

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 the 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. 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 dishcharge from our practice

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.

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:	
EMAIL (you will not be stalked...this is for us to get in touch with you)		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>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.</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

<p><u>Release of Benefits Information :</u> 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.</p>	
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: Type: _____ yes
 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

5225 SE 28th Ave
Portland, OR 97202

**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.