Practice: Santiam Foot Clinic, PC

Name: _____ **DOB:** _____

Sex: ☐ She/Her ☐ He/Him ☐ They/Them **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Email:_____ **Spouse/Partner Name:**_____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home #: _____ **Cell #:** _____ **Other #:** _____

Employer: _____ **Phone #:** _____

Emergency Name: _____ **Phone #:** _____

Primary Insurance: _____ Are you insured? ☐ Yes ☐ No

Insured Information

Subscriber Name: _____ Relationship to insured: ☐ Spouse ☐ Child ☐ Self ☐ Other

Sex: ☐ Male ☐ Female DOB _____/ _____/ _____

Policy ID: _____ Group ID _____

Secondary Insurance: _____ Are you insured? ☐ Yes ☐ No

Insured Information

Subscriber Name: _____ Relationship to insured: ☐ Spouse ☐ Child ☐ Self ☐ Other

Sex: ☐ Male ☐ Female DOB _____/ _____/ _____

Policy ID: _____ Group ID _____

How did you find out about our practice? ☐ Physician ☐ Internet ☐ Telephone book ☐ Family member ☐ Friend ☐ Google ☐ Social Media ☐ Other: _____

What is the reason for your visit today? _____

_____

Result of accident or work injury ☐ Yes ☐ No

How long has this bothered you? _____

What treatments have you tried & have they been effective? _____

_____

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? _____/10

The pain quality is: ☐ burning ☐ constant ☐ dull ☐ sharp ☐ shooting ☐ throbbing ☐ tingling ☐ other_____

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

History and Physical

Medical History:
☐ Alcoholism
☐ Allergies
☐ Anxiety disorder
☐ Arthritis *(specify)* _____
☐ Asthma
☐ Blood clot
☐ Blood disorders
☐ Cancer
☐ Circulation problems
☐ CVA
☐ Depression
☐ Diabetes (type 1, type 2)
☐ Gout
☐ Heart disease
☐ Heart murmur
☐ Hepatitis
☐ High blood pressure
☐ High cholesterol
☐ HIV
☐ Kidney disease
☐ Liver
☐ Mental illness
☐ Musculoskeletal
☐ Neuropathy *(specify)* _____
☐ Other *(specify)* _____
☐ Skin Disorders
☐ Sleep apnea
☐ Stomach/bowel
☐ Stroke
☐ Thyroid disease *(specify)* _____

Are you pregnant
☐ Yes ☐ No
Are you nursing
☐ Yes ☐ No

Surgical History: ☐ None ☐ Appendectomy ☐ C-Section ☐ Angioplasty ☐Bypass ☐ Cataracts ☐ Cholecystectomy
Please list all surgical procedures not listed above: _____
Do you have any artificial joints? ☐ Yes (where? _____) ☐ No Do you have an artificial heart valve? ☐ Yes ☐ No

Social History: How many biological children do you have? _____
Do you drink caffeine? ☐ Yes ☐ No If yes, how many cups per day? _____
Do you drink alcohol? ☐ Yes ☐ No If yes, how many cups per day? _____
Do you smoke? ☐ Yes ☐ No If yes, How many packs per day? 1 2 3 4 5 For how long? _____
Substance abuse: ☐ Yes, I have a current substance abuse problem. Please specify: _____
☐ No, I have never had a substance abuse problem
What is your occupation? _____
Do you exercise regularly? ☐ No, I do not exercise regularly ☐ Yes, I do the following regular exercise: _____
_____

Family History: *Please indicate **Mother** or **Father** only:*

☐ Alzheimers	☐ Mother	☐ Father	☐ Depression	☐ Mother	☐ Father
☐ Arthritis	☐ Mother	☐ Father	☐ Diabetes	☐ Mother	☐ Father
☐ Bleeding disorders	☐ Mother	☐ Father	☐ Emphysema	☐ Mother	☐ Father
☐ Blood Clot	☐ Mother	☐ Father	☐ Heart disease	☐ Mother	☐ Father
☐ Cancer	☐ Mother	☐ Father	☐ High blood pressure	☐ Mother	☐ Father
☐ Cataracts	☐ Mother	☐ Father	☐ Neurological	☐ Mother	☐ Father
☐ Other *(specify)*_____	☐ Mother	☐ Father	☐ Strokes	☐ Mother	☐ Father

Review of Symptoms: (*Please check the box if you currently have any of these symptoms of check "NONE")*

Cardiovascular	☐ leg pain when walking	☐ fever	☐ chest pain/pressure	☐ leg swelling	☐ cold hands/feet
	☐ fainting	☐ palpitations	☐ vascular disease	☐ valve problems	☐ **NONE**
Geniourinary	☐ blood in urine	☐ hesitancy	☐ incontinence	☐ increased urgency	
	☐ decreased frequency	☐ excessive urination	☐ kidney disease	☐ kidney stones	☐ **NONE**
Gastrointestinal	☐ abdominal pain ☐ heartburn	☐ blood in stool	☐ vomiting	☐ ulcers	☐ constipation
	☐ diarrhea ☐ trouble swallowing	☐ decrease appetite		☐ increase appetite	☐ **NONE**
Integumentary	☐ athletes foot ☐ nail abnormalities	☐ keloids	☐ itchiness	☐ dry scaly skin	☐ **NONE**
Hematoligic	☐ lower leg ulcers ☐ sickle cell disease	☐ anemia	☐ blood thinners	☐ clotting disorders	☐ **NONE**
Neurological	☐ tingling	☐ weakness	☐ seizures	☐ numbness	☐ headaches
	☐ tremors	☐ paralysis			☐ **NONE**
Musculoskeletal	☐ back pain ☐ joint swelling	☐ muscle weakness		☐ muscle pain	☐ neck pain
	☐ sciatica ☐ joint stiffness	☐ joint pain	☐ joint instability	☐ arthritis	☐ **NONE**
Respiratory	☐ chest pain	☐ wheezing	☐ COPD	☐ coughing	☐ snoring
	☐ shortness of breath	☐ emphysema			☐ **NONE**

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

Practice: Santiam Foot Clinic, PC

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to specify

Race: ☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American

☐ White ☐ Native Hawaiian or other Pacific Islander

Pharmacy Name: _____ **Phone:**_____

Primary Care Physician: _____ **City:** _____ **Date Last Seen:** _____

Height: _____ **Weight:**_____

Current Medications

☐ No Known Medications ☐ I take the following medications

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Use the back of this form if more room is needed

Allergies

☐ No Known Allergies ☐ No Known Drug Allergies

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Use the back of this form if more room is needed

PLEASE READ AND SIGN

The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Assignment of Benefits: I authorize payment of medical benefits to the practice named above

Release of Information: I authorize the release of any medical information necessary to process this claim.

HIPAA Privacy: I acknowledge that I received my HIPPA Privacy Practices Notice.

Medication History: I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____ Date: _____

Santiam Foot Clinic, PC
Patient Financial Responsibility Policy

Thank you for choosing Santiam Foot Clinic, PC for your foot care needs. We are committed to providing you with the highest quality care. Please carefully read and then sign this form to acknowledge your understanding of your financial obligations related to your treatment. If you should have any questions regarding our financial policies, please contact our office at 503-581-2505 before signing this document.

The following is our payment policy, which we require you to read and sign prior to your visit: The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for his/her treatment and care. Patients are responsible to ask about treatment coverage prior to receiving the treatment by Dr. Callahan We can provide CPT codes so patients can inquire about coverage for treatments with their insurance. There are so many different types of insurances plans that we cannot guarantee or quote coverage. It is never a guarantee until the insurance received the claim and determines coverage based off of their plan coverage. It is the responsibility of the member to know their coverage including but not limited to your deductible or copay and how other possible treatments such as injections, calluses treatment, nailcare are covered. We strongly advise that you contact your insurance company prior to your visit to know this information. **If you are a new patient to our office**, there will be an office visit charge. If any service is provided such as injection, nailcare, calluses, IPK's treatment, medical supply, or surgery is provided these services are separate from the office visit and will be billed separate. **___initials of patient**

You are required to inform us of any changes in demographic information, insurance information, referrals, and prior authorizations prior to your visit. In the event the office is not informed, you will be responsible for any charges denied at the time of service by your insurance company.

Cash Patients: Patients without insurance are required to pay in full at the time of service. Payment methods are cash, personal checks, Visa/Master card or Care Credit. We understand that financial hardships may affect your ability to pay in full. We will always do everything we can to work with you. Please ask to speak to our Billing Coordinator, at 503-581-2505 to discuss payment arrangements.

Participating Plans: You must present your insurance card, and if applicable, your insurance referral form, at every visit. We will submit your medical claim directly to your insurance company for payment on your behalf. Full payment at the time of service is expected for all patients without insurance or those covered under plans which we do not participate in.

Non-Covered Services: If your provider does not participate in your insurance plan or your services are not covered by your insurance plan, you are responsible for payment of all charges at the time of service. We will submit the claim directly to your carrier for all non- covered services.

Copayments or Deductibles: All co-pays, deductibles, and non-covered services will be collected at the time of service.

Cancellations and Missed appointments: Our Policy is to charge for missed appointments not canceled within 24 hours. A charge of $50.00 will be your responsibility and billed directly to you.

Returned Checks: If a check is returned a charge of $50.00 will be passed onto the patient.

Nonpayment: Please be aware that if a balance remains unpaid, we may refer your account to a collection agency, and you may be discharged from this practice. If this is to occur, you will be notified by regular mail that you have 30 days to find alternative medical care. During those 30 days, we will only be able to treat you on an emergency basis. Partial payments will not be accepted unless otherwise negotiated.

Payment: For your convenience, the following payment methods are accepted cash, personal check, Visa, MasterCard, American Express, and Discover or Care Credit.

I authorize payments to be made directly to the Santiam Foot Clinic, PC and fully understand that I am the responsible party for all charges incurred by me or my dependents at this facility. I also authorize the release of any and all information required to collect and process my medical insurance claims. I understand Santiam Foot Clinic will do their best with regard to the release of "minimum necessary" information under the HITECH act related to my PHI (protected health information). I understand that here will be times that the release of my name, date of birth, address, phone number(s) fax number, email, social security number, medical record number, health plan beneficiary number or account number may have to be disclosed to my insurance company, primary care physician or any other entity that Santiam Foot Clinic, PC deems necessary for payment or schedule of procedures. I have read the "Financial Policy"; I understand and agree with it. By my signature below, I hereby authorize the assignment of financial benefits directly to Santiam Foot Clinic, PC for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Policy:

_____

Print Name of Patient or Responsible Party

_____

Signature of Patient or Responsible Party

Today's Date: _____

Santiam Foot Clinic, PC
John T Callahan, DPM, FACFAS
2235 Mission St SE, Suite #150
Salem, Or 97302
Phone 503-581-2505 Fax 503-581-2515
Email: info@santiamfootclinic.com
Website: Santiamfootclinic.com

PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. I authorize Santiam Foot Clinic, PC Dr. John T. Callahan to release my records and any information requested to the following individuals:

1. _____ Relation to Patient:_____

   _____Telephone number

2. _____ Relation to Patient:_____

   _____Telephone number

3. _____ Relation to Patient:_____

   _____Telephone number

_____ _____

Patient Name (PLEASE PRINT) Date

_____

Patient Signature