ROSEBURG
FOOT & ANKLE
SPECIALISTS

New Patient Intake Form

Patient Full Name: _____

Preferred Name: _____ SS#: _____

Have you been seen here before: No Yes, When? _____

Date of Birth: _____ Age: _____ Sex: ☐ M ☐ F

Primary Language: _____ Do you need an Interpreter: ☐ Yes ☐ No

Race: ☐ White ☐ African American ☐ American Indian ☐ Asian

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic

How did you hear about us? ☐ Existing Patient ☐ Flyer ☐ Another Patient ☐ Primary care ☐ Provider Referral ☐ Radio Ad ☐ Self ☐ Social Media ☐ Website

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Widowed ☐ Divorced

Home Phone Number: _____ Can we leave a message? ☐ Yes ☐ No

Cell Phone Number: _____ Can we leave a message? ☐ Yes ☐ No

Can we Text Message? ☐ Yes ☐ No Preferred Contact Method: ☐ Home ☐ Cell ☐ Text

Email: _____ Activate Patient Portal: ☐ Yes ☐ No

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Do you have a legal guardian or power of attorney? ☐ **YES**** ☐ **NO**
If yes, please provide documentation.

Do you have an advance directive? _____

Emergency Contact: _____ Phone: _____

Relationship to Patient: _____

Guarantor Information:

Responsible party's name: _____ Relationship: _____

Date of Birth: _____ SS#: _____

Mailing Address: _____

Phone Number: _____

Is there another person you would like us to share your medical information with? ☐ YES ☐ NO

If yes, name: _____ Phone Number: _____

Insurance Information

Insured's Name: _____

Date of Birth: _____

Primary Insurance Name: _____

Policy Number: _____ Group Number: _____

Insured's Employer: (Name, City, state, Zip) _____

Insured's relationship to patient: _____

Secondary Insurance (If applicable)

Insured's Name: _____

Date of Birth: _____

Secondary Insurance Name: _____

Policy Number: _____ Group Number: _____

Insured's Employer: (Name, City, state, Zip) _____

Insured's relationship to patient: _____

Medical

Primary Care Physician: _____Date Last seen: _____

Referring Physician (if applicable): _____

Former Podiatrist: _____

What were you seen for? _____ When: _____

Pharmacy Name & Location:

_____

_____

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

_____

_____

Please list all medications you are currently taking (including over the counter meds & herbal supplements)

Medication	Dosage	How often do you take it?

Please list all prior surgeries or serious injuries:

Type of Surgery	Date	Type of Serious Injury	Date

Family History:

Condition	Mother	Father
Diabetes		
Cancer		
Heart Trouble		
High Blood Pressure		
Kidney Disease		
Stroke		
Mental/Emotional disease		
Coronary artery disease		
Thyroid Disorder		
Arthritis		

Do you have allergies to? ☐ **Medication** ☐ **Latex** ☐ **Tape** ☐ **Iodine** ☐ **Foods** ☐ **None**

Please list:

Medication	Reaction

Problem	YES	NO	Comments	Problem	YES	NO	Comments
Headaches	☐	☐		Swelling in feet	☐	☐	
Trouble w/ vision	☐	☐		arthritis	☐	☐	
Trouble with Hearing	☐	☐		Kidney disease or stones	☐	☐	
Allergies/Hay fever	☐	☐		Gout	☐	☐	
Asthma	☐	☐		Bleeding Tendency	☐	☐	
Recent weight loss	☐	☐		Scarring Tendency	☐	☐	
Thyroid	☐	☐		Joint Pain or stiffness	☐	☐	
Diabetes	☐	☐	Year Diagnosed?	Numbness in feet or legs	☐	☐	
Skin Problem	☐	☐		Cramps in feet or legs	☐	☐	
Anemia	☐	☐		Low back pain	☐	☐	
Heart	☐	☐		Psychiatric	☐	☐	
Mitral Valve prolapse/heart murmur	☐	☐		Fainting or Convulsions	☐	☐	
Poor circulation	☐	☐		Strokes	☐	☐	
High blood pressure	☐	☐		Pain in other areas	☐	☐	
Chest Pain	☐	☐		Other illness or problems	☐	☐	
Lungs (Pneumonia, TB, CHF)	☐	☐		HIV positive	☐	☐	
Shortness of Breath	☐	☐		Are you pregnant?	☐	☐	How many months?

Problem	YES	NO	Comments	Problem	YES	NO	Comments
Liver/ Gallbladder	☐	☐		Cancer	☐	☐	
Stomach trouble	☐	☐		Acid Reflux	☐	☐	
Bladder Problems	☐	☐		Blood Transfusions	☐	☐	
Abnormal Bleeding	☐	☐		Fibromyalgia	☐	☐	
Blood Clots	☐	☐		Hepatitis	☐	☐	
HIV+/AIDS	☐	☐		High Blood Pressure	☐	☐	
Neuropathy	☐	☐		Low Blood Pressure	☐	☐	
Open Sores	☐	☐		Sleep Apnea	☐	☐	
Stomach Ulcers	☐	☐		Stoke	☐	☐	

Social History:

Use of alcohol: ☐ Never ☐ Daily ☐ Weekly ☐ Monthly

Use of Tobacco:

☐ Smokeless Tobacco _____ Cans per day for _____ years

☐ Current smoker _____packs a day for _____ years

☐ Quit_____ ago

☐ Never

Use of Recreational drugs: ☐ Never ☐ Current: Use-Type_____

How Long? _____

Employer_____

Occupation: _____

How much are you on your feet at work: ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

Do others depend on you for their care? ☐ Kids ☐ Pets ☐ Elderly ☐ Disabled ☐ Other

Do you exercise? ☐ Never ☐ Daily ☐ Weekly ☐ Multiple times a week ☐ Monthly

Type of exercise_____

Reason for Visit

What foot/ankle problem are you experiencing?

_____

_____

When did this issue begin? _____

Have you had any previous treatment for this issue? ☐ Yes ☐ No

If yes, please describe:

_____

_____

_____

Rate your pain level (0 = No Pain, 10 = Severe Pain):

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

_____

Consent & Acknowledgment

I authorize benefits to be paid directly to Cordell Smith, DPM, Nathaniel Keplinger, DPM, and/or Daniel Howell, 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 event 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 changes to the above information. I acknowledge that I have received or have access to the office's privacy policy.

Patient Signature: _____ Date: _____

Legal Guardian Signature: _____ Date: _____

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General Consent for Care and Treatment Consent

TO THE PATIENT: ***You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).***

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your podiatrist about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a podiatrist and other health care designees as deemed necessary, to perform reasonable and necessary medical examinations, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedures(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Signature of Patient or Personal Representative | Date

_____ _____

Printed Name of Patient or Personal Representative | Relationship to Patient

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: _____

If patient is under 18, please complete:
Name of Responsible Party: _____
Mailing Address:

_____

_____

Phone Number: _____

Relationship: _____

Acknowledgement of Notice Privacy Practices:

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

Signature: _____

Date: _____

Acknowledgment of Receipt of HIPAA Privacy Practices

I, _____ (patient or legal guardian), acknowledge that I have received or have been provided access to a copy of Roseburg Foot & Ankle Specialists Notice of Privacy Practices. This document outlines how my health information may be used and disclosed, as well as my rights regarding this information.

I understand that:

- My protected health information (PHI) may be used for treatment, payment, and healthcare operations as permitted by law.
- I have the right to request restrictions on certain uses and disclosures of my PHI, though the office is not required to agree to these restrictions.
- I may revoke this consent in writing at any time, except to the extent that action has already been taken in reliance on this consent.

Authorization for Communication

I authorize Roseburg Foot & Ankle Specialist to communicate with me regarding my healthcare via:

- ☐ Phone Call
- ☐ Voicemail
- ☐ Email
- ☐ Text Message

I understand that electronic communications may not be completely secure, and I accept the risks involved.

Signature & Date

Patient Name: _____

Signature: _____

Date: _____

Relationship to Patient (if applicable): _____

Cordell Smith, DPM, Nathaniel Keplinger, DPM, and Daniel Howell, 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 "Mod Med". 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 Mod Med.

DATED _____ _____

Patient or Guardian Signature

_____ _____

Printed Name of Patient Printed Name of Above and Relationship

ROSEBURG
FOOT & ANKLE
SPECIALISTS

E-prescribing patient consent form

Roseburg Foot & Ankle Specialists

Patient Name: _____ **DOB:** _____

Pharmacy Name: _____

Pharmacy Address/Phone: _____

E-Prescribing is a federally mandated initiative that allows your physician to send your prescriptions electronically to your pharmacy. E-Prescribing software also allows your provider to access your medication history and avoid potential drug interactions, ensuring safe and high-quality care.

By signing this form, I understand and agree to the following:

1. ***Consent to E-Prescribe:*** I authorize Roseburg Foot & Ankle Specialists to send my prescriptions electronically to the pharmacy I have designated.
2. ***Medication History:*** I consent to my provider accessing my medication history from my pharmacy and other healthcare providers.
3. ***Benefits:*** I understand that E-Prescribing can reduce medication errors, improve efficiency, and enhance my overall care.
4. ***Privacy & Security:*** I understand that my prescription information will be handled securely and in compliance with HIPAA regulations.
5. ***Right to Revoke:*** I may revoke this consent at any time by providing written notice, but this will not affect prescriptions already sent.

I have read and understand the information above. I have had the chance to ask questions and all my questions have been answered to my satisfaction. I voluntarily give my consent for E-Prescribing.

The consent will remain in force until revoked or changed.

Patient Signature: _____ **Date:** _____

Non-Discrimination Policy

Applicable Laws and Regulations:

Roseburg Foot & Ankle Specialists is committed to providing equal access to services for all patients regardless of race, color, national origin, age, disability, or sex. We comply with all applicable federal and state civil rights laws. If you require language assistance, interpreter services are available free of charge. Roseburg Foot & Ankle Specialists complies with the following federal laws and regulations to ensure non-discrimination and equal access to healthcare services:

- **Civil Rights Act of 1964 (Title VI)**
- **Rehabilitation Act of 1973 (Section 504)**
- **Age Discrimination Act of 1975**
- **Patient Protection and Affordable Care Act (ACA) of 2010**
- **Americans with Disabilities Act (ADA) of 1990**
- **Affordable Care Act (ACA) Section 1557**
- **Code of Federal Regulations (CFR) Title 45, Parts 80, 84, 91**
- **U.S. Department of Health and Human Services (HHS) Regulations on Civil Rights and Non-Discrimination**

Please contact the designated office representative for assistance. If you speak any of the following languages, assistance is available to you:

- **العربية (Arabic):** إذا احتجت إلى مساعدة، يرجى الاتصال برقم
- **বাংলা (Bengali):** আপনি সাহায্যের প্রয়োজন হলে, দয়া করে এ ফোন করুন।
- **中文 (Chinese):** 如果您需要帮助，请拨打 。
- **Deutsch (German):** Wenn Sie Hilfe benötigen, rufen Sie bitte an.
- **English:** If you need assistance, please call
- **فارسی (Farsi):** اگر به کمک نیاز دارید، لطفا با [تماس بگیرید.
- **Français (French):** Si vous avez besoin d'aide, veuillez appeler le
- **हिंदी (Hindi):** यदि आपको सहायता चाहिए, कृपया पर कॉल करें।
- **日本語 (Japanese):** ご助力が必要な場合は、までお電話ください。
- **ខ្មែរ (Mon-Khmer, Cambodian):** ប្រសិនបើអ្នកត្រូវការជំនួយ សូមទាក់ទង ។
- **한국어 (Korean):** 도움이 필요하시면, 에 전화해 주세요.
- **Português (Portuguese):** Se precisar de ajuda, ligue para
- **Română (Romanian):** Dacă aveți nevoie de ajutor, vă rugăm să sunați la
- **Русский (Russian):** Если вам нужна помощь, пожалуйста, позвоните по номеру
- **Español (Spanish):** Si necesita ayuda, por favor llame al
- **ไทย (Thai):** หากคุณต้องการความช่วยเหลือ โปรดโทร
- **Українська (Ukrainian):** Якщо вам потрібна допомога, будь ласка, зателефонуйте за номером
- **Tiếng Việt (Vietnamese):** Nếu bạn cần trợ giúp, vui lòng gọi

For any other language assistance, please contact (541) 673-7322. For relay services, you may use the State Relay Number at (541) 677-4336.

Roseburg Foot & Ankle Specialists does not discriminate based on race, color, national origin, age, disability, or sex. If you believe you have been discriminated against, you may file a complaint with our compliance officer or the U.S. Department of Health & Human Services, Office for Civil Rights.

Sign & Date

Signature: _____ Date: _____

Relationship to Patient (if applicable): _____