

New Patient
WELCOME



Evan C. Merrill, DPM, FACFAS

Siskiyou Medical Building
2924 Siskiyou Blvd., Suite 100
Medford, OR 97504
Phone: 541-776-3338 (FEET)
Fax: 541-776-4979
Web: www.SoFootAnkle.com

Dear

Thank you for choosing Southern Oregon Foot & Ankle, LLC, the office of Dr. Evan C. Merrill for your podiatric care. Please read and complete the Patient Information, Medical History, Patient Financial Policy and Patient Privacy registration forms. In order to scan your insurance cards, take your picture, verify your personal information and review your completed forms, please arrive at least 15 minutes before your scheduled appointment.

The following items are needed along with the completed forms:

1. **Medications:** Make sure to list on the Medical History Form any medications you may currently be taking. Please check the spelling and dosage on your prescription bottles. Also, include any over-the-counter medications you may be taking.
2. **Insurance Cards:** We will scan them and they will become a permanent part of your record. If at any time your insurance changes you will need bring in the new card for scanning.
3. **X-RAYS:** Any prior x-rays of your feet taken within the last 12 month.
4. **Worker's Comp Claims or Motor Vehicle Accidents:** Please come prepared with your date of injury, claim number and other pertinent information for your claim.

Please note that you are responsible to pay all co-pays at each visit. A \$15 fee is assessed when co-pays are billed. As a new patient you will be charged for a new patient office visit. In addition there may be other charges such as x-rays and or procedures, which you and the doctor will determine at the time of your visit.

Directions: Southern Oregon Foot & Ankle, LLC is located at 2924 Siskiyou Boulevard, Suite 100, Medford, Oregon. From Interstate 5, take the South Medford #27 exit. Follow the signs to Barnett Road. At the light, take a right and head east on Barnett Road. Turn left at Murphy Road (at the corner of the Rogue Valley Medical Center). Turn right onto Siskiyou Boulevard; the building is located on the right hand side of the road just as the road curves to the right. Black Oak Pharmacy is also in this building and has signs on the building.

We look forward to meeting you.

Dr. Merrill and Staff



Patient Information

(VERIFY INFORMATION & PLEASE PRINT)

Name (first): _____ (middle): _____ (last): _____

SSN#: _____ Date of birth: _____ Gender: _____ AKA: _____

Street address: _____ City: _____ State: _____ Zip code: _____

Home phone: _____ Work phone: _____ Cell phone: _____ Fax: _____

Preferred/message phone (please circle): Home Work Cell Email address: _____

Mailing address (if different from street address): _____

Race: African American ___ American Indian ___ Caucasian ___ Eastern Indian ___ Hispanic ___ Asian ___ Decline ___ Other _____

Ethnicity: Hispanic/Latino ___ Non Hispanic/Latino ___ Decline ___ Language: English ___ Spanish ___ Other: _____

Marital Status: _____ Level of Education: _____ Student: Full time ___ Part. Time ___

Employment _____ Primary Doctor _____

Preferred Pharmacy: _____ Referral Source: _____

PERSON RESPONSIBLE FOR BILL (if other than the patient or if the patient is a minor) Check here if same as above

Name (first): _____ (middle): _____ (last): _____

Date of birth: _____ SSN#: _____ Gender: _____ Company name: _____

Mailing address: _____ City: _____ State: _____ Zip code: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Email: _____ Relationship to patient: _____

MEDICAL INSURANCE INFORMATION (cards or proof of coverage required) Medicare Oregon Health Plan

Primary Insurance: _____ Policyholder name: _____ Relationship to patient: _____

Policy holder birth date: _____ Insured ID#: _____ Group#: _____

Secondary Insurance: _____ Policyholder name: _____ Relationship to patient: _____

Policy holder birth date: _____ Insured ID#: _____ Group#: _____

Is this visit due to a work related accident or an automobile accident ? Date of Injury _____

Claim #: _____ Insurance Company: _____

EMERGENCY INFORMATION

Spouse name: _____ Spouse Employer: _____ Spouse Work Phone: _____

Emergency contact name: _____ Relationship: _____ Phone: _____

Consent and Authorizations:

I certify that the medical information given is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my condition.

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Southern Oregon Foot & Ankle, LLC, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature _____ Date _____

Patient Medical History

(PLEASE PRINT)

Southern Oregon Foot & Ankle LLC
Evan C. Merrill, DPM, FACFAS



Name (first): _____ (middle): _____ (last): _____

Current weight: _____ Height: _____ Shoe size: _____

List all allergies to medications: _____

Other allergies: LATEX -What is your reaction? _____, Tape Betadine (iodine)

List all current medications with dosage: _____

REASON FOR THIS VISIT

Describe your foot problem: _____

How long has it been bothering you? Days: _____ Weeks: _____ Months: _____ Years: _____

Does today's visit relate to an accident? No Yes If yes, is it related to: Work Auto Other _____

Date of injury: _____

Indicate any past problems of your feet and ankles: _____

Bunions	Flat Feet	Gout	Neuromas	Plantar Fasciitis
Circulation	Foot ulcer	Hammertoes	Peripheral Neuropathy	Warts
Corns & Calluses	Ganglions	Ingrown nails	Peripheral Vascular Disease	Other _____

List any past surgical procedures on your feet or ankles: _____

MEDICAL HISTORY

• Do you have Diabetes? No Type 1 Type 2 Gestational For how long? _____

Check any of the following problems you have had or have:

Anemia	Healing difficulties	Intestines	Skin
Arthritis (osteo)	Heart	Kidneys	Stomach Ulcers
Arthritis (rheumatoid)	Hepatitis	Lung condition	Stroke
Asthma	High Blood Pressure	Neurological Disorder	Thyroid
Frequent Infections	High Cholesterol	Rheumatic Fever	Tuberculosis

Additional details on any of the above checked problems: _____

Other medical conditions: _____

• Do you have any Artificial Joints? No Yes Where: _____

• Do you have a Heart Valve Implant? No Yes

Are you under a physician's care? No Yes If yes, for what condition? _____

Family Physician: _____ Approximate date you last saw this doctor: _____

May we contact your physician about your health? No Yes

Patient Medical History

Patient Name: _____

SURGICAL HISTORY

List any other major surgeries: _____

SOCIAL HISTORY

Do you smoke? No Yes Number of packs per day for _____ (yrs./mos.) _____

Do you drink alcohol or beer? No Yes Frequency _____

Do you use medical marijuana? No Yes

FAMILY HISTORY

Mother: Living Deceased Cause: _____

Father: Living Deceased Cause: _____

Brother: Living Deceased Cause: _____

Sister: Living Deceased Cause: _____

Check family (blood relative) history of:

Arthritis

Circulation problems in legs or feet

Heart Disease

Bleeding Disorder

Flatfeet

Neurological Disorder

Bunions

Hammertoes

Stroke

Signature _____ Date _____

Patient Financial Policies

Welcome to Southern Oregon Foot and Ankle

This form should help you clearly understand our financial policy. If you have any questions regarding your responsibility please do not hesitate to ask.

- If you do not have medical insurance or if the deductible of your insurance policy has not been met, full payment is expected on the day of service. Payment options are Cash, Check, VISA, MasterCard and Discover Card.
- Co-pays must be paid at each visit per your insurance contract.
NOTE: WHEN CO-PAYS MUST BE BILLED, THERE IS AN ADDITIONAL \$15 BILLING FEE.
- If you have insurance but do not provide the information at the time of visit, payment in full is expected. We will give you 48 hours to provide the insurance information before processing your payment.
- If payment has not been made for 60 days, once the balance becomes your responsibility, the account may be assessed a finance charge of 1.5% per month.
- For surgical procedures you will be asked to pay for a portion of the cost prior to surgery. The labs, hospital and anesthesiologist charges are billed separately and you will receive a statement from those providers.
- For worker's compensation cases or motor vehicle accidents, we will bill the appropriate insurance. If your claim is denied you will be responsible for payment in full.
- If you are being treated as part of a personal injury lawsuit or claim, payment of the bill remains your responsibility. We cannot bill your attorney for charges incurred due to your personal injury.
- By signing this form you are giving Southern Oregon Foot and Ankle LLC authority to release any information required to complete your insurance claim. The authorization will be effective until you choose to revoke in writing.

By signing this form you understand this policy and are bound by it.

Signature of Patient

Print Patient's Name

Date of Birth

Signature of Responsible Party (if not the patient)

Print Name of Responsible Party

Date of Birth

Today's Date

Co-Payment: The amount determined by your insurance policy that you must pay at each office visit at the time of service.

Co-Insurance: An amount (which is usually a percentage) of the fee that you are required to pay as determined by your insurance.

Deductible: The amount you must pay out of your pocket before your insurance will pay for services.

Southern Oregon Foot and Ankle - Evan C. Merrill, DPM, FACFAS
Siskiyou Medical Building, 2924 Siskiyou Boulevard, Suite 100, Medford, Oregon 97504
Phone: 541-776-3338 - Fax: 541-776-4979 - Web: www.SoFootAnkle.com



PART ONE

Authorization for Release of Information (PLEASE PRINT)

Patient Name: _____ Date of Birth: _____

A. I authorize Southern Oregon Foot & Ankle, LLC (SOFA) to discuss my medical care and may release my confidential protected health information (see items checked below) to the following:

Name of individual _____ Relationship to patient _____

Name of individual _____ Relationship to patient _____

Information that may be released to the above individuals:

Any information Results from tests or x-rays Financial information Medical information

B. SOFA may leave medical or billing messages on my preferred phone number. Yes No

C. When authorized, SOFA may email medical health information (chart notes and/or x-rays) Yes No

Rights of the patient: I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Southern Oregon Foot & Ankle, LLC, 2924 Siskiyou Boulevard, Suite 100, Medford, OR 97504. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward from the date on the revocation.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization on behalf of the patient.

Signature of patient or personal representative Date: _____

PART TWO

Acknowledgement of Receipt of Notice of Privacy Practices
from Southern Oregon Foot & Ankle, LLC

I acknowledge that I was provided or offered a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read, if I so choose) and understood the Notice.

Patient (please print) or name of authorized representative (if applicable)

Signature Date _____

_____ Initial of SOFA employee who witnessed this signature