PATIENT INFORMATION

How did you first hear about us? ☐ Doctor Referral ☐ Friend ☐ Internet ☐ Phone book ☐ Other

Patient Information

Name________________________________Date of birth___________ ☐ M ☐ F

Mailing Address____

City______________________________ State__________________ Zip Code______________

Home Phone________________ Work Phone________________ Cell Phone_________________

Social Security #_____________________________________ Occupation__________________

Employer's Name and Address____

Primary Insurance Information

Insurance Name________________________________ Subscriber Name_____________________

Subscriber's Date of Birth________ Relation to Patient ☐ Self ☐Spouse ☐ Parent ☐ Other

Insurance Address____________________________ City___________ State______ Zip_____

Subscriber ID____________________ Subscriber Social Security #___________ Group ID _____

Secondary Insurance Information

Insurance Name________________________________ Subscriber Name_____________________

Subscriber's Date of Birth________ Relation to Patient ☐ Self ☐Spouse ☐ Parent ☐ Other

Insurance Address____________________________ City___________ State______ Zip_____

Subscriber ID____________________ Subscriber Social Security #___________ Group ID _____

Agreement and Consent

I authorize the release of any medical information necessary to process insurance claims. I also authorize payment of medical benefits directly to Deschutes Foot & Ankle for professional services rendered. I understand that Deschutes Foot & Ankle will bill my insurance as a courtesy, but I am responsible for any balance not covered by my insurance.

I understand that patient balances carried past 30 days will accrue a 9% interest charge. I acknowledge receipt of the Deschutes Foot & Ankle policy. I acknowledge receipt of the Notice of Privacy Practices from Deschutes Foot & Ankle.

I give permission to the physician(s) at Deschutes Foot & Ankle to administer treatment and to perform such procedures as my be deemed necessary or advisable in the diagnosis and/or treatment of the foot and related conditions after I have consented. By Oregon law, I am entitled to know the procedure, alternatives and risks involved, with a detailed explanation if so desired.

I understand that undesirable outcomes MAY OCCUR with procedures and adverse side effects or reactions MAY OCCUR with mediations. I will be responsible for following the doctor's instruction and that my non-compliance may result in a poor outcome and may be grounds for termination of the doctor/ patient relationship. I will also be responsible for continuing any recommended follow up care and for any poor outcome which may result from the lack of doctor recommended follow up care.

Cancellation Policy
Please provide a minimum of 24 hours notice if you must cancel an appointment.

Who should we contact in case of an emergency? ______________________________

Phone Number ______________________ Relationship ______________________

______________________________ ______________________

Signature of Responsible Party Date