McMINNVILLE
FOOT & ANKLE
SPECIALISTS

JASON S. SABATINI, DPM
PODIATRIC PHYSICIAN &
SURGEON

PATIENT INFORMATION

Date: _____ Chart Number: _____(Completed by staff)

Name: _____ Age: _____ Sex: M F
(Last) (First) (Middle)

Date of Birth: _____ Social Security #: _____ Marital Status: S M D W

Mailing Address: _____
(Street) (Apt Number)

_____
(City) (State) (Zipcode)

Home Phone: _____Mobile: _____Work: _____

E-Mail Address: _____

Employer: _____ Occupation: _____

Emergency Contact Name: _____

Emergency Contact Number:_____ Mobile: _____

Primary Care Physician: _____

Preferred Pharmacy:_____ Location:_____

Referral/How did you hear about us? _____

Race: _____ Primary Language: _____

Primary Medical Insurance:

Name of Insurance Company: _____

Name of Subscriber: _____ DOB: _____

ID#: _____ Group #: _____

Secondary Insurance: _____

ID #: _____ Group #: _____

Patient Name: _____ **Date of Birth:** _____

Medical History:

Current Primary Problem: _____

Where is the Problem located? _____ Date Problem started? _____

When does it hurt? _____

Is the pain (circle): Sharp/Dull/Throbbing/Burning/Shooting/Continuous/Intermittent/Localized

Does anything make the pain better or worse? _____

Have you had any prior treatments for this problem? (please describe) _____

_____

Please indicate if you have a history of any of the following (use back of page for additional information)

Presently Pregnant or Nursing	Yes__ No__	HIV/AIDS	Yes__ No__
Visual Problems	Yes__ No__	Diabetes Type I or II	Yes__ No__
Hearing Difficulty	Yes__ No__	Thyroid Problems	Yes__ No__
Asthma	Yes__ No__	Gout	Yes__ No__
Emphysema	Yes__ No__	Pain in calves w/walking	Yes__ No__
Shortness of Breath	Yes__ No__	Arthritis	Yes__ No__
Pulmonary Emboli	Yes__ No__	Rheumatoid Arthritis	Yes__ No__
Tuberculosis	Yes__ No__	Skin Changes	Yes__ No__
Heart Attack	Yes__ No__	If Yes, Explain: _____	
Stroke	Yes__ No__	Ulcers	Yes__ No__
Chest Pain/Angina	Yes__ No__	If Yes, Explain: _____	
High Blood Pressure	Yes__ No__	Psoriasis	Yes__ No__
Hepatitis	Yes__ No__	Varicose Veins	Yes__ No__
Liver Problems	Yes__ No__	Dizziness/Fainting	Yes__ No__
Kidney Problems	Yes__ No__	Seizures	Yes__ No__
Bleeding Problems	Yes__ No__	Cancer/Malignancy	Yes__ No__
Blood Clots in Legs	Yes__ No__	If Yes, Explain: _____	
Pacemaker	Yes__ No__		

Indicate any sensitivity to the following:

Novocain ____ Soaps ____ Latex ____

Iodine ____ Tape ____ Other ____

Do you use:

Tobacco: _____ How much ___ pack/day ___ years

Alcohol: _____ How much ____ drinks/week

Allergies (include type of reaction): _____

_____

Surgeries/Injuries/Illnesses (Include year): _____

_____

_____

Current Medications (Include all non-prescription medications and dosage): _____

_____

_____

Family History: _____

_____

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MEDICAL INFORMATION RELEASE FORM AND CONSENT TO TREATMENT

Patient Name: _____ Date of Birth: _____

Release of Information

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information. This information may be released to:

[ ] Spouse Full Name_____

[ ] Child(ren) Full Name _____

[ ] Other Full Name _____

[ ] Information is not to be release to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Preferred Contact Number [ ] home [ ] work [ ] cell number: _____

If unable to reach me: You may leave a [ ] detailed message [ ] a message asking to return your call

By signing this form, I authorize McMinnville Foot & Ankle Specialists access to view and transfer all current prescriptions from the global pharmacy database to my patient chart. I consent to be treated by the providers of McMinnville Foot & Ankle Specialists. I ask for and allow the medical providers and staff to give me the needed medical treatment and services recommended by my physician.

I understand that treatment and services may include, but are not limited to, the following:

- Routine Exams
- Casts/Splints
- Injections
- X-rays
- Diagnostic Tests
- Lab Tests
- Screening Tests

I understand that no promises have been made to me about the results of any treatment of services.

Signature of Patient/Representative: _____ Date: _____

McMinnville Foot & Ankle Specialists - Payment Policy

Our Practice is committed to providing the utmost courtesy and the best treatment for our patients. If there are any questions about our policies, please ask.

Patient's Name: _____ Date of Birth: _____

1. **PODIATRIC MEDICAL SERVICES**: Fees for services are due at the time of your visit. We require all patients to pay their deductible, copay and/or coinsurance payment at the beginning of each visit. As a form of payment, we accept cash, checks or all major credit cards (Visa/MasterCard/American Express).
2. **HIGH DEDUCTIBLE INSURANCE** - If you have a high deductible, you will be required to pay for 50% of your visit on the date of service, or $125.00 (whichever is less). We will bill insurance as a courtesy for you, but it is your responsibility to meet the deductible amounts. We will verify eligibility and deductible amounts prior to your service date, but patients are responsible for knowing and meeting their deductible amounts. **The Final responsibility for payment of your account is yours.**
3. **INSURANCE BILLING**: Please provide accurate, complete and detailed information regarding your insurance plan. It is your responsibility to speak with your insurance representative prior to treatment to verify coverage and eligibility for Podiatric Medical Services. The responsible party is obligated for payment in full of this account. As a courtesy, McMinnville Foot & Ankle Specialists, verifies your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan. If your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received. Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan.
4. **BILLING POLICY**: It is the policy of this office to send a monthly statement showing the current balance due. The end of the billing period is the 25th of each month. Full payment is expected upon receipt. **The Final responsibility for payment of your account is yours.**
5. **DELINQUENT ACCOUNTS**: All accounts over sixty (60) days, will be considered PAST DUE. A $5.00 late fee will be assessed. However, if there has been no payment made on your account after 90-days (after insurance has been billed), you will be given a final notice and an outside collections agency may be employed to recover the balance due. If your account is turned over to an outside collections agency, an additional $75.00 service fee & accrued late fees will be added to the outstanding balance.
6. **RETURNED CHECK FEE**: In the case of a returned check, you will be liable for the face value of the check and an additional $25.00 fee. This fee cannot be billed to your insurance and is your responsibility.
7. **MISSED APPOINTMENT**: If for any reason you cannot keep a scheduled appointment, please call at least one (1) business day (24 hours) in advance of your appointment. If you fail to provide at least 24 hours notice we reserve the right to charge a $50.00 fee for habitually missing an appointment. This fee cannot be billed to your insurance company and is your responsibility. **We reserve the right to discharge patients who habitually miss their appointments without notice.**
8. **NO INSURANCE POLICY** - We will happily see patients with no insurance, but payment is due at the time of service. We do offer a 10% discount for services normally billed to insurance as a courtesy.
9. **REFERRALS** - Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by another physician does not necessarily guarantee that your insurance will cover our services.
10. **RECORD REQUEST** - If you need copies of your chart notes and/or X-rays a fee of $0.05 per copy is assessed. All mail must be certified to be HIPAA compliant and a release of information form must be filled out before records can be sent. Charts that need to be mailed to an alternate provider will incur a shipping and handling fee.

Your signature certifies that you have read, understand, and agree to the policies stated above, authorize the release of any medical information necessary to process this claim for services rendered, and authorize payment of medical benefits to McMinnville Foot & Ankle Specialists for services described on itemized statements and/or insurance forms.

Patient/Representative Signature: _____ Date: _____

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HIPAA CONSENT & ACKNOWLEDGMENT

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice also contains a Patient Rights section describing your patient rights under the law. You have a right to review this Notice before signing this Consent. The terms of the Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to this restriction, but if we do, we shall honor the agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for:

- Treatment (including direct and indirect treatment by other healthcare providers involved in your medical care).
- Payment from your insurance company or other third party payers.
- The day-to-day Healthcare Operations of our practice.

You have the right to revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date you revoke this consent is not affected. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient Understands that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operation
- The practice has a Notice of Privacy Practices, and the patient has the opportunity to review this Notice
- The practice reserves the right to change the Notice of Privacy Practices
- The patient may revoke this consent in writing at any time
- The practice may condition receipt of treatment upon the execution of this consent

Patient Name: _____ Date of Birth: _____

Signature of Patient/Representative: _____ Date: _____