Patient Registration

Patient Information

Patient Full Name: **Last** **First** **M.I.** ☐ **M** ☐ **F**

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

By what name do you preferred to be addressed?

Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner ☐

Patient's Address

City **State** **Zip**

Preferred Phone ☐ Home ☐ Cell ☐ Work

Alternative Phone ☐ Home ☐ Cell ☐ Work

E-mail Address (required for access to your online patient portal)

Social Security # **Birth Date**

I would like automated reminders by: ☐ Email ☐ Phone ☐ Text (Choose up to 3)

Employer **Occupation**

Emergency Contact/Relationship **Phone**

Insurance

Patient is: ☐ **Subscriber** ☐ **Spouse** ☐ **Dependent**

Name of insured (if other than self) **Birth Date** **SSN**

Name of insured's employer **Insured's work phone number**

Name of person responsible for paying the bill (the Guarantor):
☐ **Same as patient** ☐ **Same as insured**

Guarantor's Address
☐ **Same as patient** ☐ **Same as insured**

Guarantor's Telephone

L&I Injury

If injured on the job, fill this portion out.

Date of Injury **Type of Injury** ☐ Work ☐ Auto ☐ Other

Has a claim been filed? ☐ **Yes** ☐ **No** **Claim#:** **Where was claim filed?**

Cause of injury

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Lower Extremity Medical History, Referral Information, Doctors and Pharmacies

Name: _____ **Date**: _____

What is the chief complaint(s) that brings you to our office for medical treatment? (Include foot, ankle, leg, knee, hip and back complaints: _____

Symptoms of Current Problem (circle or fill in your answer)

Which Side : Right Left Both **Type of Pain :** Dull Achy Throbbing Burning Sharp Shooting

Area of Pain : Bottom of Heel Back of heel Arch Ball of foot Big toe Top of foot Ankle No Pain

Other/Details: _____

On set : Slow Sudden Traumatic **Has pain gotten** : Better Worse Stayed the Same

How long has this been a problem for you?: Days Weeks Months Years

What aggravates condition? Walking Running Standing Shoes Activities First steps after rest

Other: _____ **Severity** : Mild Moderate Severe

What have you tried for the pain? Changing shoes Anti-inflammatory meds Decreasing activities Ice Heat Prefabricated Arch Supports Custom Orthotics Stretching Injections Physical Therapy Surgery Antibiotics Other OTC Meds Padding Massage Acupuncture Soaking

Other: _____

After it starts, how long does pain last? _____

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

How did you hear about our office?

Relative Friend Google Bing Other Web Search Facebook Yelp Insurance Company Mail Phone Book TV Other: _____

From My Doctor (name/specialty/city): _____

Who is your primary care physician and what other doctors treat you regularly?

Primary Care Physician: _____ MD DO PN

Date last seen: _____ I don't have a primary care physician

Other doctors and their specialties: _____

List your primary pharmacy (name and location) - This is where we will send any prescriptions

Primary pharmacy (include city and street): _____

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NAME: _____ DATE: _____

Past Medical History, Social and Family History Form

General

What is your weight: _____

What is your height: _____

What is your shoe size: _____

Allergies and Drug Intolerance

- Adhesive/Tape
- Aspirin
- Codeine
- Iodine
- Local Anesthetics
- Penicillin
- Seafoods
- Sulfa
- Other: _____
- No Known Allergies

Medications

List all medications(and doses) you are taking:

Surgeries, Injuries, Illnesses

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

General Medical History

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

Personal			Family
yes	no	Anemia	yes
yes	no	Arthritis: Type: _____	yes
yes	no	Artificial Heart Valve or Joints	yes
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
yes	no	High Blood Pressure	yes
yes	no	HIV Positive	yes
yes	no	Kidney Problems	yes
yes	no	Leg Cramps	yes
yes	no	Liver Disease	yes
yes	no	Lung/Respiratory	yes
yes	no	Menopause	yes
yes	no	Mental Illness	yes
yes	no	Phlebitis / Clots	yes
yes	no	Psoraisis	yes
yes	no	Rheumatic Fever	yes
yes	no	STD	yes
yes	no	Stroke	yes
yes	no	Thyroid Problems	yes
yes	no	Tuberculosis	yes
yes	no	Ulcers—Stomach	yes
yes	no	Weight Change	yes

Mental / Emotional

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

Exercise and Orthotics

In what athletic activities do you participate? _____

days per week exercising? _____

Do you wear store-bought arch supports? yes no

Do you wear custom orthotics? yes no

If yes, who made them: _____

How old are the orthotics: _____

Social History

Your occupation? _____

Do you smoke? yes no

Are you a past smoker? yes no

How Much? packs/day _____

Years Smoked: _____

Drink Alcohol?: yes no

How Much: _____

Recreational Drugs? yes no

What: _____

Pregnant or possibly pregnant? yes no

The US HITECH Act requires us to ask the following questions:

Preferred Language: English

Other: _____

Race:

- American Indian or Alaska native
- Asian
- Asian Indian
- Black/African American
- European
- Native Hawaiian/Pacific Islander
- White
- Other: _____
- **Decline**

Ethnicity:

- Hispanic/Latino
- Not Hispanic/Latino
- Other: _____
- **Decline**

Review of Symptoms

Check all that you are currently experiencing.

GENERAL
- Fever
- Chills
- Sweats
- Weight Loss
- Weight Gain
- Other_____

EYES
•Please circle right, left or both
- Vision changes R L Both
- Eye injury R L Both
- Eye irritation R L Both
- Other_____

EARS/Nose/Throat
•Please circle right, left or both
- Hearing loss R L Both
- Earache R L Both
- Smell Disorder
- Balance problem
- Sore Throat
- Other_____

CARDIOVASCULAR
- Chest Pain
- Irregular beat
- Heart Valve problems
- Edema
- Other_____

RESPIRATORY
- Cough
- Difficulty sleeping
- Wheezing
- Other_____

GASTROINTESTINAL
- Nausea
- Vomiting
- Diarrhea
- Abdominal pain
- Other_____

GENITOURINARY
- Pain with urination
- Frequent urination
- Difficulty starting or maintaining urination
- Other_____

MUSCULOSKELETAL
- Muscle cramps or aches
- Joint pain or swelling
- Back pain
- Other_____

CIRCULATION
- Leg cramps
- Blood Clots
- Other_____

NEUROLOGICAL
- Headaches
- Seizures/Stroke
- Numbness/Tingling
- Other_____

PSYCHOLOGICAL
- Depression
- Anxiety
- Other

ENDOCRINE
- Cold intolerance
- Heat intolerance
- Excessive thirst or urination
- Other_____

HEMATOLOGICAL
- Abnormal bruising
- Abnormal bleeding
- Other_____

SKIN
- Rash
- Itching
- Suspicious lesions
- Other_____

I have answered the above questions to the best of my ability. By typing your name below, you are signing this document electronically. You agree your electronic signature is the legal equivalent of your manual signature on this Agreement.

Signature/e-Signature:_____ Date:_____/_____/_____

*Note: Your e-signature does act as your real signature

Financial Policy for **ELITE FOOT AND ANKLE Associates LLC**

Thank you for choosing our office as part of your health care team. In our effort to provide personalized care in the most efficient and economical manner possible, we are providing to all of our patients this copy of our Financial Policy. We ask that you take a few moments to read our Financial Policy and sign below.

Insurance Coverage

Your insurance policy is a contract that exists between you and your insurance company. Our relationship is with you, the patient, and not the insurance company. If you have questions about your coverage, please call the phone number provided on the back of your insurance card. New insurance companies are continually forming and existing insurance companies are rapidly changing. It is your responsibility to know the specifics of your policy (referral requirements, in and out of network physicians and facilities, etc.). Most private insurance policies (non Medicare/Medicaid) plans now have deductibles, copayments, coinsurances, maximums and limitations (out of pocket expenses). **If your annual out of pocket expenses have not been met, you will be required to pay a $150 deposit at the time of your visit**. This will be applied to your account and a statement will be sent reflecting any additional fees owed following response from your insurance carrier. **These measures maintain compliance with the "No Surprise Act".** In lieu of a deductible deposit, a valid credit card will be required and stored securely. Upon claim response from your insurance, you will receive a statement, if the statement goes unpaid your credit card will be charged and a detailed statement will be provided along with a paid receipt.

We rely on you to inform us of all insurances in effect and to notify the office immediately of any changes with your insurance. If you do not inform us of changes, you will be responsible for the services rendered. When multiple policies exist, it is the patient's responsibility to inform us which policy is the primary plan. If we are not provided ALL insurance information at the time of service, you will be responsible for paying Elite Foot & Ankle directly and then submitting for reimbursement from your insurance company. As a courtesy our staff performs eligibility and benefit checks on the day of service (as requested from insurance).

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. Please check your coverage for anticipated services prior to your appointment. Because your insurance policy is a confidential agreement between you and your insurance company, we are rarely privileged to know what services are covered on your particular plan.

The cost of custom orthotics, boots and other DME is NON-REFUNDABLE and MAY NOT BE RETURNED for a refund because these are medical devices and orthotics are a custom made item.

All charges are the responsibility of the patient. We will bill your insurance company as a courtesy, but any services not covered by your policy are the patient's responsibility.

Please initial each line indicating your understanding of our policies:

_____**COPAYMENTS & INSURANCE:** If you have not met your annual max OOP we require a **$150** deposit on top of your co-pay. This will cover your portion of the services rendered. In Lieu of the deposit, you can leave a credit card on file and we will charge the card after we hear back from your insurance. We shall send refunds at the end of every quarter or at the end of your treatment if there is credit after we have heard back from your insurance. It is a requirement of your insurance company that we collect your copay. Payment is required before meeting with the doctor.

_____**SELF-PAY:** Full payment is due at time of service. A down-payment will be required before seeing the doctor. **At a minimum, an evaluation and management fee will be charged.** Additional procedures/services may be recommended by the doctor but you will be informed of these charges before proceeding with treatment.

_____

_____**REFERRAL:** If your insurance plan requires a referral from your primary care doctor, you will be required to obtain it prior to your visit. Without a referral available, we may need to reschedule your appointment otherwise you will be responsible for the charges.

NO SHOW & CANCELLATION: 24 hours notice is required for cancellation of your appointment and failure to do so will incur a **$250** fee. Failure to provide **24 hours notice** to cancel a procedural visit will incur a **$300** fee.

_____**SURGERY:** We require a **$250** deposit prior to surgery. Failure to provide 5 business days notice of cancellation prior to scheduled surgery date will incur a $500 fee.

BALANCES/COLLECTION FEES: Any statement that is not paid within 20 days will incur a **$25** statement fee for every statement sent after the first one. ***Payments can be made securely through the system generated link on your statement.***

_____**FMLA/DISABILITY/MEDICAL RECORDS:** The first copy of your medical records is free of charge, then a **$30** fee for additional copies will be charged (per state guidelines).

_____**OREGON HEALTH PLAN PATIENTS:** We are only on open card, CareOregon, MODA, & Providence OHP plans. **We are NOT on:** PacificSource, Trillium, Kaiser, Yamhill, or any other OHP plans. You agree to take responsibility for the charges for your appointment if you are on any OHP plan other than open card, CareOregon, MODA, or Providence OHP plans. Please know your insurance plan.

I have read and understand the Financial Policy of **ELITE FOOT AND ANKLE Associates LLC**

Patient's Name (print):_____**Date of Birth:**_____

Patient's/Guardian's 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: _____