FAMILY FOOT CLINIC

HIPAA AUTHORIZATION FOR USE/DISCLOSURE OF INFORMATION, CONSENT TO

RECEIVE TEXT MESSAGES

Family Foot Clinic respects the privacy of our patients, visitors, and staff. Ensuring that medical information is kept confidential is among our highest priorities. To ensure that Family Foot is acting in accordance with your wishes, using your personal information with your authorization, and communicating with you in a manner with which you authorize, we ask you to fill out and sign this form. Family Foot Clinic will keep a copy of your written permission on file.

I specifically authorize text messaging communication with Family Foot Clinic. The phone number I want text. communications sent to is ____. I understand that text. message communications may be unsecured. I understand that the risk of unsecured text messages is the potential that the communication could be read by a third party. I understand my mobile provider's standard rates for sending and receiving text messages will apply.

I am not required to sign this authorization. Family Foot does not condition treatment, payment, benefit eligibility, or enrollment activities on the signing of this form. I can request a copy of this authorization be mailed to me.

I understand that I may revoke or withdraw this permission at any time to prohibit future use of my information. To do so, I must send written notice to the Family Foot Clinic Privacy Officer at 1880 Willamette Falls Dr. #111 West Linn Oregon 97068. I understand that Family Foot Clinic, as well as other persons or entities, will retain copies of any such electronic or printed versions and shall retain these versions forever and that any revocation of this authorization will only extend to the versions of the information within Family Foot Clinic's control that have not been previously published. If not revoked/withdrawn by me, this authorization expires ten (10) years from the date that I sign it.

Patient Name: ____

Signature: ____________________________________ Date: _______________________

Address: ____

____

Phone: ____

For personal representatives, please provide the following:

I, _____________________________, represent that I am the health care agent/ guardian/ surrogate/ parent of the patient above.

Personal Representative Signature: ____

Address: _____________________________________ Phone: _________________________

*If you are the health care agent or guardian, please provide proof of your authority to act on behalf of the patient.

Patient Information

Last Name | First | Middle | Sex: M/F | Date of Birth | Nickname

Mailing Address | City | State | Zip Code | Marital Status

Social Security# | Home Phone# | Mobile Phone#

Employer | Occupation | Email

Primary Care Physician (PCP) | City Of PCP | Date PCP Last Seen | PCP Phone#

Emergency Contact Name | Relationship | Contacts Phone #

PERSON RESPONSILE FOR BILL *(IF DIFFERENT THAN ABOVE)

Name | Birth date (mm/dd/yyyy) | Sex: M/F | Relationship to Patient

Mailing Address | City | State | Zip Code

Home Phone # | Mobile Phone #

INSURANCE INFORMATION

Primary Insurance | Subscriber Name | Birthdate(mm/dd/yyyy)

Insurance ID # | Group # | Effective Date | Co-Payment

Secondary Insurance | Subscriber Name | Birth Date (mm/dd/yyyy)

Insurance ID # | Group # | Effective Date | Co-Payment

REFERRAL

- ○ Internet
- ○ Hospital/ER
- ○ Insurance
- ○ Dr. ______________________________
- ○ Friend/Family ______________________
- ○ Other ______________________________

MEDICAL HISTORY (CHECK ALL THAT APPLY)

PLEASE STATE CURRENT FOOT OR ANKLE CONCERNS:____

ANY ALLERGIES: ☐ *NO DRUG ALLERGIES* ☐ADHESIVE TAPE ☐ ANTI-INFLAMMATORIES (IBUPROFEN, ETC) ☐LATEX ☐ IODINE
☐ANTIBIOTICS:_____________________ ☐PAIN MEDICATION:________________________ ☐ ANESTHETIC:______________________
☐ OTHER:____

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

YEAR	SURGERY/PROCEDURE	YEAR	INJURY/FRACTURE

MEDICATIONS: *LIST CURRENT MEDICATIONS INCLUDING DOSAGES* ☐ **SEE ATTACHED LIST**

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	☐ ***NONE***
☐ 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: __________________________

PREFFERRED PHARMACY/LOCATION*:*____

DO YOU USE TOBACCO? ☐YES ☐ NO ***IF YES*, IN WHAT FORM/HOW OFTEN:** ___________________________________

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:** ____________________________

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 hereby give my permission for Dr. Keeler and/ or staff of Family Foot Clinic to administer treatment as deemed necessary in the diagnosis and/or treatment of any podiatric medical condition. I understand that my health insurance may include information both created and received by Family Foot Clinic 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 Family Foot Clinic may use and disclose my health information 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 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 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 Family Foot Clinic 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 Family Foot Clinic 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 will be in the waiting 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 Family Foot Clinic 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

Patients are responsible for all charges resulting from treatment provided by 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**. Statements are sent out monthly. Outstanding balances are subject to 1.5% per month interest. The undersigned authorizes and releases all banks, persons, and companies listed on this application to furnish information and authorizes the checking of credit. The undersigned agrees to pay all collection costs, court costs, and legal fees incurred to collect delinquent balances. Accounts subject to collection activity may be charged a 33.3% service fee. Established patients with delinquent balances will be asked for payment 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 co-payments, co-insurance, deductibles, and non-covered services are due at the time of service.** A $5.00 handling fee may be added co-payments not paid at the time of service.
- **If payment is not received from your insurance company within 120 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 accounts or other problems are subject to a $30.00 service fee.**
- Any account over 120 days will be assessed a fee of $20 per month.
- **If you are unable to keep an appointment, we require a 24-hour notice.** There will be a $50.00 charge to all "no show" or cancelled appointments under 24 hours.

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**.** I authorize any insurance benefits to be payable directly to the physician. **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-** For us 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/Pre-Authorizations

<u>If your medical insurance requires a referral or pre-authorization for treatment, it is your responsibility to obtain this prior to your appointment. Any charges accrued by not having such will be the patient's responsibility.</u>

I have read the above financial policy for Family Foot Clinic. I accept this policy for my treatment.

Print patient name: ______________________________ Date: ___________________

Signature of Patient: ____

Medical Information Release Form

(HIPAA Release Form)

Name: ___________________________________ Date of Birth: _____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse____

[ ] Child(ren)______________________________________

[ ] Other____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:__________________

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] ____

The best time to reach me is (*day*)___________________ between (*time*)_________

Signed: ______________________________________ Date: ____/____/_____

Witness:______________________________________ Date: ___/____/______