CASCADE ORTHOPEDIC
SPECIALISTS
1813 W Harvard Ave, Ste 110 - Roseburg, OR 97471

Patient's Name _____ Male __ Female __
Last First MI

Date of Birth _____ SS# _____ – _____ – _____

Physical Address _____
Street City State Zip

Mailing Address _____
Box City State Zip

Home Phone (____)_____ Work (____)_____ Cell (____)_____

Email _____ Pharmacy: _____

By listing phone numbers above, you are authorizing the use of those numbers as a means to contact you. **Please indicate primary contact number: Home ___Work ___ Cell ___**

Marital Status: Single __ Married __ Partnership __ Divorced __ Widowed __ Separated __

Employer _____ Occupation _____

Driver's License Number _____ State _____

Emergency Contact _____ Phone _____

RESPONSIBLE PARTY/ GUARANTOR (to whom statements are sent)

Guarantor's relationship to patient: Self/Spouse/Parent/Step-parent/Legal Guardian/Other _____

Guarantor's Name _____ Date of Birth _____
Last First MI

Guarantor's Address _____
Box/Street City State Zip

Guarantor's Employer _____ (___)_____ _____
Name Phone Guarantor's SSN

Employee Initials: _____

ADDITIONAL DOCTORS YOU SEE:

Primary Care_____

Other_____

INSURANCE INFORMATION:

(ALL COPAYS ARE DUE AT THE TIME OF CHECK IN.)

Patient Name: _____ DOB: _____

PRIMARY INSURANCE

Insurance Name _____ Member/Policy ID # _____

Group# _____ Subscriber Name _____ DOB _____

Claims Address _____ Phone Number _____

Subscriber SSN: _____-_____-_____ Effective date _____

SECONDARY INSURANCE

Insurance Name _____ Member/Policy ID # _____

Group# _____ Subscriber Name _____ DOB _____

Claims Address _____ Phone Number _____

Subscriber SSN: _____-_____-_____ Effective date _____

TERTIARY INSURANCE

Insurance Name _____ Member/Policy ID # _____

Group# _____ Subscriber Name _____ DOB _____

Claims Address _____ Phone Number _____

Subscriber SSN: _____-_____-_____ Effective date _____

____ *SELF-PAY*

* (Requires a $100 deposit at the time of service.)

Consent to Treatment and Authorization
Cascade Orthopedic Specialties

The undersigned patient or authorized individual acting on behalf of the patient understands and agrees as follows:

Cary T. Sanders, M.D., Brandon Bishop DPM, Benjamin Baird PA-C as part of Cascade Orthopedic Specialists:

1. Reserve the right to designate any qualified physician to perform and administer care and treatment in his absence. This is to provide care on a continuous basis and especially in emergency situations. Dr. Sanders and Dr Bishop share the emergency, night, weekend and holiday call on a rotation basis with other qualified orthopedic surgeons and podiatrists.
2. Is granted permission to release to the insurance carrier and/or referring physician information in connection with treatment rendered to the patient on the patient's behalf in compliance with HIPAA guidelines. In work compensation cases the patient gives permission to release information to the workers compensation carrier in compliance with the industrial injury laws. If you do not desire this, please inform us in writing of your request. Your patient confidentiality is respected and vigorously protected. Our interest is in helping you obtain insurance benefits in a timely fashion.
3. The patient assigns all insurance benefits and authorizes direct payment to Cascade Orthopedic Specialists. I understand that I am financially responsible for all charges and that insurance is billed as a courtesy. It is understood in the event that the patient's insurance company does not make a payment or only a partial payment, the obligation remains. All co-pays and co-insurance are due at the time of service. Service is provided personally to the patient and not to the insurance company. Under no circumstances are services rendered on a contingency basis such as in accident claims or litigation.
4. I understand it is my responsibility to provide Cascade Orthopedic Specialists with accurate and current insurance information.

_____

Patients name

_____

Patient/Guardian Signature Date

PHONE: 541-391-8155 FAX: 541-391-8154
CARY SANDERS, M.D.
BRANDON BISHOP DPM
BENJAMIN BAIRD, PA-C

PROTECTED HEALTH INFORMATION DISCLOSURE AUTHORIZATION

Patient Name: _____ Patient Date of Birth: _____

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
  The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
  The practice may condition receipt of treatment upon execution of this consent
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May we phone, email or send a text to you to confirm appointments? Yes or No
May we leave a voicemail on your answering machine or cell phone? Yes or No
May we discuss your medical condition with any member of your family? Yes or No

Please complete the contact information below.

Contact Name	**Relationship**	**Phone**
Example name	*Spouse*	*541 999 9999*
_____	_____	(____) _____ -_____
_____	_____	(____) _____ -_____
_____	_____	(____) _____ -_____
_____	_____	(____) _____ -_____
_____	_____	(____) _____ -_____

Signature_____ Date _____

If you are signing as the patient's guardian or legal power of attorney (documentation required):

Print Name _____ Describe Authority _____

CASCADE ORTHOPEDIC
SPECIALISTS
1813 W Harvard Ave, Suite 110
Roseburg, OR 97471
Phone: (541) 391-8155
Fax: (541) 391-8154

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Please read all information and instructions before completing and signing the authorization form.

Patient's Name _____ Birth Date _____
(PLEASE PRINT) LAST FIRST MI

Reason for release (i.e. transferring care): _____ Previous Last Name: _____

INFORMATION TO BE RELEASED BY:	INFORMATION TO BE RELEASED TO:
☐Cascade Orthopedic Specialists	☐Cascade Orthopedic Specialists
Organization/Person	Organization/person
Street Address	Street Address
City State Zip	City State Zip
Phone Fax	Phone Fax

TYPE OF MEDICAL INFORMATION REQUESTED:

___ LAST FULL YEAR OF CHART NOTES FROM DATE OF LAST SERVICE
___ LAST FULL YEAR OF LABS/PATHOLOGY FROM DATE OF LAST SERVICE
___ LAST FULL 2 YEARS OF IMAGING REPORTS FROM DATE OF LAST SERVICE
___ MOST RECENT REPORTS: __ EKG __ MAMMOGRAM __COLONOSCOPY __ PAP SMEAR __ DEXA/BONE DENSITY
___ MY HEALTH INFORMATION RELATING ONLY TO THE FOLLOWING TREATMENT OR CONDITION: _____
___ MY HEALTH INFORMATION ONLY FOR THE FOLLOWING DATE(S): _____
___ OTHER: _____

INITIAL ONLY!!! PROTECTED OR SENSITIVE INFORMATION: I understand that certain information cannot be released without specific authorization as required by Federal/State Law. BY INITIALING I authorize the release of the following protected or sensitive information:

_____HIV/AID related records
_____Mental Health Information
_____ Drug/Alcohol diagnosis, treatment or referral information
_____ Genetic Testing Information

- MINORS AGE 13-17: A minor patient's signature is required in order to release the following information: (1) conditions relating to the minor's reproductive care including, but not limited to : contraception, pregnancy, and pregnancy termination, sterilization, and sexually transmitted diseases (age 14 and older), (2) alcohol and/or drug abuse (age 13 and older), and (3) mental health conditions (age 13 and older)-
- I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected under Federal law.
- I also understand that the information used or disclosed pursuant to this authorization may be subject to disclosure of HIV/AIDS information, mental health information, generic testing information and drug/alcohol diagnosis, treatment or referral information.
- You may revoke this authorization IN WRITING at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization was obtained as a condition of obtaining insurance coverage.

To revoke this authorization, please send or deliver a written statement to:
Cascade Orthopedic Specialists.
1813 W Harvard Ave, Suite 110
Roseburg, OR 97471

I have read this authorization and I understand it. Unless specified, this authorization will expire one year from date signed.

(Specified Expiration Date)

_____ _____ _____
(Signature of Individual or Personal Representative) (Date Signed) (Description of Personal Representative's Authority)