Lyndon G. Johansen, D.P.M., P.C.

12658 S.E. Stark Street
Portland, OR 97233
503/256-4018
Fax: 503/256-6298

Dear New Patient:

Thank you for scheduling your first appointment with Dr Lyndon G. Johansen. We hope you will feel comfortable and secure with the treatment you receive from our office.

Prior to your first appointment please take a few minutes and complete the following papers, which you will need to bring with you at the time of your appointment.

1) **REGISTRATION** form. Please fully complete this form and sign the **ASSIGNMENT AND RELEASE** section.
2) **Patient Medical Information.** Dr Johansen will use this form to review your past medical history. Fill out this form the best you can. Please bring your current medication list. If you have any questions on this form please ask Dr Johansen. This will become part of your confidential medical record in our office. We can release your records only if you give us written permission.
3) **Medical Insurance Disclaimer.** This form states that if for some reason your insurance company denies payment for a non-covered service with Dr Johansen, you are liable for that charge and we will bill you for the balance.
4) **Patient Consent For Use and Disclosure of Protected Health Information.** This is the privacy act that the government has put into place, please sign this form. We have an explanation letter that we would be very happy to let you read when you come into the office.
5) **Financial Policy.** Payment will be expected within 30 days unless prior arrangements have been made.

It is important that at the time of your appointment you have your **insurance card, co-pay** and **referral**, if applicable, with you so we may bill your insurance company. Please notify our receptionist of any changes in your insurance, primary care physician or addresses.

It is our office policy to **collect co-pays at the time of service**. We accept check, cash, Visa, Mastercard and Discover.

Enclosed you will find a map showing where we are located and descriptions on how to get here.

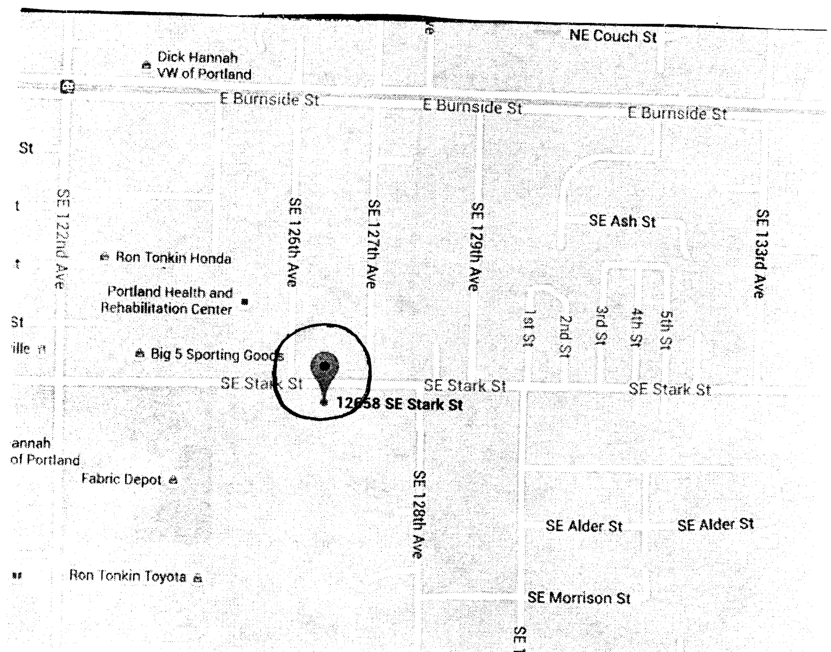
Thank you again for choosing to see Dr Johansen. We are looking forward to working with you.

Sincerely yours,

Dr Lyndon Johansen and Staff

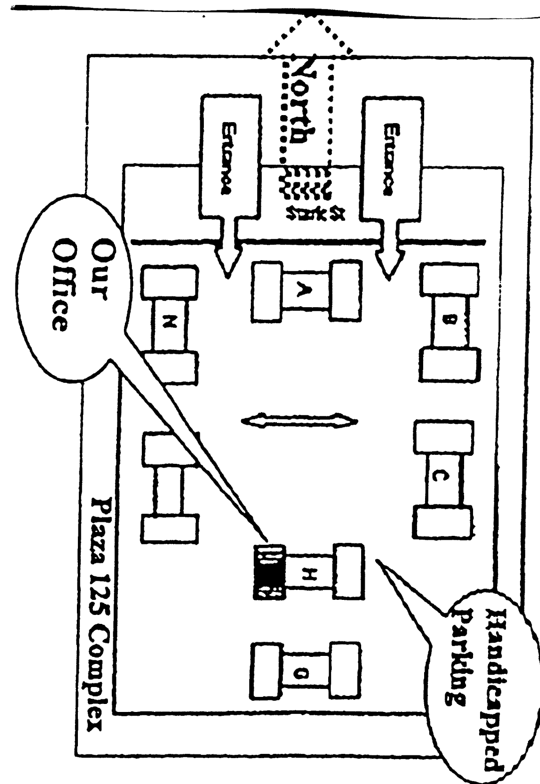
Directions to Our Office
12658 SE Stark St. Building H

FROM I-84 going EAST -
Take Exit 10 (122nd Ave). Travel south on 122nd until you reach Stark St. Turn Left onto Stark and right into Plaza 125.



FROM 1-84 going WEST -
Take exit 13 (181st Ave). Travel south on 181st. Turn right on Stark and left into Plaza 125 just before reaching 122nd Ave.

FROM I-205 going NORTH -
Take exit 20 (Stark/Washington). Turn right onto Washington. Continue on Washington until it turns into Stark. Turn right into Plaza 125 just after crossing 122nd Ave.



FROM I-205 going SOUTH -
Take Glisan/Stark exit. Travel across Glisan St and stay right. Turn left on Washington. Continue on Washington until it turns into Stark. Turn right into Plaza 125 just after crossing 122nd Ave.

By Bus or MAX -
The #20 Bus will take you to our office. There is a bus stop at 128th and Stark just a block or so from our office.

Handicapped Parking:
Handicapped parking on the east end of Building "H"

Lyndon G. Johansen, D.P.M., P.C.
Plaza 125 12658 SE Stark Street Portland, OR 97233
503-256-4018

Patient Information

Name: ______________________________ Social Security #: ____________

☐ If minor, accompanied by: ______________________ Relationship: ____________

Address: ____

City: ____________ State: ________ Zip: __________ Home Phone: ____________

Email: ______________________________ ☐ Please add to email recipient list.

Sex: ☐ M ☐ F Birthdate: __________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by: ______________________ Occupation: ____________

Business Address: ______________________ Business Phone: ____________

Name and phone number of your Primary Care Provider: ______________________

Emergency Contact: ______________________ Phone: ____________

How did you hear about us? ______________________________

Primary Insurance

Insurance Company: ______________________ Phone: ____________

Subscriber/Policy holder: ____________ ID#: __________ Birthdate: ________

Employed by: ______________________ Occupation: ____________

Secondary Insurance

Insurance Company: ______________________ Phone: ____________

Subscriber/Policy holder: ____________ ID#: __________ Birthdate: ________

***New Federal Guidelines require us to gather this information.**

*Race: ___ American Indian or Alaska Native ___ Asian ___ Black or African American

___ Native Hawaiian or other Pacific Islander ___ Caucasian

*Ethnicity: ___ Hispanic or Latino ___ Not Hispanic or Latino

*Preferred Language: ___ English ____ Other ____________ ___ Interpreter Required

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with ______________________(Insurance Company) and assign directly to ***Dr. Lyndon G. Johansen, D.P.M.*** 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 payment of benefits. I authorize use of this signature on all insurance submissions.

Responsible Party Signature: ______________________ Relationship: __________ Date: ________

Financial Policy

Lyndon Johansen DPM
503-256-4018
503-256-6298(fax)

12658 SE Stark St
Building H
Portland, OR 97233

This is an agreement between Dr Lyndon Johansen DPM, as creditor, and the Patient/Debtor named on this form.

In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Dr Lyndon Johansen DPM.

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance that is patient responsible, any re-billing charges to the account.

Re-billing Fee: A re-billing fee of $5 will be imposed on each account that is over thirty (30) days past-due.

Required payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

Payment options if you have no insurance:

1. You choose to pay by __cash or __credit card on the day that treatment is rendered.
2. On extensive treatment, you may prefer to secure a bank, credit union, or other third-party financing for the entire amount and make payments to the lending institution.

Payment options if you have insurance:

1. You choose to pay your deductible of $______ and any out-of-pocket portions at the time services are rendered by __cash, __check, or __credit card.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Medical Insurance Disclaimer: I, do hereby acknowledge an agreement to waive my rights of healthcare coverage under my benefits for ***non-covered services*** with Lyndon G. Johansen DPM. Furthermore, I understand and agree that with or without the proper authorization that some procedures rendered to me by the above physician may not be covered by my health care benefits plan. The doctor's office is not responsible for determining coverage for services. I agree that I am completely responsible for payment in full for these ***non-covered services***. I certify that I have read and do understand the contents of this disclaimer.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. **If you have a co-pay or deductible, you must pay that at the time of service.** It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

__________**Initial**

Returned checks: There is a fee (currently $25) for any checks returned by the bank.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Multnomah County, OR.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Workers Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patients Name: ______________________________

Responsible Party: ______________________________
(if not the patient)

Signature:______________________________ Date:______________

Co-Signature:______________________________ Date:______________

Lyndon G. Johansen, D.P.M., P.C.

Patient Consent for Use and Disclosure Of Protected Heath Information

I hereby consent for Lyndon G. Johansen DPM, PC and office staff to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

* Dr. Lyndon G. Johansen DPM, PC's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Lyndon G. Johansen and office staff reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Lyndon G. Johansen DPM, PC Privacy Officer at 12658 SE Stark St. Portland, OR 97233.

With this consent, Dr. Lyndon G. Johansen and office staff, PC may call my home or other alternative location to leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, laboratory results and prescriptions, among others.

I have the right to request that Dr. Lyndon G. Johansen and office staff, PC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Dr. Lyndon G. Johansen and office staff, PC's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon prior consent. If I do not sign this consent, or later revoke it, Dr. Lyndon G. Johansen and office staff, PC may decline to provide treatment to me.

______________________________ ________

Patient Signature **Date**

Lyndon G. Johansen D.P.M.

NAME: ______________________________ DOB: __________ DATE: __________

Please explain recent foot problem: ______________________________

____

Describe symptoms: Ache, Burning, Sharp, Other ______________________________

On a pain scale 1-10 (10 most severe) rank your pain: 1 2 3 4 5 6 7 8 9 10

Have you ever had, been treated or injured your feet/ankles? YES NO If yes: ______________

____

Please CIRCLE the level of activity that best describes you: Very Active Active Moderately Active Sedentary

Alcohol Use: Never. Quit. Social responsible drinker.

Have you ever been treated for or been addicted to alcohol or drugs? YES NO

Smoking: Never. Quit. Less than ½ pack/day. More than ½ pack/day. Smoked for _____ years.

Current Flu Vaccination? YES NO

Current Tetanus? YES NO

Surgeries in the past 10 years: ***Denies*** ______________________________

____

Medications currently taking: *(Prescription, vitamins or over the counter medication)* ***Denies*** __________

____

____

Preferred Pharmacy: ______________________ Address: ______________

Allergies: *CIRCLE* ***No Known Allergies*** **Tape Codeine Vicodin Penicillin Latex**

Local anesthetics (Novocaine or Lidocaine) Iodine Shellfish Sulfa

Please list other allergies to medications: ______________________________

Family history of foot problems: **Father:** YES NO If yes: ______________

Mother: YES NO If yes: ______________

Family history: *CIRCLE* **Mother:** Diabetes Cancer Heart Disease Other: ______________

Father: Diabetes Cancer Heart Disease Other: ______________

Approximate: Height ____ ft ____ in Weight _______lbs Shoe Size _______

Office Use Only: ***BP*** _______ ***P*** _______ ***R*** _______ ***T*** _______

Reviewed by: ______________________________ Date: ________

NAME: ____ DOB: __________ DATE: ___________

Please circle any of the following conditions/symptoms that you have been treated, diagnosed with or experienced. **If nothing applies, please circle *Denies*.** (If you have any questions, please ask the physician.)

Constitutional: ***Denies*** Chronic fatigue, History of migraine headaches, Recent chills, Recent fever, Recent headaches, Other _________

CV: ***Denies*** Claudication (Severe burning pain in legs and feet when walking), Chest pain, Cold feet, Chest tightness, Heart palpitations, Other _________

Endocrine: ***Denies*** Cold intolerance, Extreme thirst, Heat intolerance, Other __________

ENMT: ***Denies*** Dentures, Difficulty hearing, Difficulty swallowing, Ringing in the ears, Other __________

Eyes: ***Denies*** Cataracts, Double vision, Loss of vision, Diabetic retinopathy, Other ________

GI: ***Denies*** Chronic diarrhea, Recent blood in stool, Recent heartburn, Recent nausea, Recent stomach pain, Recent vomiting, Other _________

GU: ***Denies*** Dialysis, Erectile dysfunction, Frequent urination, Kidney stones, Recent burning with urination, Other _________

Immunologic: ***Denies*** Anemia, History of HIV or AIDs related concerns, Recent arthritic flare up, Seasonal allergies, Slow healing, Other __________

Integumentary: ***Denies*** Corns/Callouses, Dry skin, Foot Ulcers, Ingrown toenails, Itchy skin, Melanoma, Plantar warts, Psoriasis, Skin CA, Thick nails, Other _________

Lymphatic: ***Denies*** Bleeding Problems, Bruise easily, Edema legs/feet, Other _________

MSK: ***Denies*** Ankle pain, Foot pain, Hip pain, Knee pain, Low back pain, Sciatica, Toe pain, Other __________

Neurological: ***Denies*** Burning Feet, Numbness in feet, Seizures, Tingling feet, Tingling/Numbness in hands, Other _________

Psychiatric: ***Denies*** Bipolar, Depression, Panic attacks, Psychiatric problems, Other _________

Respitory: ***Denies*** Breathing difficulty, Shortness of Breath, Recent asthma attack, Other __________

PMH: ***Denies*** Acid reflux, Asthma, Blood Clots, History Cancer, Colitis (IBS, Crohn's, Ulcerative colitis), CHF (Congestive heart failure), COPD, Coronary artery disease, Diabetes, Fibromyalgia, Gastric ulcers, Gout, Heart disease, Heart murmur, Hepatitis, High cholesterol, HIV, Hypertension (high blood pressure), Kidney disease, Liver problems, MI (Heart attack), Sleep apnea, Stroke, Thyroid (high thyroid, low thyroid), Other: ______________________________________

Have you ever been treated or diagnosed with a medical condition that was not mentioned above? YES NO

If yes, please explain: ____

Patient Signature: ____ Date: ________

Reviewed by: ____ Date: ________