

## Welcome To Our Office

Thank you for choosing us as your podiatric physicians. We are committed to your treatment being successful, as you, the patient, are our first and foremost concern. As part of our service, 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 our **FINANCIAL POLICY** which we request you read and sign prior to any treatment. To avoid any misunderstandings, please contact us should you have any questions about our policies.

**INSURANCE:** If your doctor is a participating provider with your insurance plan, we will submit the claim to your insurance company. To do this we must have *complete and accurate* insurance information and a copy of your identification card or claim form. Your insurance policy is a contract between you and your insurance company; therefore you are responsible for payment whether or not your insurance company pays. **It is your responsibility to contact your insurance company regarding pre-authorizations, obtaining required referrals, second opinions, etc.** Failure to do so may reduce the amount of benefits paid by your insurance, and the balance will then become your responsibility to pay. All co-payments must be paid at the time of service.

**NO INSURANCE:** If you do not have insurance 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 the balance due, co-payments, deductibles, etc., are due at the time of service and may be made by *cash, check or credit card* (Visa, MasterCard). There will be a \$25.00 charge for *returned checks*. *Delinquent accounts* will be referred for collection at the discretion of the office manager.

**CO-PAYMENTS:** **Please be prepared to pay all co-payments at the time of service.** We do not send bills out for co-payments, so your visit will have to be re-scheduled if you are not prepared to pay the co-payment.

**DEDUCTIBLES:** If you have an annual deductible which has not yet been paid in full then any charges incurred up to that amount are due at the time of your visit.

**MINOR PATIENTS:** The adult or the parent (custodial guardian) accompanying a minor is responsible for payment of services. For unaccompanied minors, non-emergency treatment 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:** Please help us serve you better by keeping scheduled appointments. If it is necessary to cancel, please call our office 24 hours in advance. This allows us to accommodate our other patients. We reserve the right to charge for missed appointments.

**ORTHOTICS:** Orthotics are a non-covered service by some insurance plans. Please check with your insurance company *prior* to the examination and casting for orthotics to determine your orthotic benefits. A deposit of \$150.00 is requested at the time of the examination and casting and full payment is due when the orthotics are dispensed.

**SUPPLIES:** For your convenience we make some supplies available for purchase in the office. If you choose to purchase these items, payment is due at time of purchase. We cannot bill for these items. In addition, we contract with outside suppliers to provide some supplies through our office. If any of these supplies are used for your treatment you or your insurance will be billed for these supplies by the outside provider. Sellwood Podiatry has no part in billing for these supplies.

**Please complete the following items:**

What is your co-payment per visit: \$ \_\_\_\_\_

What is your insurance annual deductible: \$ \_\_\_\_\_ How much of the deductible is current (not yet paid): \$ \_\_\_\_\_

*(if you are not sure what your current (not yet paid) deductible is, please call your insurance company prior to your visit.)*

*Please be prepared to pay your co-payment and any charges within your current deductible at the time of your visit*

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

**SIGNED** \_\_\_\_\_

**DATE** \_\_\_\_\_

# PATIENT REGISTRATION

## Patient Information

Patient Name: Last	First	M.I.	<input type="checkbox"/> M <input type="checkbox"/> F
By what name to you preferred to be addressed?		Single Married Widowed Other	
Patient's Address:			
City		State	Zip
Home Phone:	Daytime Contact Phone:	Cell phone:	
Social Security #: <small>(not required for point-of-sale CASH PAY patients)</small>		DOB:	Age:
Employer:		Occupation:	
Emergency Contact:		Phone#:	

## Insurance

Name of insured (if other than self)	Member Number:
Name of insured's employer:	Insured's work phone number:
Patient is: <input type="checkbox"/> Subscriber <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	
<p><b>We are required to have a copy of your insurance card(s) on file in order to bill your insurance for you. If we do not have this information on file, you will be billed directly and are solely responsible for all charges. Payment is due at the time of service. If you submit you insurance card at a later date we will be glad to bill your insurance company and reimburse you when payment is received.</b></p>	

## Workers Compensation

Date of Injury:	Type of Injury:	<input type="checkbox"/> Work	<input type="checkbox"/> Auto	<input type="checkbox"/> Other
Has a claim been filed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Claim#:	Where was claim filed?	
Cause of injury:				

## Referral

Referred By:	
Primary Care Physician and Clinic Name	Phone #:
If you were not referred how did you find out about our office? <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Web Page <input type="checkbox"/> Other:	

## Signature

**Release of Benefits Information :**  
 I authorize my insurance benefits to be paid directly to the doctor. I understand that the doctors office will bill my insurance as a courtesy and that I am responsible for all co-payments, deductibles and non-covered services. I authorize the release of information required to process my claims. (If not signed payment due at time of service)  
**ALL CO-PAYMENTS DUE ON DAY OF SERVICE.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Medical History - Confidential Information

## Lower Extremity Medical History

What is the chief complaint(s) which brings you to our office for medical treatment ?

(Include foot, ankle, leg, knee and hip complaints)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Former foot and ankle physician:

Name: \_\_\_\_\_

Last visit: \_\_\_\_\_

Any previous injuries or problems to the feet, ankles or legs?

\_\_\_\_\_

## Symptoms

Which Side:  Right  Left  Both

Type of Pain:  Dull  Achy  Throbbing  
 Burning  Sharp  Shooting

Area of Pain: \_\_\_\_\_

Onset:  Slow  Sudden  Traumatic

Duration: \_\_\_\_\_

Has pain gotten:  Better  Worse  Stayed the Same

What aggravates condition?  walking  running  
 standing  shoes

What have you tried to help the pain?  Changing shoes

anti-inflammatories  decrease activities

Other: \_\_\_\_\_

How long does pain last? \_\_\_\_\_

Have you ever had a similar pain? (describe, including treatments received)

\_\_\_\_\_

## Runners Only

How long have you been running?

\_\_\_\_\_

Mileage: \_\_\_\_\_ miles per  wk  month

## Allergies and Drug Intolerance

- Adhesive/Tape  Aspirin  
 Codeine  Iodine  
 Local Anesthetics  Penicillin  
 Seafoods  Sulfa  
 No known drug allergies  \_\_\_\_\_

## Medications

List all medications you are taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## General

What is your weight: \_\_\_\_\_

What is your height: \_\_\_\_\_

What is your shoe size: \_\_\_\_\_

## Mental / Emotional

- yes  no Eating Disorder  
 yes  no Anxiety  
 yes  no Depression  
 yes  no Psychiatric  
 yes  no Alcoholism

## Surgeries, Injuries, Illnesses

List surgeries, serious injuries, and illnesses not previously listed:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Social History

Do you smoke?  yes  no

Are you a past smoker?  yes  no

How Much? \_\_\_\_\_ packs/ \_\_\_\_\_.

Years Smoked: \_\_\_\_\_

Drink Alcohol?:  yes  no

How Much: \_\_\_\_\_

Recreational Drugs?  yes  no

What: \_\_\_\_\_

Pregnant or possibly pregnant?  yes  no

Athletic Activities in which you participate:

\_\_\_\_\_

## General Medical History

Mark "yes" or "no" to indicate if you or a family member have any of the following:

### Personal

- yes  no Anemia  
 yes  no Arthritis:  yes  
Type: \_\_\_\_\_  
 yes  no Artificial Heart Valve or Joints  
 yes  no Asthma  yes  
 yes  no Back Problems  yes  
 yes  no Bleed easily  yes  
 yes  no Cancer  yes  
 yes  no Chemical Dependency  yes  
 yes  no Chest Pain  yes  
 yes  no Circulatory Problems  yes  
 yes  no Diabetes  yes  
 yes  no Epilepsy  yes  
 yes  no Fibromyalgia  yes  
 yes  no Gout  yes  
 yes  no Heart Disease  yes  
 yes  no Hemophilia  yes  
 yes  no Hepatitis  
 yes  no High Blood Pressure  yes  
 yes  no HIV Positive  
 yes  no Kidney Problems  yes  
 yes  no Leg Cramps  
 yes  no Liver Disease  yes  
 yes  no Lung/Respiratory  yes  
 yes  no Menopause  
 yes  no Mental Illness  yes  
 yes  no Phlebitis / Clots  yes  
 yes  no Psoriasis  yes  
 yes  no Rheumatic Fever  
 yes  no Stroke  yes  
 yes  no Thyroid Problems  
 yes  no Tuberculosis  
 yes  no Ulcers—Stomach  
 yes  no Venereal Disease  
 yes  no Weight Change, Recent. \_\_\_\_\_ lbs

### Family Member

**Sellwood Podiatry**  
**Brandi S. Myers DPM, LLC**

**503-235-8594**

7836 SE 13<sup>th</sup> Ave  
Portland, OR 97202  
Fax 503-235-3315

**ACKNOWLEDGMENT OF RECEIPT  
OF  
NOTICE OF PRIVACY PRACTICES**

We keep a record of the health care services we provide you. You may ask to see and copy that record. If you would like to obtain a copy of your medical records, a base clerical fee of \$19.00 is due upon receipt. 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 Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Authorized Representative (if applicable)

\_\_\_\_\_  
Signature

This form will be retained in your medical record.