Bridge City Foot & Ankle
4770 SW Watson Ave
Beaverton, OR 97005
503-427-8967 | Dr.Stach@BCFAA.com

PATIENT NAME: _____ **DOB:** _____

Privacy/HIPPA:

I understand that my healthcare information is private and that my insurance carrier will require this information in order to process claims of payment of services rendered by this medical provider. I authorize the release of the pertinent medical information to my insurance carrier(s). I also authorize payments to be made directly to the medical provider by my insurance carrier(s).

I understand that under HIPPA, I have certain rights regarding my protected health information. I understand that in addition to using my healthcare information to obtain payment form third-party payers, my healthcare information will also be used to conduct, plan, and direct treatment along with multiple health care providers and to conduct normal healthcare operations.

Rx History: I consent to have the doctor reconcile or collect information regarding my prescription history.

Privacy: I have received a copy of the privacy practices that contain a complete description of the use and disclosures of my health information. I understand that Bridge City Foot & Ankle has the right to change its notice of privacy practices and that I may contact Bridge City Foot & Ankle at any time to obtain a current copy of their privacy practices.

Consent to Routine Procedures and Treatments

I hereby authorize treatment by Bridge City Foot & Ankle LLC dba Bridge City Foot & Ankle.

I consent to routine foot care which may include but not be limited to testing (X-rays, labs, etc), standard care (nail/callus care, wound care, etc), and evaluations (interviews, diabetic foot exams, etc). Bridge City Foot & Ankle will be routinely visiting the patient's facility upon request of the patient, family/POA, and/or the nurses and staff responsible for caring for the patient. These visits will take place every 7-12 weeks.

If at any time, you would like to discontinue routine care, or skip a routine care visit, please email dr.stach@bcfaa.com or fax this request to 971-223-0969.

Financial Policy

I agree that I am responsible to pay co-pay amounts, deductibles, private pay (non-insurance covered appointments), and services not covered by my insurance company.

I understand that verification of my insurance benefits DOES NOT guarantee payment, and that I will be responsible for any charges not covered under my plan.

I understand that it is my responsibility to know my insurance plan coverage, benefits, co-pays/co-insurance, and deductibles.

PATIENT SIGNATURE: _____ **DATE:** _____

RESPONSIBLE PARTY/POA SIGNATURE: _____ **DATE:** _____