CASCADE FOOT AND ANKLE SPECIALISTS, LLC

Westside Office
12400 NW Cornell Rd., Suite 201
Portland, OR 97229
Phone: 503.643.1737 FAX: 503.643.4926

Eastside Office
5050 NE Hoyt St., Suite 138
Portland, OR 97213
Phone: 503.643.1737 FAX: 503.643.4926

Physicians & Surgeons • Foot and Ankle Surgery

Kenneth K.S. Mah, D.P.M. Clifford D. Mah, D.P.M.

www.cascadefas.com

Welcome to Cascade Foot and Ankle Specialists, LLC. Enclosed are new patient forms. To expedite your office visit, please complete the forms prior to your visit. Please bring your current insurance card and a valid Identification Card. Payment of co-pays and deductibles are required at time of visit. If you have any questions, feel free to contact us at 503.643.1737.
We look forward to meeting you.

Cascade Foot And Ankle Specialists, LLC

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Dr. Kenneth K.S. Mah, DPM **Dr. Clifford D. Mah, DPM**

PLEASE COMPLETE ALL INFORMATION OR WRITE "N/A" IF NOT APPLICABLE

Patient Name: ____ Male / Female
Last First Middle

Cell No: __________________

Social Security No.: _________________ Date of Birth: ____________ Age: _______ Home No:__________________

Street Address: ____ City, State, Zip:________________________

Billing Address (if different): __________________________________City, State, Zip:________________________

Check Appropriate Box: ◻ Minor ◻ Single ◻ Married ◻ Widowed ◻ Divorced ◻ Separated

Patient Employer: ____Work Phone:__________________________

Business Address: ____ Occupation:___________________________

Spouse/Parent/Guardian Name: ______________________________ Work Phone:__________________________

Business Address: ____ Occupation: __________________________

Responsible Party: ____Relationship to Patient:___________________
Is the responsible party a patient in this practice? YES NO

Emergency Contact: ____ Contact Phone: ________________________

How were you referred? ◻ Doctor ◻ Friend ◻ Phone Book ◻ Other:________________________

Whom may we thank for referring you?____

Primary Care Physician: ____________________________________ Date Last Seen:________________________

Medical Insurance Information

Name of Insured: ______________________________ Insurance Company:___________________________

Relationship to Patient:_________________________

Please fill below if Relationship to Patient is NOT SELF

Name of Insured:____

Street Address: ____ City, State, Zip:________________________

Home No:______________________________ Cell No:____

******This office is not responsible for billing secondary insurances. Unless your claim is forwarded directly to your secondary coverage from your primary carrier, you will be responsible for the balance owed after your primary insurance has processed the claim. Please contact your secondary coverage for directions on filing a claim. We will be happy to assist you to the best of our abilities with any questions or concerns.*

ASSIGNMENT AND RELEASE: I acknowledge that I am financially responsible for all charges. A $20.00 Non-sufficient –fund will be charged for a returned check. If you do not have insurance, payment is required at time of service. Unpaid balances over 120 days may be referred to an outside collection agency. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment of benefits. I hereby authorize Cascade Foot And Ankle Specialists, LLC to administer treatment for my podiatric medical needs.

Signature: ____ **Date**:_________________________________

Name:________________________________ Date:___________________

Lower Extremity Medical History

What is the chief complaint(s) which brings you to our office for medical treatment ?
(Include foot, ankle, leg, knee and hip complaints)___________________________
____
____
____

Date of Injury: ___________________________

Former foot and ankle physician:
Name:______________________________
Last visit:____________________________

Any previous injuries or problems to the feet, ankles or legs?________________________
____

Symptoms

Which Side: ○ Right ○ Left ○ Both
Type of Pain: ○ Dull ○ Achy ○ Throbbing
○ Burning ○ Sharp ○ Shooting

Area of Pain:___________________________
Onset: ○ Slow ○ Sudden ○ Traumatic

Duration:_____________________________

Has pain gotten: ○ Better ○ Worse ○ No Change

What aggravates condition? ○walking ○running
○standing ○shoes

What have you tried to help the pain?
○ Changing shoes ○ anti-inflammatories
○ decrease activities
Other:_________________________________
____

How long does pain last?_________________
Have you ever had a similar pain? (describe, including treatments received)
____
____

Medications

List all medications you are taking:
____
____
____
____
____

General

What is your weight:______________
What is your height: ______________
What is your shoe size:_____________

Surgeries, Injuries, Illnesses

List surgeries, serious injuries, and illnesses not previously listed:_______________________________________
____
____

Social History

Do you smoke? ◯ yes ◯ no
Are you a past smoker? ◯ yes ◯ no
How Much?____packs/ _____. Years Smoked:_______
Drink Alcohol?: ◯ yes ◯ no How Much:
Recreational Drugs? ◯ yes ◯ no What:_____________
Pregnant or possibly pregnant? ◯ yes ◯ no

Allergies and Drug Intolerance

◯ No known drug allergies
◯ Adhesive/Tape ◯ Aspirin ◯ Codeine
◯ Iodine ◯ Penicillin ◯ Seafoods
◯ Local Anesthetics ◯ Sulfa
◯ Other _____________________________________

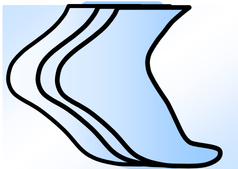
Family History

◯ Single ◯ Married ◯ Widow
# of children:_______boys ____________girls
Mother ◯alive Medical
Hx:__________________________
____
Father ◯alive Medical
Hx:__________________________
____

Personal General Medical History

Please circle for following

Diabetes	Vascular Disease	Thyroid Disease	Arthritis
High/Low Blood Pressure	Phlebitis/Blood Clots	Stomach Ulcer	Gout
Stroke	Circulation Problems	Bowel Disease/Colitis	Lupus
Angina/Chest Pain	Lung Disease	Liver Disease	Mealses
Heart Attack	Asthma	Hepatitis	Mumps
Heart Murmur	Pneumonia	Kidney Disease	Chicken Pox
Other Heart Condition	Tuberculosis	Cancer:type	Alzheimer’s Disease
Bleeding Disorder	AIDS/HIV	Rheumatic/Scarlet Fever	Psychiatric Care
Anemia	Epilepsy/Seizures	Headaches/Migraines	Neurologic Disorder
Leg Cramps	Shortness of Breath	Other:_______________________	



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FINANCIAL POLICY

Welcome To Cascade Foot And Ankle Specialists, LLC. Thank you for choosing us as your podiatric physician. We are committed to your treatment being successful, as you, the patient, are our first and foremost concern. As part of our service, we try to contain the cost of health care. In an effort to do this, we have implemented a Financial Policy.

The following is a statement of our **FINANCIAL POLICY** which we request you read and sign prior to any treatment. To avoid any misunderstandings, please contact us should you have any questions about our policies.

INSURANCE: If Cascade Foot & Ankle Specialists, LLC is a participating provider with your insurance plan, we will submit the claim to your insurance company. To do this we must have complete and accurate insurance information including social security number, home address, and phone number, and a copy of your identification card or claim form. Your insurance policy is a contract between you and your insurance company; therefore you are responsible for payment whether or not your insurance company pays. It is your responsibility to contact your insurance company regarding pre-authorizations, obtaining required referrals, second opinions, etc. Failure to do so may reduce the amount of benefits paid by your insurance, and the balance will then become your responsibility to pay.

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

PAYMENT: Payments for the balance due, co-payments, deductibles, etc., are due at the time of service and may be made by cash, check or credit card (Visa, MasterCard). There will be a $20.00 charge for returned checks. Delinquent accounts of greater than 120 day may be referred for collection.

CO-PAYMENTS & DEDUCTIBLES: Please be prepared to pay all co-payments and deductibles at the time of service.

MINOR PATIENTS: The adult or the parent (custodial guardian) accompanying a minor is responsible for payment of services. For unaccompanied minors, non-emergency treatment will be denied unless prior authorization from the parent or guardian has been made for the charges and treatment. 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.

MISSED APPOINTMENTS: Please help us serve you better by keeping scheduled appointments. If it is necessary to cancel, please call our office 24 hours in advance. This allows us to accommodate our other patients. A $35.00 charge will be assessed for missed appointments.

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 time of purchase.

Please be prepared to pay your co-payment and any charges within your current deductible at the time of your visit. I have read and agree to the terms set forth in the above financial policy. I am financially responsible for any balance due.

SIGNED____ DATE____________________

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Notice of Privacy Practices
Patient Acknowledgement

Patient Name: ____

Date of Birth:____

I have received this practices' 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: ____

Date: ____

Relationship to patient (if signed by a personal representative of patient):

____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We are required by law to provide you with this notice that explains our privacy practices with regards to your medical information and how we may use and disclose your protected health information for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information and we also describe them in this notice.

Ways in Which We May Use and Disclose Your Protected Health Information:

Following are examples of the types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment. We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. We will also disclose protected health information to other physicians who may be treating you.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment. Your protected health information will be used, as needed, to obtain payment for your health care services. *For example*, we may include information with a bill to a third-party payer that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

Health Care Operations. We will use and disclose your protected health information to support the business activities of our practice. *For example*, we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third party business associates who perform billing, consulting, or transcription services for our practice.

Other Ways We May Use and Disclose Your Protected Health Information:

Appointment Reminders. We will use and disclose your protected health information to contact you as a reminder about scheduled appointments or treatment.

Treatment Alternatives. We will use and disclose your protected health information to tell you about or to recommend possible alternative treatments or options that may be of interest to use.

Others Involved in Your Care. We will use and disclose your protected health information to a family member, a relative, a close friend, or any other person you identify that is involved in your medical care or payment for care.

Research. We will use and disclose your protected health information to researchers provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

As Required by Law. We will use and disclose your protected health information when required to by federal, state, or local law. You will be notified of any such disclosures.

To Avert a Serious Threat to Public Health or Safety. We will use and disclose your protected health information to a public health authority that is permitted to collect or receive the information for the purpose of controlling disease, injury, or disability. If directed by that health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.

Worker's Compensation. We will use and disclose your protected health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.

Inmates. We will use and disclose your protected health information to a correctional institution or law enforcement official if you are an inmate of that correctional institution or under the custody of the law enforcement official. This information would be necessary for the institution to provide you with health care; to protect the health and safety of others; or for the safety and security of the correctional institution.

Your Health Information Rights

Although your health record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you. You have the right to:

Inspect and Copy. You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request.

If you wish to inspect or copy your medical information, you must submit your request in writing, or fill out a release of information form provided by our office to our privacy officer. You may mail your request to the above listed address, fax to 503.643.4926, or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.

Request Amendment. You have the right to request that we amend your protected health information. Your request must explain why the information should be amended. Our office can provide this form for you to fill out, otherwise submit your request in writing. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of that information.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf or a form will be provided by our office. We will not be bound unless our agreement is so memorialized in writing.

Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Confidential Communication: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

File a Complaint. If you believe we have violated your medical information privacy rights, you have the right to file a complaint with our privacy officer or directly to the Secretary of Health and Human Services. You can either submit a written notice, or a form will be provided to you from our office.

Uses or Disclosures Not Covered

Uses or disclosures of your health information not covered by this notice or the laws that apply to us may only be made with your written authorization. You may revoke such authorization in writing at any time and we will no longer disclose health information about you for the reasons stated in your written authorization; a form from our office may be provided to you for your convenience. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation.

For More Information

If you have questions or would like additional information, you may contact our office at 503.643.1737.