# WESTSIDE FOOT & ANKLE SPECIALISTS

## PATIENT INFORMATION

Patient's Name: _____ Social Security #: _____

Age: _____ Sex: M/ F Date of Birth: _____ Email: _____

Home Address: _____ City:_____ State: _____ Zip: _____

Race (circle one): American Indian Asian African American Pacific Islander White

Ethnicity (circle one): Hispanic or Latino Non Hispanic or Latino Preferred Language: _____

Telephone (Hm): _____ Work: _____ Mobile: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Spouse's Name: _____ Employer: _____ Phone #: _____

Whom May We Thank for Referring You to Our Office?: Physician/Clinic Name _____

Internet Another Patient Insurance Phone Book Employee Other: _____

**PRIMARY MEDICAL INSURANCE**: _____

Address: _____ Phone #: _____

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

Insured's Social Security #: _____ Patient ID#: _____ Group #: _____

Insured's Employer: _____ Phone #: _____

**SECONDARY MEDICAL INSURANCE** _____

Address: _____ Phone #: _____

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

Insured's Social Security #: _____ Patient ID#: _____ Group #: _____

Insured's Employer: _____ Phone #: _____

### Notice of Privacy Practices Patient Acknowledgement

I have received this practices' Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices upon request.

Signature: _____ Relationship to patient:_____ Date:_____

Please indicate below the name(s) of any person(s) you allow Westside Foot & Ankle Specialists to disclose personal/medical information to.

| | |
|---|---|
| _____ | _____ |
| Name | Relationship |
| _____ | _____ |
| Name | Relationship |
| _____ | _____ |
| Name | Relationship |

## Medical History

Please Mark all that apply:

- □ AIDS/HIV
- □ Anemia
- □ Anxiety
- □ Anesthesia Problems
- □ Angina
- □ Arthritis
- □ Artificial Heart Valves
- □ Artificial Joints
- □ Asthma
- □ Balance Problems
- □ Bipolar Disorder
- □ Bleeding Problems
- □ Blood in Urine/Stool
- □ Breathing Problems
- □ Cancer
- □ Chest Pain
- □ Chills
- □ Circulatory Problems
- □ Congestive Heart Failure
- □ Depression
- □ Diabetes: Diet – Oral Med—Insulin
- □ Diarrhea
- □ Dialysis
- □ Difficulty Swallowing
- □ Dizziness
- □ Double Vision
- □ Dry Eye
- □ Eye Problems
- □ Fatigue
- □ Fever
- □ Frequent Urination
- □ Glaucoma
- □ Headaches/Migraines
- □ Hearing Loss
- □ Heart Attack
- □ Heart Disease
- □ Hepatitis
- □ Hiatal Hernia
- □ High Blood Pressure
- □ High Cholesterol
- □ Incontinence
- □ Infections
- □ Irregular Heart Beats
- □ Joint/Bone Pain
- □ Kidney Problems
- □ Liver Disease
- □ Loss of Vision
- □ Nausea
- □ Neuropathy
- □ Numbness
- □ Pacemaker
- □ Pregnant or Possibly Pregnant
- □ Prostate Problems
- □ Rash
- □ Respiratory Disease
- □ Seizures
- □ Sexually Transmitted Disease
- □ Shortness of Breath
- □ Skin Conditions
- □ Sleep Apnea
- □ Snoring
- □ Stroke
- □ Swelling
- □ Thyroid Problems
- □ TMJ
- □ Tuberculosis
- □ Ulcers
- □ Unexplained Weight Gain
- □ Unexplained Weight Loss
- □ Vomiting

Reason for today's visit: _____

_____

Date of onset: _____ Prior Treatments: _____

Pain Level: 1 2 3 4 5 6 7 8 9 10 (worst) Please circle one: Sharp Burning Dull Aching Intermittent Constant

Hospitilizations/Surgeries (last 10 years): _____

_____

Family Physician: _____ Phone #:_____ Last Visit: _____

Smoking Status (circle one): Current Everyday Current Someday Former Smoker Never Smoked Status Unknown

Alcohol Use: _____ Illicit Drug Use: _____

Height: _____ Weight: _____ Shoe Size: _____

### Medications

Include Prescriptions, over-the-counter medications and vitamins:

_____

_____

_____

_____

_____

Pharmacy Name(s): _____

Pharmacy Phone(s): _____

Do you take oral contraceptives? Yes ___ No___

### Allergies

- □ Adhesive/Tape
- □ Anticoagulant Therapy
- □ Aspirin
- □ Codeine
- □ Demerol
- □ Iodine
- □ Local Anesthetics
- □ Novocaine
- □ Penicillin
- □ Seafood
- □ Sulfa
- □ Latex

□ Other _____

**I certify that the above information is true to the best of my knowledge**: _____/_____

Patient Signature Relationship if minor

### Office Use Only

Respiration: B/P: BMI:

Patient Name: _____ DOB: _____ Initial Visit: _____

# Westside Foot & Ankle Specialists Joint Notice of Privacy Practices

This Joint Notice of Privacy Practices (Notice) describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The Notice is being provided to you on behalf of Westside Foot & Ankle Specialists, its medical staff and other providers (collectively referred to herein as "we" or "our").

**Westside Foot & Ankle Specialists is committed to protecting the confidentiality of your health information.**
We are required by law to maintain the privacy of your protected health information (commonly called PHI or health information), including PHI in electronic format. We are also required to notify you of our legal duties and privacy practices regarding your health information and abide by the practices of this Notice, unless more stringent laws or regulations apply. The Notice applies to all Westside Foot & Ankle Specialists facilities, services and programs that provide health care to you.

**Application of this Notice**
The information privacy practices described in this Notice will be followed by:

- Any health care professional that treats you at any of our locations.
- All facilities, departments and units, clinics and other affiliates.
- All workforce members such as employees, medical staff, trainees, students, volunteers and other persons under our direct control whether or not they are paid by us.
- Other health care providers that have agreed to abide by this Notice of Privacy Practices.

This Notice provides detailed information about how we may use and disclose your health information with or without authorization as well as more information about your specific rights with respect to your health information.

**Uses and disclosures of your health information that we may make without your authorization**
**To contact you:** Your information may be used to contact you to remind you about appointments, provide test results, inform you about treatment options or advise you about other health-related benefits and services.
**Treatment:** Your information may be shared with any health care provider who is providing you with health care services. This includes coordinating your care with other health care providers and providing referrals to other health care providers. Examples of health care providers who may need your information to treat you include your doctor, pharmacist, nurse and other providers such as physical therapists, home health providers, and X-ray technicians. We may share your information electronically with your health care providers in order to make sure they have your information as quickly as possible to treat you. We may share your health information with any family member or friend who is assisting with your health care. We will only do this if you agree or do not object, and will only share with them the information they need in order to help you. If you are unable to either agree or object to such a disclosure, we may disclose your health care information as necessary if we determine that it is in your best interest based on our professional judgment.
We may disclose health information to a family member, relative or another person who was involved in your health care or payment for health care when you are deceased if not inconsistent with your prior expressed preferences.

**Payment:** In order to obtain payment for your health care services, we may have to provide your health information to the party responsible for paying. This may include Medicare, Medicaid (state health plan) or your insurance company. Your insurance company or health plan may need your information for activities such as determining your eligibility for coverage, reviewing the medical necessity of the health care services provided to you or providing approval for hospital services or stays.
**Health care operations:** Your health information may be used in order to support our business activities and to assure that quality health care services are being provided. Some of these activities include quality assessments, peer or employee review, training of medical personnel, licensure and accreditation, data aggregation and audits by regulatory agencies.
We may share you PHI with third parties who perform services such as transcription or billing. In those cases, we have written agreements with the third parties that they will not use or disclose your health information except if permitted by law.
**You have the right to opt out of receiving such communication.** If you do not want to receive these materials, please contact our office and request that these materials not be sent to you.
**Other uses and disclosures that we may make without your authorization**
There are a number of ways that your health information may be used or disclosed without your authorization. Generally, these uses and disclosures are either required by law or for public health and safety purposes.
**When required by law:** We may use or disclose your health information when required by law. If this happens, we will comply with the law and will only disclose the information necessary.
**Public health:** We may disclose your health information to a public health authority for public health activities. Public health activities include preventing or controlling disease, injury, disability, and responding to reports of abuse, neglect or domestic violence. We may disclose your health information to a person or agency required to report adverse events, product defects or problems, biologic product deviations or for product recalls, repairs or replacements. Any disclosures of this nature will be made consistent with state and federal law.
**Health oversight:** We may disclose your health information to health oversight agencies for oversight activities authorized by law, such as audits, investigations, and inspections. Health oversight agencies include government agencies that oversee the Health care system, government benefit programs, government regulatory programs and civil rights.

**Legal proceedings:** We may use or disclose your health information in response to a court or administrative order in an administrative or judicial proceeding, or in response to a subpoena, discovery request or other legal process.
**Law enforcement:** We may use or disclose your health information for law enforcement purposes. Examples include (1) responding to legal processes; (2) providing limited information to identify or locate a suspect; (3) providing information about crime victims; (4) reporting suspicion that death has occurred as a result of criminal conduct; (5) reporting a crime which occurred on our premises; and (6) for medical emergencies, reporting where it appears likely a crime occurred.
**Preventing a serious threat:** We may use or disclose your health information if we believe in good faith that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or of the public. Disclosure may only be made to a person reasonably able to prevent or lessen the threat.
**Military activity and national security:** We may disclose the health information of Armed Forces personnel: (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits; or (3) to a foreign military authority if you are a member of that foreign military service. We may also disclose your health information to authorized federal officials to conduct national security and intelligence activities, including the provision of protective services to the President or others legally authorized to receive information.
**Inmates/arrestees:** We may use or disclose your health information as necessary to comply with worker's compensation laws and other similar legally established programs.

**Your Rights**
**Right to request restrictions:** You have the right to ask us to place restrictions on the way we use or disclose your health information for treatment, payment or health care operations. We will consider your request but are not required to agree to the restriction (except as described below). If we agree to a restriction, we will not use or disclose your health information in violation of that restriction unless it is needed for an emergency. If a restriction is no longer feasible, we will notify you.
**Right to restrict disclosure to health plans:** You may request in writing, at the time of service that we not disclose information to health plans where you have paid for items or services out of pocket in full. We must agree not to disclose this information to your health plan if certain conditions are met.
**Confidential communications:** We will accommodate reasonable requests to communicate with you about your health information by different methods or alternative locations. For example, if you are covered on a health plan but are not the subscriber, and would like your health information sent to a different address than the subscriber, we can usually do that for you.
**Breach notification:** You have the right to receive notification of breaches of your health information as required by law.
**Access to your health information:** You have the right to receive a copy of your health information that we maintain, with some limited expectations. You may request access to your information in writing, and you may request a copy of your information in electronic format. We reserve the right to charge a reasonable fee for the cost of producing and providing your health information. You have the right to request that your health information be sent to any person or entity, such as another doctor, caregiver or online personal health record.
**Amendment of your health information:** You have the right to ask us to amend any of your health information. You need to request this amendment in writing and submit it to the facility's medical records department. We may deny your request in certain situations, such as when the health information in your records was created by another provider or if we determine your information is accurate and complete. Any denials will be in writing. You have the right to appeal our denial by filling a written statement of disagreement.
**Accounting of certain disclosures:** You have a right to a listing of the disclosures we make of your health information, except for those disclosures made for treatment, payment, or health care operations, or those disclosures made pursuant to your authorization. The type of disclosures typically contained in a listing would be disclosures made for mandatory public health purposes, law enforcement, legal proceedings, or for other required reporting such as birth and death certificates.
**Exercising your rights:** To exercise any of the above rights or if you need to share your health information with someone for purposes other than those listed here, contact the appropriate medical records department.

**Questions and complaints**
If you have questions or are concerned that any of your privacy rights have been violated please contact our Privacy Officer: Jalinda Lowry at (503)-245-2420

You also have the right to complain to the Secretary of Health and Human Services at:

Office of Civil Rights – AK, WA, OR, MT
U.S. Department of Health and Human Services
2201 Sixth Avenue- M/S: RX-11
Seattle, WA 98121-1831

Office of Civil Rights- CA
U.S. Department of Health and Human Services
90 Seventh Street, Suite 4-100
San Francisco, CA 94103

You will not be retaliated against for filing a complaint.

**Changes to Joint Notice of Privacy Policy**
We reserve the right to change the terms of our Notice at any time. New Notice provisions will be effective for all protected health information that we maintain. You may request a current copy from the medical records department, privacy officer, or registration staff at any time.

Effective October 1st, 2013

Westside Foot & Ankle Specialists

Podiatric Physicians and Surgeons
Jason Surratt, DPM
Thomas Melillo, DPM
Michael Gentile, DPM
Yama Dehqanzada, DPM
Todd Galle, DPM

Phone: (503) 245-2420 www.portlandfootdocs.com Fax:(503) 245-2445

*Conservative and Sugical Treatment of:*

*Ankle/Foot Arthritis*

*Ankle /Foot Fractures*

*Ankle/Foot Sprains*

*Bunions*

*Chronic Join Pain*

*Congenital Deformities*

*Flat Feet/High Arch*

*Hammertoes*

*Heel Pain*

*Infections (Bacterial, Fungal , Viral)*

*Ingrown Nails*

*Nerve Problems/Neuromas*

*Orthotics*

*Revisional/Redo Foot & Ankle Surgery*

*Sports Injuries*

*Tendon Problems/Tears*

# Payment Policy

**Initials**

_____ **Patient Responsibility:**
Patients are responsible for all charges resulting from treatment provided by Westside Foot & Ankle Specialists. Payment is due in full within 30 days of receiving your first statement unless other financial arrangements have been made with the Business Office.

_____ **Co-pays:**
All co-pays, if required by your plan, are due at the time of service for each visit.

_____ **Payment Arrangements**:
All patients will be required to pay their balances within 30 days of receiving their first billing unless payment arrangements have been made with the business office. Please Contact our business office as soon as possible after receiving your statement if payment arrangements are needed, 503-245-2420.

_____ **Uninsured Patient Deposits:**
Patients without insurance will be required to make a deposit at the time of the visit for all appointments, as follows:

New Patient Office Visits: $120 Procedures: $100
Return Patient Office Visits: $50 Surgery: 50% of the total cost

_____ **Referrals & Preauthorizations:**
Our office will attempt to acquire a referral from your primary care doctor if your health plan requires one. Referrals can be difficult to obtain. Please be aware that if you choose to be seen before you have received a valid authorization, your insurance may not pay for the visit. If you are having a procedure that requires prior authorization, our office will obtain this for you. We cannot guarantee payment for services or quote benefits from your health plan. Patients are ultimately responsible for knowing their coverage limitations and benefits.

_____ **Insurance Billing:**
As a courtesy we will bill your primary and secondary insurance for you. However, primary responsibility for the account is yours. Providing correct insurance billing information is the responsibility of the patient. If your insurance changes, please present your new card at your visit. If you do not have your insurance card with you at the time of your visit you will be billed for the services.

_____ **Collections:**
We reserve the right to send accounts with a balance that been outstanding over 60 days from the date of service or the date of payment received from your insurance provider, whichever is more, to a collection agency.

By signing below, I am stating that I understand the above information pertaining to the payment policy at Westside Foot & Ankle Specialists and agree to adhere to the patient responsibility requirements.

_____ _____
Patient Signature Date

_____ _____
Patient Name (please print) Date of Birth