FINANCIAL POLICY

We Accept Visa and Mastercard

Welcome To Our Office

Thank you for choosing us. 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. .

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. <u>If you fail to call and do not show up for your initial appointment, you will not be rescheduled. Failure to show without prior cancellation for two consecutive follow-up visits will result in discharge from our practice</u>

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.	□ M □ F
By what name to you preferred to be addressed?		Single Married Partnered Other	
Patient's Address: Email: Address:			
City	State	Zip	
Home Phone:	Daytime Contact Phone:	Cell phone:	
Social Security #: (not required for point-of-sale CASH PAY patients)		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: □ Subscriber □ Spouse □ Dependent	

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.

Workers Compensation

Date of Injury:	Type of Injury: □ Work □ Auto □ Other
Has a claim been filed? □ Yes □ 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? □ Yellow Pages □ Web Page □ 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 ?

____

____

____

____

Former foot and ankle physician:
Name:________________________________

Last visit:______________________________

Symptoms

Which Side: Right Left Both

How long?

____

What makes it better?

____

What makes it worse?

____

How long does pain last?

____

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

____

ACTIVITIES

What are your current activities?

____

____

____

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 <u>not</u> 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:__________

Pregnant or possibly pregnant? yes no

General Medical History

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

Personal			Family Member
yes	no	Anemia	
yes	no	Arthritis: Type:_________	yes
yes	no	Artificial Heart Valve or Joints	
yes	no	Asthma	yes
yes	no	Cancer	yes
yes	no	Chemical Dependency	yes
yes	no	Chest Pain	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	Liver Disease	yes
yes	no	Lung/Respiratory	yes
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	Weight Change, Recent. _____lbs	

Sellwood Podiatry
Brandi S. Myers DPM, LLC

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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.