____

Specialty Care Physician: _____ **Reason:** _____

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. 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 choose 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: _____

Agreements

Workers Compensation & Motor Vehicle Accidents

_____ **(Initial)** At Coastline Foot and Ankle Center, we DO NOT attend patients with workers compensation and/or motor vehicle accidents claims. Please initial acknowledging that the patient's visit is not related to a worker's injury or a motor vehicle accident.

Acknowledgment 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 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.

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: _____

Name:_____ Relation: _____

Print Patient Name: _____ Date: _____

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

Health History

Please list any serious health/medical conditions/hospitalizations/surgeries that have occurred in the past 5 years including dates (if possible):

_____

_____

_____

Allergies: Penicillin / Aspirin / Iodine / Latex / Sulfa / Local Anesthetics / Adhesive Tape

Other: _____

Medications: Please list all **CURRENT** medications (including prescribed, supplements & over the counter medications)

☐ Please check mark if a medication list was provided to a receptionist @ check in

Medication Name / Dosage / Frequency:

_____

_____

_____

Height: _____ Weight: _____ Shoe Size: _____

What is your foot/ankle problem? When did it begin? What have you tried for relief?

_____

_____

Family History: Please list any blood relatives if they have had any of the following conditions:

Diabetes	_____	Heart Troubles	_____	Unknown Family History
High Blood Pressure	_____	Birth Abnormalities	_____	
Arthritis	_____	Cancer	_____	

THE FOLLOWING QUESTIONS BELOW MUST BE ANSWERED

- Do have an Advanced Directive? Yes / No (*A medical form that is filled out with your pcp or the hospital appointing someone to make medical decisions for you if you are in a condition where you can't make those decisions*)
- Are you diabetic? Yes / No → if yes, A1C: _____ Type I / Type II → Fasting Blood Sugars: _____
- Do you smoke tobacco? Yes / No → if yes, how many cigarettes per day? _____
- Do you chew tobacco? Yes / No
- Are you a previous smoker? Yes / No
- Do you drink alcohol? 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? Yes / No

REVIEW OF SYSTEMS

Please **circle** any conditions you are **CURRENTLY** experiencing:

General:	Skin:	Head/Eyes/E.N.T	Pulmonary:	Cardiovascular:
• Fever • Significant Weight Change • Fatigue • Weakness	• Rash • Change in skin pigmentation • Dryness • Itching	• Dizziness • Recent Head Injury • Corrective Lenses • Glaucoma • Sinusitis • Nasal Obstruction • Sleep Apnea • Obstructive Sleep Apnea	• Difficulty Breathing • Wheezing • Cough • Chest pain	• Palpitation • Hypertension • Recent Heart Attack • Murmur • Stroke

Peripheral Vascular:	Endocrine/Immune:	Musculoskeletal:	Neurological:	Psychological:
• Varicose Veins • Lower Extremity Swelling • Anemia • Thrombosis • Tendency to Bleed • Hepatitis Type: _____	• Diabetes Type I Type II • Hypothyroidism • Hyperthyroidism	• Osteoarthritis • Rheumatoid Arthritis • Fibromyalgia	• Gait / Coordination Problems • Numbness / Tingling in Limbs • Paralysis	• Memory Loss • Depression • Anxiety • Drug / Alcohol Abuse