Cascade Foot Center

Patient:

Name: _____ SSN _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Date of Birth ___/___/___

Email: _____ Marital Status M / S / D / W

Language Preference: _____ English _____Spanish _____ Other: _____

Race: ____ American Indian or Alaska Native _____Asian _____Black or African American

____ Native Hawaiian or Other Pacific Islander _____ White

Ethnicity: ____ Non Hispanic or Latino _____ Hispanic or Latino

Employer: _____ Position: _____

Primary Care Physician: _____ Last time seen by PCP: ___/___/___

Pharmacy you use: _____

Responsible Party (if other than patient)

Name: _____ Relation to Patient _____

Date of Birth: ___/___/___ Sex: M / F Social Security Number: _____

Employer: _____ Work Phone: _____

Emergency contact Information:

Name: _____ Relation to patient: _____ Phone number: _____

Contact Preference for appointment reminders: (initial by all approved)

___ Patient , ___ Spouse _____, ___ anyone answering the phone, ___ Other_____

Federal Government Requirements for 2018:

Have you had your Flu shot this season (Oct 1st 2017-March 31st 2018) Yes / No

Have you ever had a Pneumococcal Vaccination in your lifetime? Yes / No

Do you have an Advance Care Plan or a Surrogate Decision maker? Yes / No

Notice of Patient Privacy Practices (HIPAA)

I understand that under the health Insurance Portability and Accountability Act of 1996 (HIPAA). I have certain rights to privacy regarding my protected health information. I understand my health information can and will be used to (1) conduct, plan and direct my treatment and follow up among multiple healthcare providers who may be involved in that treatment directly and indirectly. (2) Obtain payment from third-party payers. (3) Conduct normal healthcare operations such as quality assessments and physician certifications. I know that I can request a copy of the Notice of Privacy Practices which contains a more complete description of the uses of disclosures of my health information from Cascade Foot Center at anytime. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact Cascade Foot Center at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that Cascade Foot Center restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I understand that Cascade Foot Center is not required to agree to my restrictions but if it does agree, then it is bound to abide by such restrictions. I permit Cascade Foot Center to communicate test results, doctor's instructions, and appointment reminders in the above marked manner.

Patient or Responsible Party Signature: _____ Date: ___/___/___

Medical History

Describe your current foot problem: _____

Past foot or ankle surgeries: _____

How many hours do you spend on your feet each day? (Circle one) 0-1 2-4 5-8 9-12 over 12

Do you drink alcohol? No / Yes If yes: Daily / Weekly / Monthly

Do you use tobacco or nicotine products?(circle one) Never/ current everyday user/ current someday user/ former

Do you use Recreational Drugs? No / Yes

Family History:

Diabetes: Mother ___ Father ___ Foot Problems: Mother ___ Father ___

Heart Disease: Mother ___ Father ___ Blood Disorders: Mother ___ Father ___

Surgical History:

Do you have a history of trouble with anesthesia? N / Y If yes explain: _____

Cardiac Surgeries: N / Y Do you have heart valve troubles? N / Y Artificial heart valve? N / Y

Do you have a pacemaker? N / Y Do you have any stents? N / Y

Orthopedic Surgeries: N / Y If yes, list surgeries _____

Do you have artificial joints? N / Y If yes, which joints? _____

List major surgeries in the last 10 years: _____

List Medications you take on a regular basis: (or attach a list)_____

_____

_____

Do you have allergies to any medications, Latex, or Iodine? N / Y If yes, which ones: _____

Check any of the following you have/had a problem with:

___ Anemia	___ Cancer of _____	___Gout of _____	___ Diabetes I or II
___ Arthritis	___Circulation	___ Heart Problems	___ Kidney Problems
___ Asthma	___ Depression	___ Hepatitis	___ Liver Problems
___ Bladder	___ Emotional/Psychiatric disorder	___ High blood pressure	___ Neurological disorder
___ Troubles Healing		___ Rheumatic Fever	___ Intestinal Problems
___ Prostate		___ Other: _____	

Height: _____ Weight: _____ Shoe Size: _____

Billing / Account Policy: (PLEASE READ THE FOLLOWING CAREFULLY AND ASK QUESTIONS BEFORE SIGNING)

Patient financial Responsibility, You are financially responsible for payment of your medical care at Cascade Foot Center If you are uncertain whether your services or products are covered by your insurance plan, you should confirm this with your insurance carrier prior to your appointment. You are responsible to obtain referral and/or authorizations for your services as may be required by your policy. Our office is not responsible for charges denied because of referral was not obtained before services were rendered. Co-payment are due at the time of your appointment. When we are given complete billing information, we are able to bill most insurance companies directly for you. You are responsible for deductibles, copayments, and services or products not covered by your insurance carrier**. If you have a balance owing to us, the balance is due within 45 days of the date of our first statement**. If you are unable to pay within 45 days, you must contact our Accounts Department to establish a payment plan to ensure no further action will be taken on your account. Your first two monthly statements will be sent to you free of charge. After that time, each billing statement issued will incur a $4.00 statement fee until your account is paid in full. If you do not have insurance coverage, we currently offer our patients a 10% discount off our regular fee schedule. Payment of your bill is DUE AT TIME OF SERVICE. If you have a high deductable a $100 payment is due at time of service. There will be a $25.00 fee for any check returned by your bank for non-sufficient funds. **I understand there will be a $20.00 "NO SHOW" cancellation fee charged to me if I fail to have a 24 our notice.** If we are required to turn over your account for collections, in addition to your account balance, you agree to pay any and all collections fees whether litigation is commenced or not, including attorney fees. I understand and agree to the terms of Cascade Foot Center Billing *Policy.*

*Patient/ Responsible Party Signature:*_____ *Date:* ___/___/___