Medford Foot and Ankle Clinic, P.C.

Michael A. DeKorte, DPM, FACFAS*
Rick E. McClure, DPM, FACFAS*
Jeffery D. Zimmer, DPM

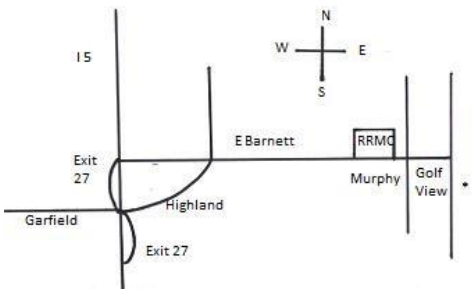
Dear Patient,

Thank you for choosing Medford Foot and Ankle Clinic for your podiatric care. Enclosed are the registration and medical history forms. Please complete the enclosed forms and bring them to your scheduled appointment. Please arrive 30 minutes before your scheduled appointment. We have included a checklist of items you will need to bring to your appointment.

1. Completed Registration & Medical History Forms Enclosed (3 pages)
2. Your insurance card (we will ask to copy your insurance cards and personal ID such as a driver's license)
3. Any prior x-rays of your feet taken within the past 12 months. If you do not have x-rays to bring, they may be ordered by the podiatrist and taken at your visit.
4. If you are diabetic, Please bring or have faxed to our office a copy of your most recent HBA1C lab. (Available from your primary care doctor)

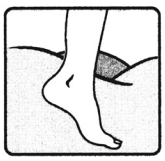
If you are on a managed care plan, workers compensation or Medicaid: a referral from your primary care provider is necessary. Workers Compensation requires you be referred by an MD or DO prior to your visit.

The Medford Foot &Ankle Clinic is located at 713 Golf View Drive, Medford, Oregon. From Interstate 5 take Exit 27, go north on Highland, then East on Barnett Road (towards Rogue Regional Medical Center), turn right on Golf View Drive (Approximately ¼ mile past Rogue Regional Medical Center). The clinic is the second building on the left.



We look forward to meeting you.

The staff at Medford Foot & Ankle Clinic.



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Please complete all questions

PATIENT INFORMATION (PLEASE PRINT)

NAME (last, first, middle) | DATE

ADDRESS | CITY | STATE | ZIP

HOME PHONE | CELL PHONE | SOCIAL SEC. NO.

DATE OF BIRTH | AGE | SEX M F | MARITAL STATUS S M W D SEP

PATIENT'S EMPLOYER | POSITION/OCCUPATION

For access to your "Health Vault" an email address is required
E-MAIL: | PERSONAL PHYSICIAN

PREFERRED METHODS OF CONTACT: ❒ PHONE ❒ E-MAIL ❒ MAIL ❒ SMS / TEXT

ALLOWED TELEPHONE CONTACT: ❒ PATIENT ONLY ❒ PATIENT AND/OR SPOUSE ❒ SON/DAUGHTER ❒ ANYONE ANSWERING PHONE

EMERGENCY CONTACT

NAME | RELATIONSHIP

ADDRESS | HOME PHONE

PRIMARY LANGUAGE:_____ ETHNICITY: ❒ NON HISPANIC ❒ HISPANIC/LATINO ❒ NOT SPECIFIED *(This section is government required)*

RACE: ❒ WHITE ❒ BLACK ❒ ASIAN ❒ AMER. INDIAN ❒ PACIFIC ISLANDER ❒ NOT SPECIFIED *(This section is government required)*

REFERRED BY: ❒ PHYSICIAN ❒ FRIEND ❒ PHONE BOOK ❒ INTERNET ❒ ADVERTISEMENT

PERSON RESPONSIBLE FOR BILL (IF OTHER THAN ABOVE OR IF PATIENT IS A MINOR)

NAME | RELATIONSHIP

ADDRESS | CITY | STATE | ZIP

HOME PHONE | WORK PHONE

INSURANCE INFORMATION

PRIMARY INSUR. CO.	INSURED NAME	INSURED BIRTHDATE	RELATIONSHIP TO PATIENT	ID#	GROUP#
SECONDARY	INSURED NAME	INSURED BIRTHDATE	RELATIONSHIP TO PATIENT	ID#	GROUP#

AUTHORIZATIONS

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Medford Foot & Ankle Clinic, PC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance; and for obtaining any referrals or authorizations if required by my insurance carrier. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Date_____ Signed _____

Patient Name:_____ Date:_____

GENERAL HEALTH INFORMATION

Shoe Size _____Weight _____Height _____Most Current Blood Pressure:_____

Are you **allergic or sensitive** to:

Medication Allergies: (list) _____

Tape?_____ Betadine (Iodine)_____ Latex?_____

Any problem with local anesthetics? _____

Any problems taking aspirin or ibuprofen?_____

Name of your Pharmacy:_____

List **Current Medications and Supplements/Vitamins**:_____

_____

_____

_____

_____ *Provide an additional sheet if necessary*

Smoking: ❒ Never Smoked ❒ Former Smoker ❒ Current Smoker

Do you drink alcohol or beer? ❒ Yes ❒ No Frequency: _____

Work / Activity ❒ Sit at Job ❒ Stand at Job ❒ Stands & Walks at Job ❒ Retired

Do you have Diabetes? No_____ Yes_____ If Yes, How Long?_____

Do you take Insulin? No_____ Yes_____

List any serious illnesses _____

List any major surgeries _____

_____

Are you under a physician's care for any of the above? No_____ Yes_____

If yes, for what condition?_____

Physician treating this condition?_____

Last date you saw this doctor?_____

May we contact your physician about your health? No_____ Yes_____

MEDICAL INFORMATION

This Information is Important For Our Records And Your Health

Describe your foot problem _____

_____

_____

_____

How long has it been bothering you?_____ Days _____ Weeks _____Years

List any past problems of your feet and ankles _____

_____

Patient Name: _____ Date: _____

List any past surgical procedures on your feet or ankles _____

_____

_____

Do you have any artificial joints? ❒ Yes ❒ No If yes, where? _____

_____

Do you have a Heart Valve Implant? ❒ Yes ❒ No

Check ( ) any of the following you have, or have had a problem with:

( ) Anemia	( ) Frequent Infections	( ) Hormones	( ) Rheumatic Fever
( ) Arthritis	( ) Gout	( ) Intestines	( ) Skin
( ) Asthma	( ) Healing	( ) Kidneys	( ) Stomach Ulcers
( ) Bladder	( ) Heart	( ) Lungs	( ) Tuberculosis
( ) Cancer	( ) Hepatitis	( ) Neurological Disorder	( ) Unexplained Weight Loss

FAMILY HISTORY

Please list family member (blood relative) that has a history of:

( ) Arthritis Relation: _____

( ) Bleeding Disorder Relation: _____

( ) Bunions Relation: _____

( ) Circulation problems in legs or feet Relation: _____

( ) Diabetes Relation: _____

( ) Flat Feet Relation: _____

( ) Hammertoes Relation: _____

( ) Heart Disease Relation: _____

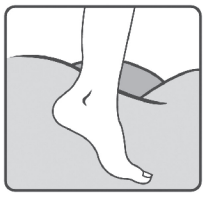
( ) Neurological Disorder Relation: _____

( ) Stroke Relation: _____

CONSENT

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

Signature _____ Date _____



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Patient Payment Policy

Your insurance company may pay all, a portion or none of your bill for services provided. Because of this you are asked to assume responsibility for any uncovered balance on your account. Payment guidelines for office charges are as follows:

Insured Patients

- We bill all insurance plans, according to the insurance provided by the patient at time of service. It is your responsibility to give us updated insurance information.
- Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and federal law. Please help us in upholding the law by paying your co-payment at each visit. Additionally, you may have coinsurance and/or deductible amounts required by your insurance carrier. Any outstanding balance on your account, after adjusting for all of your insurance's responsibilities, will be billed to you.
- Payment in full is due at the time of service, for patients who do not provide a copy of their insurance card.
- Payment plans are not accepted for co-payments.
- Medical services that are considered by your insurance company to be non-covered, out of network, or not medically necessary will be your responsibility. Payment plans available for these services upon request.

Uninsured Patients

- You will be asked to pay for the services in full at the time of service. A 10 % discount will be given if paid in full at time of service. If you are unable to pay for the services in full, you will need to make a $100 deposit on your account and establish a payment plan with the billing department **before** your scheduled appointment.

All Patients

- Payment is to be paid in full within 30 days of receiving your statement. All billing disputes must be submitted in writing within 30 days of receipt of statement. All patient responsible balances that remain delinquent after 90 days may be referred to a collection agency with a 20% fee added to your balance for collection fees.
- Patients who directly receive insurance payments for services provided at our office are asked to send the check with EOB to our Billing Department as soon as possible.
- If you are unable to keep your appointment with us, please give us at least 24 hours notice. This courtesy enables us to offer your original time to another patient that needs to be seen. After three occurrences, without 24hours notice there will be a $25.00 charge.
- Checks returned to us from the bank for non-payment or insufficient funds, will be charged $25.00.

I have read and understand the above payment policy.

_____ _____

Signature *Date*

Medford Office: 713 Golf View Dr. • Medford, Oregon 97504-9643 • Phone 541-770-1225 • Fax 541-770-1245
www.medfordfoot.com
** Fellow American College of Foot and Ankle Surgeons*

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Authorization to Disclose

Name of Patient; _____

I understand that if the person (s) or entity (ies) that receives the information is not a health care provider or a health plan covered by federal privacy regulations, the information described below is no longer protected by those regulations.

This authorization may be revoked at any time, and must be in writing, signed by me or on my behalf, and delivered to the address at the bottom of this form. This shall remain in effect from the date of signing until rescinded by patient or on my behalf.

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION & BILLING INFORMATION REGARDING PATIENT BELOW

This authorization must be written, dated and signed by patient or by a person authorized by law to give the authorization.

I authorize Medford Foot and Ankle Clinic Staff to release specific health information regarding my care and treatment; and to discuss billing and accounting inquiries on my behalf. To the following recipient (s):

Name: Relationship:

_____

_____

Print Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

Rev. 5/16

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