Klamath Falls Foot and Ankle, LLC
Jeff Merrill, DPM, FACFAS

Patient Information Form

Today's Date: ____/____/____
Patient Name: _____ _____ ____
Last First MI
Date of Birth: ____/____/____ Age: _____ Sex: M F
Home Address: _____
City/State: _____ Zip: _____
Mailing address (if different than home address):
_____
City/State: _____ Zip: _____
May we leave a message?
Home Phone #: (_____) _____-_____ Yes No
Work Phone #: (_____) _____-_____ Yes No
Cell Phone #: (_____) _____-_____ Yes No
E-mail: _____
Employer: _____ Occupation: _____

Do you have a legal guardian or healthcare power of attorney? Yes No
If yes, Name: _____ Relationship: _____
Phone #: (_____) _____-_____

Emergency Contact: _____
Relationship to You: _____ Phone #: (_____) _____-_____

Primary Care Doctor: _____
Pharmacy: _____

Who is responsible for payment? _____
Relationship to patient? _____
Address: _____ City/State: _____
Zip: _____ Phone #: (_____) _____-_____

Please list all medications you are currently taking (include prescriptions, over-the-counter medications and herbal supplements):

Name	Dose

Please list all prior surgeries:

Type of Surgery	Date	Type of Surgery	Date

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Please list all prior hospitalizations (other than for surgery):

Reason For Hospitalization Date Reason For Hospitalization Date

_____ _____

_____ _____

Use of Alcohol: ☐ Never ☐ No longer use ☐ History of alcohol abuse ☐ Occasional

Use of Tobacco: ☐ Never ☐ Quit – how long ago? _____

☐ Smoke ____ packs/day for ____ years

Use of Recreational Drugs: ☐ Currently Use ☐ Never ☐ Quit – How long ago? _____

Type of drugs:_____

Do you have a family history of: ☐ Diabetes: Type 1 or Type 2 ☐ Cancer ☐ Heart Disease

☐ Heart attack ☐ Stroke ☐ Coronary Artery Disease ☐ Blood Clots

Allergies: ☐ Medications _____

☐ Foods _____ ☐ Tape ☐ Latex ☐ Shellfish ☐ Iodine

☐ Other _____ ☐ None Known

Have you ever had any of the following?

Acid Reflux	Y	N	Fibromyalgia	Y	N	Neuropathy	Y	N
Anemia	Y	N	Gout	Y	N	Open Sores	Y	N
Arthritis	Y	N	Heart Attack	Y	N	Pneumonia	Y	N
Asthma	Y	N	Heart Disease/Failure	Y	N	Polio	Y	N
HIV/AIDS	Y	N	Hepatitis	Y	N	Rheumatic Fever	Y	N
Abnormal Bleeding	Y	N	High Blood Pressure	Y	N	Skin Disorder	Y	N
Blood Clots	Y	N	Kidney Disease	Y	N	Sleep Apnea	Y	N
COPD/Emphysema	Y	N	Low Blood Pressure	Y	N	Stroke	Y	N
Cancer	Y	N	Migraine Headaches	Y	N	Thyroid Disease	Y	N
Diabetes: Type 1 or Type 2 (circle)	Y	N	Mitral Valve Prolapse	Y	N	Tuberculosis	Y	N

Other Health Conditions: _____

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

_____ _____

Print name of patient, parent or guardian If other than patient, relationship to patient

_____ _____

Signature Date

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Consent Form

Initials

_____ I authorize the disclosure of all personal and health information to the individuals, e.g. family members or caregivers, listed below:

_____ _____

_____ _____

_____ _____

_____ HIPPA Notice of Privacy Practices: We are required by law to maintain the privacy of protected health information. Initialing here is acknowledgement that you have received or declined the Notice of Privacy Practice. Copies are available upon request.

_____ Release of Information: I authorize release of any information concerning patient's health care for the purpose of coordinating health care with other medical facilities.

_____ Consent for Treatment: I understand that providing complete health information is necessary for services. I have provided this information to the best of my knowledge. I understand that it is my responsibility to inform Dr. Merrill of any changes in my medical status. I give consent and authorize recommended treatment while I am under Dr. Merrill's care.

_____ Electronic Records: This office keeps records for all patients on a web-based electronic record system and participates in an electronic prescriptions program. We take the protection of your information seriously and comply with all government regulations regarding privacy. I consent to have my medical records kept in a web-based electronic health record and agree to be enrolled in an electronic prescription program.

_____ Medical Photographs: Medical photographs are taken as documentation of the status of your condition. Medical photographs can be taken on your initial visit as well as throughout your care to document changes. I consent to having medical photographs taken.

_____ _____

Print name of patient, parent or guardian | If other than patient, relationship to patient

_____ _____

Signature | Date

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Financial Policy

Please read and sign this form to acknowledge your understanding of our patient financial policies.

What am I responsible for?

Payment of co-pays, coinsurance, deductibles, and all other services or products not covered by your insurance plan are due at the time of service. We will bill your insurance company for all billable products and services. Once your insurance has responded, the remaining balance is your responsibility, and you will receive a statement.

How may I pay?

We accept payment by cash, check, Visa, or MasterCard. Please note if paying by cash, you must pay the exact amount, as we cannot give change.

Do I need a referral?

If your insurance company requires a referral and/or prior authorization, you are responsible for obtaining it. Failure to obtain a referral and/or prior authorization may result in a lower payment or no payment from your insurance company and the balance will be your responsibility.

Self-pay Accounts

You will be advised of an estimate of the amount needed to pay for your services and you will be asked to make payment in full at the time of service. If needed, extended payment arrangements are available. Please ask to speak with our office staff to discuss a payment plan.

Surgery

If Dr. Merrill recommends surgery, we will request a pre-surgical deposit, the amount of which depends on your coverage and deductible.

Outstanding Balance Policy

It is our policy that all past due accounts be sent two statements. If payment is not made on your account, a ten-day payment due statement will be sent, followed by a single phone call in an effort to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency. In the event an account is turned over to collections, the person financially responsible for the account will be responsible for all collection costs.

No Show Policy

A $50 charge will be implemented for all established patients who fail to show for an appointment without prior communication with our office. Extenuating circumstances may be discussed with our office staff.

I understand and accept this financial policy.

_____	_____
Print name of patient, parent or guardian	If other than patient, relationship to patient
_____	_____
Signature	Date

Revised May 2020