RFAS- 2300 NW Stewart Pkwy Roseburg, OR 97471 Phone: 541-673-7322 _____

Patient Information for Roseburg Foot and Ankle Specialists

Name:_____**Date of Birth**:_____**Age**:_____**Male**:_____**Female**: _____

Social Security Number (Required for certain insurances):_____

Mailing Address: _____

Email Address: _____**Primary Language:** _____

Home Phone: (___) ___-_____**Cell**: (___) ___-_____**Work**: (___) ___-_____

Marital Status: Single Married Widowed Divorced **Preferred form of Contact:** Email Phone

Race: White, African American, American Indian, Asian **Ethnicity:** Hispanic or Latino, Non-Hispanic

Pharmacy of Choice: _____

Emergency Contact: _____**Phone**: (___) ___-_____

Relation to patient: _____

Name of person we can discuss your medical care with: _____

Phone Number: _____ **Address:** _____

If patient is under the age of 18:

Responsible party full name: _____**Date of Birth**: _____

Address:_____**Phone**: (___) ___-_____

Relationship to patient:

Primary Insurance Company Name:

Insured's Name: _____**Date of Birth:** _____

Insured's Employer: (name, city, state, zip) _____

Insured's relationship to patient:

Secondary Insurance Company Name:

Insured's Name:_____ **Date of Birth:** _____

Insured's Employer: (name, city, state, zip) _____

Insured's relationship to patient:

I authorize benefits to be paid directly to Cordell Smith, DPM, Nathaniel Keplinger, DPM, Daniel Howell, DPM and/or Logan Gull, DPM. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered. I agree, in the vent of non- payment, to bear the cost of collections and/or court costs and reasonable legal fees. I have read all the information and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify this office of any changes in my status or of the above information

Patient Signature: _____ ***Date***: _____

Yes	No	Problem	Comments and approximate dates
		Allergic reaction to medication	
		Headaches	
		Trouble with vision	
		Trouble with hearing	
		Allergies / Hay fever	
		Asthma	
		Recent weight loss	
		Thyroid	
		Diabetes	What year were you diagnosed?
		Skin problems	
		Anemia	
		Heart	
		Mitral valve prolapse/heart murmur	
		Poor circulation	
		High blood pressure	
		Chest pain	
		Lungs (Pneumonia, TB, CHF)	
		Shortness of breath	
		Liver or gallbladder	
		Stomach trouble	
		Swelling in feet or ankles	
		Arthritis	
		Kidney disease or stones	
		Gout	
		Bleeding tendency	
		Scarring tendency	
		Joint pain or stiffness	
		Numbness in feet or legs	
		Cramps in feet or legs	
		Low back pain	
		Do you smoke? How much?	
		Do you drink alcohol? How much?	
		Psychiatric	
		Fainting or convulsions	
		Strokes	
		Pain in other areas	
		Other illnesses or problems	
		HIV positive	
		Are you pregnant? How many Months?	
		Cancer	

Please list any serious injuries or operations and the date of the episode: _____

_____

_____

_____

Former Podiatrist: _____

Why did you see your former podiatrist? _____

Primary Care Physician: _____ Has he/she requested you be seen in this Office? _____

Who referred you? _____

What problems bring you to this office? _____

_____

Have you previously had physical therapy? When, Where, for what condition?

_____

_____

Is there anything you wish to tell the physician privately? Yes: _____ No: _____

Indicate which of your immediate relatives have had any of the following conditions:

Cancer: _____ Diabetes: _____

Heart trouble: _____ High blood pressure: _____

Kidney disease: _____ Mental/emotional disease: _____

Stroke: _____ Arthritis: _____

Patient Signature: _____ Date: _____

Legal guardian signature: _____ Date: _____

Witness: _____ Date: _____

Reviewed by: _____ Date: _____

Cordell Smith, DPM, Nathaniel Keplinger, DPM, Daniel Howell, DPM and Logan Gull, DPM

PATIENT FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT

OFFICE PAYMENT POLICY

Because there are immediate expenses to provide a service to our patients, we expect you to contribute your portion when applicable. The following forms of payment are required.

Co-Payments: Due at each visit prior to seeing the provider.
Insurance: We will bill your insurance as a courtesy. Deductibles, patient balance responsibility beyond insurance, and all balances are due in full before the end of each month.
Self-Pay: Is due **in full** at the time of service.

Patient responsibility: Balances are due within thirty days of the date of service. If canceling an appointment, 24-hour advance notice is required, if canceling within less than 24 hours, there is a $25 fee. No-call, no-shows will incur a $50 fee.

Non-Covered Services: Non-Covered services are the responsibility of the patient/guardian. Non-Covered services vary from each insurance company. These may include, but are not limited to, durable medical items.

Name of Person we can speak with regarding balance of your account:
_____ Phone Number: _____

I have read the above Office Payment Policy and as a patient, or legal guardian of a minor or impaired patient, I understand regardless of any insurance coverage I may have, I am responsible for payment of this account. I understand there is no interest or finance charge on current accounts; however, I am also aware that **delinquent accounts beyond 90 days are subject to other collection means at my own expense.**
I have read, understand, and agree to the above Office Payment Policy in accordance with the terms set forth in the policy of this office. I also hereby attest that I have given payment information to the best of my knowledge for complete and timely payment.

Signature: _____ Date: _____

Printed Name: _____ Patient name (if different): _____

Acknowledgement of Notice Privacy Practices:

I, _____ Have read/received a copy of the Privacy Practices for RFAS
Patient's name

Signature: _____ Date: _____

Cordell Smith, DPM, Nathaniel Keplinger, DPM, Daniel Howell, DPM, and Logan Gull, DPM
PATIENT AUTHORIZATION FOR ELECTRONIC HEALTH RECORDS

To provide better care to our patients, we have chosen to participate in an electronic health records system called "Healow". Under that system, each patient has a single, secure set of electronic information that can be accessed by participating physicians and other providers from their offices, urgent care facilities, the emergency room, the hospital, and other locations. Among other benefits, that system:

- allows immediate access to results of tests, imaging procedures and other potentially critical information for routine and emergency treatment;
- allows the coordination of prescriptions and care by multiple providers;
- provides you and your physician or other providers with reminders and information from national health treatment databases;
- reduces the chances of error; and otherwise improves the quality of care you receive;
- helps in the processing of insurance and other claims

We recognize the importance of keeping your individual information confidential. Accordingly, Healow has, through contracts and strict rules, limited access to individual information to health care providers and those providing assistance to them, and only for the purposes of providing health care to you and related activities. Your privacy is also protected by state and federal law. By obtaining care from us, you consent to our participation in the Healow system, and use of that system to provide care to you, to the fullest extent permitted by law. If you do not consent, you must find care elsewhere.

I ACKNOWLEDGE AND CONSENT TO USE OF Healow.

DATED _____ _____

Patient or Guardian Signature (circle one)

_____ _____

Printed Name of Patient Printed Name of Above and Relationship

Roseburg Foot and Ankle Specialist

Medication List

Patient Name: _____DOB: _____Date: _____