Northwest Foot & Ankle

Welcome to Northwest Foot & Ankle

** In order to provide you with the best possible care and experience, we require this form be completed prior to your initial appointment. Failure to complete this form will result in a delay of your appointment. (If more room is needed, please contact us.) Thank you and welcome to our clinic!

PATIENT INFORMATION: Please complete **ALL** of the entries!

Today's Date:_____ Patient Name:_____

Date of Birth:_____ Age:_____ ☐ Male ☐ Female

Home Phone:_____ Cell/Mobile Phone:_____ Email Address:_____

Address:_____ City, State, Zip:_____

Insurance Provider:_____ *HSA/FSA cards are generally accepted*

- Patients insured under these plans will NOT be reimbursed for visits and will NOT receive a Superbill to submit: Medicare, Oregon Health Plan (OHP), CareOregon, HealthShare Oregon, FamilyShare, Tricare, Medicaid, or any other govt. issued plans.
- We **cannot** see patients who are using Auto Accident coverage of any kind.

Employer:_____ Occupation:_____ Work Phone:_____

Emergency Contact:_____

Relationship:_____ Emergency Contact Phone:_____

Primary Care Physician:_____ Phone:_____

Address:_____ Date last seen by PCP:_____

Pharmacy:_____ Pharmacy Phone:_____

How did you find out about us / who may we thank for referring you to us?_____

May we contact you via email for feedback, updates, and newsletters? ☐ Yes ☐ No

PATIENT COMPLAINTS: Check ALL that apply

☐ Right Foot ☐ Corns ☐ Bunions ☐ Headaches ☐ Flat feet ☐ Calluses ☐ Pain in heels

☐ Left Foot ☐ Back pain ☐ Thick nails ☐ Warts ☐ Knee pain ☐ Ankle sprains

☐ Ingrown toenail(s) ☐ Leg cramping ☐ Feet cramping ☐ Other_____

Please explain your current foot or ankle problem:_____

When did the problem start?_____

What has been done to treat the problem?_____

Is this injury work related? How?_____

Do we have your permission to send imaging results to your PCP or referring medical provider?_____

9600 SW Nimbus Ave, Suite 160. Beaverton, OR, 97008 • Phone: 503.243.2699 • Fax: 503.243.2698
www.nwfootankle.com • frontdesk@nwfootankle.com

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PATIENT HEALTH INFORMATION:

Weight: _____ Height: _____

Shoe Size: _____ Width: _____

How is your general health? Good ☐ Fair ☐ Poor ☐

	Yes	No
Do you have a history of low back pain?	☐	☐
Are you regularly tired and exhausted?	☐	☐
At work, do you spend more than 30% of your time on your feet?	☐	☐
Did anyone in your family (mother, father, grandparents) have similar foot problems?	☐	☐
Have you been treated by a doctor in the past 2 years?	☐	☐
Are you subject to prolonged bleeding?	☐	☐
Is there a family history of diabetes?	☐	☐
Do you smoke cigarettes?	☐	☐
If yes, how many per day? _____		
Have you ever fainted in a doctor's or dentist's office?	☐	☐
Have you had previous care by a podiatrist?	☐	☐
Date last seen: _____		
Dr's Name: _____		
Is your current pain/injury keeping you from regular activities?	☐	☐

Have you ever been treated for any of the following?

☐ Epilepsy/Seizures ☐ Gout ☐ Heart Disease
☐ Stomach ulcer ☐ Stroke or Heart Attack
☐ Phlebitis ☐ Diabetes ☐ Anemia
☐ Kidney Bladder ☐ Difficulty in healing
☐ Liver Disease ☐ Rheumatic fever
☐ Thyroid Disease ☐ Tuberculosis
☐ Shortness of breath ☐ High/low blood pressure
☐ Depression or Anxiety ☐ Accident/Injury
☐ Vascular/Circulatory Disease ☐ Cancer
☐ Immune Disease (HIV, AIDS, Hepatitis ☐A, ☐B, ☐C)

Have you experienced any ill effects from any of the following?

☐ Penicillin ☐ Aspirin ☐ Cortisone
☐ Sulfa Drugs ☐ Novacain ☐ Tape
☐ Codeine ☐ Any antibiotics
☐ Latex ☐ Peanuts

Others, please list: _____

Are you allergic to any medications?

If yes, please list ALL: _____

SERIOUS ILLNESSES:

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

SURGERIES and HOSPITALIZATIONS:

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

MEDICATIONS/Vitamins, Supplements, and over-the-counter products such as Advil, Tylenol, etc. (include dosage of each):

This section is important…Please do not skip!! *If a list is available, please give to the receptionist in order for us to make a copy for your records.

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____
7. _____ 8. _____ 9. _____

********** **FOR OFFICE USE ONLY** **********

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Office Policy

**We do not bill insurance companies or 3rd party injury policies. We are not and will not be bound by what insurance companies may request.

Billing Policy:

-_☐_ The fees charged are standardized and based on a relative value scale that takes into account the time, skills, and professional components required for each visit and procedure. They are comparable to fees charged in this and neighboring communities by other competent physicians. An estimate for the charge of any procedure will be given when requested.

-_☐_ We accept **Visa, MasterCard, AMEX, Debit, Check, or Cash - most HSA/FSA cards are accepted as well.**
- PATIENTS ARE REQUIRED TO PAY IN FULL AT THE TIME OF SERVICE
- If you have insurance that pays out-of-network, we will provide you with the necessary document (called a Superbill) so you can submit it to your insurance company for reimbursement.
-A $25.00 fee, plus any bank fees, will be charged for all returned checks.

-_☐_ If for some reason you have a balance remaining, it is considered delinquent 30 days from the date of service. At the discretion of the manager, all accounts 60+ days delinquent will be referred to an outside collection agency. A $50 fee will be charged if the account is placed with an outside agency. We will be unable to see you until the account and fees are paid in full.

Appointments:

-_☐_ For the comfort and well-being of both patients and staff, we ask that you do NOT wear perfumes, colognes, or any other type of scented products to your visit. Many people have allergies to scented products and it can pose a severe health risk to them. We thank you in advance for honoring this policy!

-_☐_ We do our best to reach patients and confirm their appointments, however we cannot guarantee a reminder call. Patients are responsible for showing up to their appointment date/time. Please be sure to mark your calendar or set a reminder for your appointment. (See Cancellation Policy below)

Cancellations:

-_☐_**If you need to cancel or reschedule, you must notify our office at least 24 business hours prior to your scheduled appointment.**
-Failure to do so will result in the loss of your pre-paid deposit for the office fee.

Returns/Refunds:

- _☐_ Unless otherwise noted, products can be returned or exchanged within 30-days of purchase (in original condition and with original packaging)
- _☐_ Charges for patient services, procedures, custom orthotics, and other custom accessories are non-refundable and non-exchangeable.

PLEASE NOTE:
We are a teaching clinic and do have medical students, medical residents, and visiting doctors observing our doctors in the treatment room with patients.

I understand and agree that I am responsible for payment to Northwest Foot and Ankle for any and all charges to my account. If it becomes necessary to enact collections of any amount owed on this or subsequent visits, I agree to pay for all costs and expenses, including reasonable attorney fees.

_____ _____

Signature **Date**

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Acknowledgment of Receipt

I, _____ have been notified of the Notice of Use of Private Health Information from Northwest Foot and Ankle, which was both offered to me as a copy for my records, and posted in the office in accordance with the standards for Privacy of individually Identifiable Health Information ("Privacy Rule") established by the U.S Department of Health and Human Services of implement the requirement of the Health Insurance Portability and Accountability Act of 1966 (HIPAA). I have also been given the opportunity to have any questions regarding this notice answered by my healthcare provider or staff, as well as the appropriate contact information to the Office of Civil Rights.

_____ _____

Signature of Recipient Date

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