Elite Foot and Ankle Associates, LLC

Trevor J Haynes, DPM, FACFAS, FACPM

37569 Hwy 26
Sandy, OR 97055
503-668-5210

10373 NE Hancock St. #118
Portland, OR 97220
971-254-8944

11815 SW KingJames P #60
Tigard, OR 97224
503-639-8107

332 NW 1st Ave
Canby, OR 97013
503-639-8107

PATIENT HISTORY

Today's Date: ___/___/___

Name: _____SSN_____ Date of Birth: ___/___/___ Age: ____

Briefly describe what brought you in today:

_____

_____

Duration of the condition _____ Prior treatments_____

Was this an injury? Y / N Is this a Worker's Compensation claim? Y / N

Previous foot & ankle physicians _____ Treated for _____

Primary Care Provider (PCP) _____ Location _____

MEDICATIONS

Pharmacy: Location: Phone:

~~Medication~~	~~Strength (mg)~~	~~Dose (every _ hrs)~~	~~Indication~~

ALLERGIES

Medication allergies (and reaction): _____

_____Food, environmental allergies:_____

PAST MEDICAL HISTORY

_____

_____

_____

_____

Are you Diabetic? Y / N Treating physician _____ Last HbA1C _____

Are you pregnant? Y / N How many months? _____

PAST SURGICAL HISTORY

Procedure	Year	Surgeon / Location (foot & ankle only)

FAMILY MEDICAL HISTORY

FATHER	MOTHER	BROTHER	SISTER

SOCIAL HISTORY

Physical Activity	Frequency	Level (rec, competitive, pro)

Occupation:_____
Do you smoke tobacco? Y / N packs per day ____ years smoking ____ Quit date: _____
Do you chew tobacco? Y / N cans per day _____
Do you drink alcohol? Y / N Frequency _____
Recreational drug use? Y / N Substance _____ Frequency _____

REVIEW OF SYSTEMS

Indicate any conditions or symptoms you are experiencing, including changes to your usual state of health, by circling below:

General/Constitutional: overall health change in appetite chills fatigue nausea
Endocrine: diabetes irregular menses thyroid problems weakness
Respiratory: asthma breathing pattern breathing problems chest pain cough
Cardiovascular: chest pain at rest chest pain with exertion claudication cyanosis
Gastrointestinal: abdominal pain blood in stool change in bowel habits colitis constipation
Hematology: bleeding problems easy bruising prolonged bleeding recent transfusion
Genitourinary: difficulty urinating frequent urination heavy uterine bleeding kidney problems
Musculoskeletal: arthritis back problems history of Gout joint stiffness swollen joints
Peripheral vascular: blood clots in legs cold extremities pain/cramping in legs after exertion ulceration of feet
Neurologic: balance difficulty gait abnormality paralysis seizures stroke

NOTICE OF PRIVACY PRACTICES (HIPAA REGULATIONS)

- You were provided with a document entitled "Notice of Privacy Practices." It is required by governmental regulations that all medical facilities provide you with this notice. Please check the box to acknowledge that you have read (or had the opportunity to read if you chose) and understand the notice. This is a copy of the notice that is yours to keep. If you do not want the copy, simply return it to the receptionist with your other materials.

CONSENT

I certify that the information above is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures, including therapeutic and diagnostic injections, as may be deemed necessary in the diagnosis and/or treatment of my feet.

Signature: _____ **Date: ____/____/____**

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

FINANCIAL POLICY FOR ELITE FOOT AND ANKLE ASSOCIATES, LLC

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE: We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However; that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any copayments, which are usually 20% of the allowed amount for an item or service.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

COPAYMENTS AND DEDUCTIBLES: All co-payments and deductible must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

SELF PAY: Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment of these services.

FMLA, DISABILITY, & WORK RELEASE FORMS: Due to the administration and doctor time it takes to fill these document documents out, a $25 fee will be added to your account for each occurrence.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of this visit. If you do not have a referral from your primary care physician at the time of a visit, you will be financially responsible for all services received due in full upon completion of the visit. Full credit will be given if a referral is presented to our office within 48 hours of this visit. You will also be given the option to reschedule your appointment.

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

PATIENT BILLING: You will be sent up to three notices for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account may be forwarded to collections. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check or VISA/Mastercard, Am Ex, & Care Credit. An additional $35.00 will be added to your statement if the check is returned for insufficient funds. In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance. All custom orthotics are NON returnable/refundable. Payment is due at time of molding.

I have read the above policy regarding my *financial responsibility* to Elite Foot & Ankle Associates, LLC for medical services provided. I agree to pay Elite Foot & Ankle Associates, LLC any balance unpaid by my insurance carrier for myself or the below named person.

PRIVACY STATEMENT: Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

PATIENT ACKNOWLEDGE OF NOTICE OF PRIVACY PRACTICES: By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices, and that I have (or had the opportunity to read if I so chose) and understand the Notice and agree to it's terms.

Assignment of Benefits

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **Elite Foot and Ankle Associates, LLC,** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions. I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information and acknowledge I was provided with a copy of the Notice of Privacy Practices and understand and accept it's terms:

PRINT Patient Name: _____ Signature:_____

FINANCIALLY RESPONSIBLE PARTY:

PRINT Name: _____ Signature: _____

Relationship to Patient: _____ Date: _____

Name of Insurance Plan: _____

Member ID#: _____ Group#_____

Payer ID (if shown on card):_____ Copay to see Specialist: $_____

Secondary Plan (if any): _____

Member ID#: _____ Group#_____

*Failure to provide accurate insurance information will result in you receiving a bill for our services.

Notice to Patients

Although we try our best, due to the constant changes in insurance policies and coverage, it is NO LONGER possible for us to interpret each individual policy.

IT IS YOUR RESPONSIBILITY to know your coverage and to make sure we are contracted with your particular plan. Sometimes insurance will put us on their policy but leave out specific plans. They don't tell us which ones and we can't always tell what kind of plan you have. It is also your responsibility to know if your specific insurance plan requires a referral to see a specialist and have that sent to us prior to your visit.

Please check your coverage for anticipated services before your appointment. Please remember your insurance coverage and related costs are **between you and your Insurance Company and/or Employer**, **NOT** between the Insurance Company and the Doctor.

Because your insurance policy is a confidential agreement between you and your insurance company, we are rarely privileged to know what services are covered.

I have read the above and understand.

_____ _____

Patient Signature Date

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