NORTHWEST EXTREMITY
SPECIALISTS

Name: _____ Date of Birth: _____
First Middle Initial Last

Age: _____ Social Security #: _____What is your assigned gender? Male/Female

What is your preferred Gender? Male/Female/Other: _____

Mailing Address: _____ City: _____

State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____Work Phone: _____

Email: _____ Contact by email? Yes/No

Marital Status(circle one): Single Married Domestic Partner Widowed Legally Separated Divorced

Race(circle all that apply): White Black/African American Asian Hispanic Native American Native Hawaiian/Pacific Islander Declined

Ethnicity(circle one): Not Hispanic/Latino Hispanic/Latino Declined

Preferred Contact (circle one): Phone- home/mobile/work Email Text

Employer: _____ Occupation: _____Phone:_____

Spouse/Parent/Guardian: _____Phone:_____Employer: _____

Emergency Contact Name: _____Relationship: _____Phone:_____

Primary Care Physician: _____ Phone: _____

Date Last Seen: _____

Whom may we thank for referring you:

Physician/Clinic Name: _____(first & last name, clinic name)

Another Patient:_____

(circle) Internet Insurance Hospital Family/Friend Other: _____

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ASSIGNMENT AND RELEASE:

I give permission to Northwest Extremity Specialists, LLC to administer treatment and to perform such procedures as may be necessary in my diagnosis and/or treatment. I also give my permission to electronically check my medication history.

_____

Patient Name (please print) Patient/Guardian Signature Date

Patient Name: _____ Date of Birth: _____

REASON FOR TODAY'S VISIT

Injured Body Part (foot, leg, ankle):_____
_____
(circle all that apply)
Date of Onset/Injury: _____Pain Level: None 1 2 3 4 5 6 7 8 9 10 (worst) **Location:** R / L / Both
Type of Pain: Sharp Burning Dull Aching Intermittent Constant Throbbing Shooting
Onset: Slow Sudden Traumatic **Is Pain Getting:** Worse Better No Change
Prior Treatments: _____
What makes it worse: Walking Running Standing Shoes Other: _____
Is this a work related or Motor vehicle injury? Yes/No **Is this a second opinion?** Yes/No
Previous Physician Treating Injury: _____
Vein Screening Questionnaire:
Are your legs heavy, tight, tired, dull or achy? Yes/No
Do you have swelling in the legs and/or ankles and/or varicose veins? Yes/No
Is the skin just above the ankle brownish-red or discolored? Does it feel leathery, hard, or itchy? Yes/No

MEDICAL HISTORY

Height: _____ Weight: _____ Shoe Size: _____ BP: _____ Pulse: _____

Medications	Allergies
Include Prescriptions, over-the-counter medications and vitamins (please provide a list or attach an additional page if necessary): _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ Pharmacy Name(s): _____ Pharmacy Phone(s): _____ Do you take oral contraceptives? Yes ___ No___	(circle all that apply) NO ALLERGIES Adhesive/Tape Local Anesthetics Anticoagulant Therapy Novocaine Aspirin Penicillin Codeine Seafood Demerol Sulfa Iodine Latex Metal/Nickel Other _____

SOCIAL HISTORY: Alcohol use/frequency: _____ Drug Use/Frequency: _____
SMOKING STATUS (circle one): Current Everyday/Current Someday/Former Smoker/Never Smoked/Unknown

Hospitalizations/Surgeries (last 10 years): _____
_____

FAMILY HISTORY (circle all that apply): Heart Disease Early Deaths Bleeding High Blood Pressure
Asthma COPD High Cholesterol Thyroid Disorder Osteoporosis Diabetes Stroke Cancer
(other)_____

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Patient Name: _____ Date of Birth: _____

Active Medical Problems

(circle all that apply)
AIDS/HIV Anesthesia Problems Artificial Heart Valves Artificial Joints Bipolar Disease Bleeding Problems Cancer Circulatory Problems Hepatitis Hiatal Hernia High Blood Pressure High Cholesterol Infections Neuropathy Pacemaker Prostate Problems Seizures Sexually Transmitted Disease Sleep Apnea Snoring Thyroid Problems TMJ Tuberculosis

Are You Currently Experiencing Any of the Following Symptoms?

General: Fatigue Fever Chills Sweating Heavily at Night Recent Weight Loss Recent Weight Gain

Head: Headache Sinus pain

Eye: Worsening vision Floaters Double vision Blurry Vision Pain w/Eye Movement Red Eyes Sensitivity to Light Glasses Contacts Glaucoma Dry Eye Loss of Vision

ENT: Hearing Loss Earache Draining from Ear or Nose Ringing in Ear(s) Sneezing Nasal Itching Sore Throat Mouth Sores Dry Mouth Difficulty Swallowing

Cardiovascular: Chest Pain Crushing Chest Pain Heart Palpitations Leg Pain w/Exercise Heart Attack Heart Disease Angina Congestive Heart Failure

Pulmonary: Difficulty Breathing Shortness of Breath Wheezing Orthopnea Cough Loose Cough Dry Cough Coughing up Blood Asthma

GI: Decreased Appetite Anorexia Heartburn Nausea Vomiting Abdominal Pain Jaundice Diarrhea Constipation Ulcers

GU: Blood in Urine Urine odor abnormal Painful Urination Change in Urine Frequency Frequent or Excessive Nighttime Urination Incontinence Urinary Urgency Kidney Problems Liver Disease Blood in Urine/Stool Dialysis

Endocrine: Diabetes Mellitus Excessive Thirst Heat Intolerance Cold Intolerance Excessive Sweating Feelings of Weakness

Musculoskeletal: Back pain Muscle Aches Muscle Cramps Joint Pain Joint Swelling Joint Stiffness Arthritis

Neurologic: Dizziness/Vertigo Fainting Confusion Memory Loss Speech Disturbance Limb Weakness Paralysis Tingling Involuntary Movements Balance Problems Numbness □Stroke

Psychological: Anxiety Depression

Skin: Dry Skin Itching Peeling of Skin Skin Scaling Rash Skin Discoloration

NORTHWEST EXTREMITY SPECIALISTS

Podiatric Physicians and Surgeons

Jason Surratt, DPM
Thomas Melillo, DPM
Peter Pham, DPM
Yama Dehqanzada, DPM
Todd Galle, DPM
Mia Horvath, DPM
Lacy Beth Lockhart, DPM
Clifford Mah, DPM
Denny Le, DPM
Manny Moy, DPM
Cara Beach, DPM
Lauren Eller, DPM
Lisa Yoon, DPM

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 Northwest Extremities Specialists, LLC to disclose personal/medical information to.

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

NORTHWEST EXTREMITY SPECIALISTS

Financial Policy

Thank you for choosing Northwest Extremity Specialists. The following is a statement regarding our financial policy. All patients must accept our financial policy before receiving treatment. Full payment of your bill is considered part of your treatment. Co-pays, deductibles, and co-insurance are due at the time services are rendered. We require proof of current insurance at check-in, those patients without proof of coverage may be required to pay in full or be asked to reschedule their appointments.

Method of Payment: We accept check, Visa, MasterCard, American Express and Discover. Please note, NES does not accept cash at any location.

Cancellation and No Show Policy

In the event you are unable to attend your appointment, we kindly ask that you call to cancel or reschedule with at least 24 hours' notice. While we understand that emergencies can arise, we encourage open communication to avoid unnecessary fees. Appointments that are missed or not canceled within this time frame will be subject to a $50 no-show fee. This fee will be charged at your next appointment and must be paid prior to being seen by the provider. We appreciate your understanding and cooperation in helping us provide the highest level of care to all our patients.

Payment Guarantee

For services rendered by Northwest Extremity Specialists you guarantee payment of your account for all costs that will not be paid by an insurance carrier, government payer (including Medicaid), and other third-party payer (together, referred to as "PAYER"), including if at a later date after initial approval your Payer denies your claim. You further understand that any out-of-network charges may be your responsibility as determined by your PAYER. You acknowledge that if your dependent is provided services, you will be responsible for payment under these same policies, terms, and conditions. The "Responsible Party" listed on the Patient Data Sheet will be sent the Statement and shall be responsible for paying it. If the Responsible Party is not, you and that person does not pay the bill, YOU are responsible for satisfying the Statement.

Your insurance

As a courtesy to you, we will submit medical claims to your insurance company. Any balance after processing of our claim by your carrier is your responsibility. We extend this courtesy to any secondary insurance which is on file at the time of your visit. Billing additional or insurance not on file at the time of service is the patient's responsibility. Your insurance policy is a contract between you and your insurance company. You are responsible for verifying if providers are in-network with your insurance company. Billing your insurance does not necessarily ensure payment by the insurance company nor does it release the responsible party from its financial obligation to our office for any unpaid balance. In case of an insurance partial payment, the balance is due by YOU, and we will send you a billing statement. Balances over 120 DAYS due may be sent to a collection agency unless other arrangements have been made. Should you require a payment plan, our office manager will be glad to discuss your options with you. It is your responsibility to know your insurance benefits as it may not cover all of the services provided to you. These bills are non-negotiable.

Accepted Insurance Policies

For current health insurance information, please call your health insurance administrator to verify provider enrollment with the physicians of Northwest Extremity Specialists. With constant changes in health insurance coverage, and plans merging and restructuring, we may not be enrolled as providers with your plan.

We must emphasize that as providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility from THE DATE SERVICES ARE RENDERED. Therefore, it is necessary for you to know what benefits your insurance plan provides for you.
We may also elect to discharge you from our practice should you fail to comply with our policy.

We will bill for out of network benefits, but this may cause a higher out of pocket for you as the patient. We try and verify all eligibility for the date of service and let you know prior to appointment.

Self-Pay

If you do not have insurance coverage at the time of your visit, we request that you pay for services at the time of your visit.

Motor Vehicle Accidents (MVAs) and Third-Party Insurance Policies

NES will bill your motor vehicle insurance. You are required to provide your private/commercial health insurance information, which will be billed should your MVA (PIP) coverage become exhausted. NES also requests the MVA form to be filled out and signed at your initial visit.

Completion of Forms

You will be charged a fee of $25.00 for the completion of forms such as AFLAC, FMLA, etc. Payment is due at the time that you pick up these forms. Please allow 7-10 days for completion. We also require that all forms need to be picked up by the individual or emailed. We will not fax the forms to the insurance company.

Overdue and Collection Accounts

Patients with past due accounts will be asked to make payment in full before being seen at NES. We reserve the right to forward your account to a collection agency if it is determined to be uncollectible. If your account is referred to an outside collection agency you will be required to pay any unpaid balance before further appointments can be scheduled. If your account has been sent to collections or you file bankruptcy, for future appointments you will be required to pay cash in advance for any services.

Minors

Minors who are 15 years or older can consent to medical and dental services without parental consent in the State of Oregon. This includes hospital care, as well as medical, dental, optometric, and surgical diagnostic care. We may request that parents sign a release of information to discuss medical care of the minor.

Supplies

For your convenience we make some supplies available for purchase in the office. If you choose to purchase these items, payment is due at the time of purchase.

I have read and understand this office financial policy and agree to comply with and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name | Patient Date of Birth

Responsible party member's name | Relationship

Responsible party member's signature | Date