



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: _____

Home Phone #: (____) ____ - _____

Cell Phone #: (____) ____ - _____

E-mail: _____

Do you have a legal guardian or healthcare power of attorney? Yes No

If yes, Name: _____ Relationship: _____

Phone #: (____) ____ - _____

Next of Kin: _____

Relationship to You: _____ Phone #: (____) ____ - _____

Primary Care Doctor: _____

Pharmacy: _____

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

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

Reason For Hospitalization	Date	Reason For Hospitalization	Date



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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:

_____	_____
_____	_____

_____ I consent to receive email, text, and voicemail from Klamath Falls Foot and Ankle, LLC employees and Jeff Merrill, DPM, FACFAS.

_____ 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, and credit card.

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.

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