CASCADIA FOOT & ANKLE
Podiatric Physicians & Surgeons

1400 Valley River Drive Ste 210
Eugene, Oregon 97401

(p) 541-600-4630 (f) 877-370-7523
email info@cascadiafootandankle.com

REGISTRATION FORM

Name____Date of Birth ___________
First Middle Initial Last

Age __________ Sex ☐ Female ☐ Male ☐ Undifferentiated

Mailing Address____City ______________________

State___________Zip _____________

Cell Phone_____________________Home Phone_________________Work Phone ________________

Please circle each phone for which it is ok to leave a message. Cell Home Work

Employer _________________________________ Occupation ___________________________

Email ____________________________________

Marital Status
Never Married
Married
Domestic Partner
Widowed
Separated
Divorced

Race
White
Black/African American
Asian
Hispanic/Latino
American Indian/Alaska Native
Hawaiian/Pacific Islander
Declined

Ethnicity
Not Hispanic/Latino
Hispanic/Latino
Declined

Parent/Guardian (if applicable) ______________________ Phone ____________________

Emergency Contact Name ______________________ Relationship ____________ Phone ______________

Primary Care Physician____ Phone _________________

How did you find us? Referral Doctor_______________________Family/Friend _______________

☐ Google ☐ Website ☐ Instagram ☐ Facebook ☐ Lapiplasty Research ☐ Insurance ☐ Drive By ☐ Other

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ASSIGNMENT AND RELEASE

I give permission to Cascadia Foot & Ankle Specialists 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

INSURANCE INFORMATION

Primary Insurance ____

Policy Holder______________________________Relationship_____________________ DOB ________

Policy Holder Employer _________________________________

Secondary Insurance ____

Policy Holder______________________________Relationship_____________________ DOB ________

Policy Holder Employer _________________________________

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

____	____________________________________
Name	Relationship
____	____________________________________
Name	Relationship
____	____________________________________
Name	Relationship

____ ______________________

signature date

Patient Name____ Date of Birth ___________________________

REASON FOR TODAY'S VISIT____

____

Date of Onset/Injury____________________________ **Pain Level** None 1 2 3 4 5 6 7 8 9 10 (worst)

Location Right / Left / Both

Type of Pain Sharp Burning Dull Aching Intermittent Constant Throbbing Shooting

Onset Slow Sudden **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

Medications
Include prescriptions, over-the-counter medications, and vitamins (please provide a list or attach an additional page if necessary) ____ ____ ____ ____ ____ ____

ALLERGIES (List all allergies to medications)____

PHARMACY NAME ____

SOCIAL HISTORY Alcohol use/frequency________________________Drug Use/Frequency _____________

SMOKING STATUS (circle one) Current Everyday/Current Someday/Former Smoker/Never Smoked/Unknown

Hospitalizations/Surgeries ____

____

CASCADIA FOOT & ANKLE
Podiatric Physicians & Surgeons

FAMILY HISTORY

(please circle all that apply)

Heart Disease
High Blood Pressure
Cancer
Asthma
COPD
High Cholesterol
Thyroid Disorder
Osteoporosis
Diabetes
Stroke
Early Deaths____________
Other___________________

ACTIVE MEDICAL PROBLEMS

(please circle all that apply)

Diabetes
High Blood Pressure
Cancer(type)
Depression
Heart Disease
Artificial Heart Valve
Artificial Joints
Bleeding Problems
Circulatory Problems
Hepatitis
High Cholesterol
Infections
Neuropathy
Pacemaker
Prostate Problems
Seizures
Sleep Apnea
Thyroid Problems

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS?

(please circle all that apply)

GENERAL
Fatigue
Fever
Chills
Recent weight gain/loss
Depression
Other:_______________

CARDIOVASCULAR
Chest pain
Heart palpitations
Leg Pain w/ Exercise
Heart Attack
Heart Disease
Other:____________

PULMONARY
Shortness of Breath
Wheezing
Cough
Asthma
Other:_________

GI
Decreased appetite
Heartburn
Nausea/Vomiting
Abdominal pain
Diarrhea/Constipation
Other:________________

ENDOCRINE
Diabetes
Excessive thirst
Heat/Cold intolerance
Excessive sweating
Weakness
Other:____________

MUSCULOSKELETAL
Back pain
Muscle Pains/Cramps
Joint pain/swelling
Arthritis
Foot/Ankle Pain
Other:____________

NEUROLOGIC
Dizziness/Vertigo
Limb weakness
Paralysis
Tingling
Numbness
Other:_______________

SKIN
Dry Skin
Warts
Fungus
Ingrown toenail
Corn/Callus
Rash
Other:___________

ENT/EYES
Hearing Loss
Ringing in ears
Difficulty Swallowing
Blurry vision
Glasses/Contacts
Glaucoma
Other:_______________

CASCADIA FOOT & ANKLE SPECIALISTS FINANCIAL POLICY

Welcome to Cascadia Foot & Ankle Specialists. Thank you for choosing us as your podiatric physician. Our main priority is your foot and ankle healthcare and general well-being. We look forward to being part of your healthcare team. The following is a statement of our Financial Policy which we request you read and sign prior to any treatment.

CHARGES

When you see the physician, you will be billed an office visit charge for the evaluation and management of your condition. All other services are billed separately, such as x-rays, injections, surgical procedures, toenail removal, and others. If you have a co-pay, it applies to the office visit charge only. All other services typically fall under your deductible or co-insurance.

CO-PAY

We are obligated to collect your co-pay by your insurance plan at the time of service. Your co-pay applies to the office visit charge only. All other services fall under your deductible or co-insurance. See "CHARGES" above for more information.

HIGH DEDUCTIBLE HEALTH PLANS

If you have a High Deductible Health Plan all of your charges including the office visit apply toward your deductible and your plan does not pay until your deductible has been met. If you haven't met your deductible, we require payment at the time of service of $100 towards the office visit charge and half the charge of any other services during the visit. To make payment convenient, we accept all major credit cards including Care Credit.

INSURANCE

All services are provided to you with the understanding that you are responsible for the cost whether or not your insurance pays. Not all services are covered under every plan. Your insurance policy is a contract between you and your insurance company, therefore you are responsible for understanding your coverage. If you have a question about whether a service or procedure is covered, contact your insurance plan directly. **You are responsible for knowing if a referral is required, which providers are participating, which facilities are covered, and what ancillary services you must use.**

If we are participating with your insurance plan, we will bill your insurance company once as a courtesy. If your insurance company does not respond within 30 days, we will follow up with an inquiry on your behalf. If your insurance company does not respond within 60 days of claim submission, a statement will be sent to you. You should then call your insurance company to inquire why the claim was not paid. We are able to assist you once you have contacted your insurance company for clarification. You are ultimately responsible for payment of all services you receive. In order to file your claim, we will need complete and accurate insurance information from you. We will need to scan your insurance cards and personal ID before we can see you.

Insurance is complicated and we encourage our patients to reach out to their plans with questions.

NO INSURANCE OR NON-PARTICIPATING INSURANCE

If you do not have insurance or the doctor is not a participating provider with your insurance plan, full payment is due at the time of each visit.

PAYMENT

Payments for any co-pays, deductibles, co-insurance, or balance due is due at the time of service. You will receive a statement showing itemized charges and payments monthly after your insurance claim has finalized. Insurance can take up to 60 days to finalize. A $25 charge will be applied to your account for any returned checks.

MINOR PATIENTS

The adult or the parent (custodial guardian) accompanying a minor is responsible for payment of services. Young adults (age 18 & over) are legally responsible for their accounts unless a parent accompanies them to the initial appointment and signs this financial agreement, regardless of insurance coverage.

CONTINUED ON BACK

MISSED/NO SHOW APPOINTMENTS

We require 24 hours notice when canceling your appointment. This allows us to accommodate other patients in that open spot. A $100 fee will be assessed for missed and no show appointments without 24 hours notice.

REFERRALS

It is your responsibility to obtain any required referral from your insurance company. Failure to do so may reduce the amount of benefits paid by your insurance, in turn increasing the patient responsibility. Please be aware that if you choose to be seen before you have received a valid referral, your insurance may not pay for services rendered.

COLLECTIONS

Account balances 60 days old are considered past-due and 90 days old are considered delinquent. Account balances 120 days or older will be referred to a third party collection agency. However, we do reserve the right to send any account to collections, regardless of the amount of days past due. Your foot and ankle healthcare is our first priority and we understand people can find themselves in financial distress. Please contact our business office if you are having trouble paying your balance.

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.

By signing below, I understand the above information pertaining to the financial policy at Cascadia Foot & Ankle Specialists and agree to adhere to the patient responsibility requirements. This document may not be altered in any way.

____ ______________________________

Signature of financially responsible party date

____

Printed name of financially responsible party

CASCADIA FOOT & ANKLE SPECIALISTS

Podiatric Physicians and Surgeons

Drew D. Pearson, DPM

Notice of Privacy Practices Patient Acknowledgement

I have received this 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: ____________

CASCADIA FOOT & ANKLE SPECIALISTS

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 Cascadia Foot & Ankle Specialists, its medical staff and other providers (collectively referred to herein as "we" or "our").

Cascadia 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 Cascadia 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 Monica Pearson, at 541-600-4630.
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.