Family Foot Clinic

Date:_____

PATIENT REGISTRATION

SSN#_____ BIRTH DATE _____ AGE _____ MARITAL STATUS_____ SEX_____

LAST NAME _____ FIRST NAME _____ MI____ TITLE _____

STREET ADDRESS _____ ZIP _____ CITY_____ STATE_____

EMPLOYER_____ OCCUPATION _____ EMAIL _____

ETHNICITY _____ RACE _____ PRIMARY LANGUAGE _____

PRIMARY CARE PHYSICIAN _____REFERRING PHYSICIAN_____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

EMERGENCY CONTACT_____ PHONE_____ PREFFERED PHARMACY_____

RESPONSIBLE PARTY ☐ SELF (SKIP TO"*INSURANCE*") ☐ OTHER (SEE BELOW)

LAST NAME _____ FIRST NAME _____ RELATIONSHIP _____

STREET ADDRESS _____ CITY _____ STATE _____

ZIPCODE _____ BIRTH DATE_____ PHONE _____

INSURANCE

INSURANCE ID _____ GROUP/PLAN ID _____

RELATIONSHIP _____ EFFECTIVE DATE _____ CO-PAY _____

CARDHOLDER LAST NAME _____ CARDHOLDER FIRST NAME _____

CARDHOLDER STREET ADDRESS _____ CITY _____

STATE _____ ZIP _____ SEX _____ CARDHOLDER BIRTHDATE _____

PLEASE READ THE FOLLOWING: I hereby give my permission for Dr. Gerald Peterson and/or his associates to administer treatment as may be deemed necessary in the diagnosis and/or treatment of any podiatric medical condition.

OFFICE POLICIES: **All non-covered services are due at the time of service.** As a courtesy to me, my insurance claim will be processed provided all necessary information is presented. I understand that if my insurance company requires that my primary care physician refer me to Dr. Peterson or Dr. Keeler and I have not obtained that referral, that any and all charges incurred will be, my responsibility. I also understand that I must notify Dr. Peterson of any need to pre-authorize treatment, and I accept responsibility for all charges for which pre-authorization is not obtained. **COPAYMENTS ARE DUE AT THE TIME OF SERVICE.** Statements are sent out monthly. My account will be assessed a rebilling charge of $20.00 per month for any balance over 60 days. Balances are not carried over 90 days. If my insurance company has not paid within that time frame, the balance over 90 days will become my responsibility. If payment does not result, my account will be assigned to collections. I understand that if it becomes necessary to use outside collection efforts to bring my account to a paid status, which I will be charged any and all collection costs at the time the account is assigned. Also, I hereby authorize any insurance benefits to be payable directly to the physician. I am financially responsible for all non-covered charges. I also authorize the physician to release any medical information necessary in processing my insurance claim to my insurance company. A charge of $30.00 will be added to all returned checks. If you are unable to keep an appointment, we require you to give us 24 hour notice. There will be a $25.00 charge to all "no show" appointments or canceled appointments under 24 hours.

***Signature of Patient or Authorized Person**: _____ ***Date**: _____

MEDICAL HISTORY (CHECK ALL THAT APPLY) **Name:**_____

PLEASE STATE CURRENT FOOT OR ANKLE PROBLEMS: _____

_____

ANY ALLERGIES: ☐NO DRUG ALLERGIES ☐ADHESIVE TAPE ☐ ANTI-INFLAMMATORIES (IBUPROFEN, ETC) ☐LATEX ☐ IODINE
☐ANTIBIOTICS:_____ ☐PAIN MEDICATION:_____ ☐ANESTHETIC:_____
☐ OTHERS:_____

LIST ANY MAJOR SURGERIES OR PROCEDURES AND ANY INJURIES OR FRACTURES YOU HAVE HAD (ALL BODY PARTS):

YEAR	SURGERY/PROCEDURE	YEAR	INJURY/FRACTURE

MEDICATIONS: LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING DOSAGES

_____

_____

_____

_____

HEALTH HISTORY (CHECK ALL THAT APPLY):

☐ PACEMAKER	☐LOSS OF VISION	☐DIFFICULTY BREATHING	☐ STROKE	☐ ARTIFICIAL JOINTS
☐ HEART ATTACK	☐ HEARING LOSS	☐ SHORTNESS OF BREATH	☐ HIGH CHOLESTEROL	☐ ULCERS
☐ ASTHMA	☐ ANESTHESISA PROBLEMS	☐DIALYSIS	☐LEG PAIN W/ EXCERSICE	☐ DRY SKIN
☐ HYPERTENSION	☐ CHEST PAIN	☐ LIVER DISEASE	☐MUSCLE CRAMPS	☐ SKIN DISCOLORATION
☐ DIABETES MELLITUS	☐ CRUSHING CHEST PAIN	☐ KIDNEY PROBLEMS	☐ TINGLING	☐TUBERCULOSIS
☐ ARTHRITIS	☐ CONGESTIVE HEART FAILURE	☐ URINE FREQUENCY	☐ NUMBNESS	☐RECENT WEIGHT LOSS
☐ HEPATITIS	☐ARTIFICIAL HEART VALVES	☐ URINE URGENCY	☐ VERTIGO	☐RECENT WEIGHT GAIN
☐ BLEEDING PROBLEMS	☐ PALPITATIONS	☐ URINE ODOR (ABNORMAL)	☐ FAINTING	
☐ CANCER	☐ ANGINA	☐ EXCESSIVE SWEATING	☐ PARALYSIS	
☐NEUROPATHY	☐ HEART DISEASE	☐ NIGHT SWEATS	☐ SEIZURES	
☐ ALZHEIMERS	☐ BACK PAIN	☐SLEEP APNEA	☐ BALANCE PROBLEMS	

HEALTH HABITS : HEIGHT_____ WEIGHT_____ SHOE SIZE_____ HOSPITAL PREFERENCE_____
DAILY CAFFINE INTAKE_____ SLEEPING HABITS_____ LIVE ALONE?_____

TOBACCO	**DO YOU USE TOBACCO?** ***IF YES*: CIGARETTES** - HOW MANY PACKS/DAY? _____ **CIGARS** - #/WEEK?_____ **SMOKELESS TOBACCO** - CANS/WEEK? _____
ALCOHOL	**DO YOU DRINK ALCOHOL?** ☐YES ☐NO ***IF YES*: WHAT FORM AND HOW OFTEN? _____** **DO YOU USE RECREATIONAL DRUGS?** ☐ YES ☐NO ***IF YES*: WHAT FORM AND HOW OFTEN? _____**
INJECTIONS	**DATE OF LAST FLU SHOT? ____/_____/_____ DATE OF LAST PNEUMONIA SHOT? ____/_____/_____**
ACTIVITY	**HOW OFTEN ARE YOU ON YOUR FEET DAILY? _____** ☐10% ☐25% ☐ 50% ☐75% ☐90%

FAMILY MEDICAL HISTORY: LIST ANY SIGNIFICANT HEALTH PROBLEMS THAT YOUR BLOOD RELATIVES HAVE HAD (*ex:heart* disease*,diabetes,foot conditions)*
☐ *Check here if you are adopted or if you do not know your family medical history*

MOTHER	
FATHER	
SIBLINGS	

ACKNOWLEDGMENT AND CONSENT

I understand that Family Foot Clinic

(Referred to below as "This Practice") will use and disclose health information about me. I understand that my health insurance may include information both created and received by This Practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

I understand and agree that This Practice may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment.
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment.
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care.
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of this Practice's Notice of Privacy Practices, in effect will be in the waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above, and that I have received a copy of the Notice of Privacy Practices.

Print patient name: _____ Date: _____

Signature of Patient: _____

Financial Policy

Dr. Peterson
Dr. Keeler
1880 Willamette Falls Dr Ste 111
West Linn, Oregon 97068
(503) 657-1900

Patients are responsible for all charges resulting from treatment provided by Dr. Peterson or Dr. Keeler. As a courtesy to our patients we bill most insurance carriers directly. However, primary responsibility for the account is yours. **Payment is due within 30 days from the point your insurance pays on your claim**. Established patients with delinquent balance will be asked for payment at the time of service. All co-payments, co-insurance, deductibles and non-covered services are due at the time of service. **Minors:** The undersigned will agree to be responsible for payment of balances for services rendered to minors.

Payment Terms

- All new patients are required to pay for services in full, or insurance listed co-pays the day of the appointment. **Please note:** A new patient is defined as one who has not received professional services from Dr. Peterson or Dr. Keeler., within the last 3 years.
- **A $5.00 handling fee is added to co-payments not paid at the time of service.** It is your responsibility to make sure your co-payments are made.
- **If payment is not received from your insurance company within 60 days, we will require payment from you**. Payments received from your insurance company after you have paid will promptly be refunded to you.
- **Checks returned for insufficient funds, closed account, or other problems are subject to a $30.00 service fee.**
- Accounts subject to collection activity may be charged a $30.00 Service fee.

Insurance Billing

Providing correct insurance billing information is the responsibility of the Patient. If your insurance changes, please present your new card. Notification of any changes of your primary care physician is also required. If complete billing information is not provided, the services will be billed directly to you**. Medicare-** we accept assignment on Medicare. If you have a secondary insurance, please provide that information so that we may bill for you. **Worker's Compensation-** In order to file a worker's compensation claims, we will need the name of your insurance carrier, date of your injury and your claim number.

Referrals

<u>If your medical insurance requires a referral, it is your responsibility to obtain this prior to your appointment.</u>

I have read and received a copy of the Payment Policy for Dr. Peterson or Dr. Keeler. I accept this policy for my treatment.

Print your Name Date

Signature Date