Patient Registration and Health History

Welcome to Colorado Foot and Ankle. We are pleased that you have chosen us as your foot and ankle provider.

I. Patient Information

Date _____

Patient_____ Sex: M or F

Address_____

City_____ State_____ Zip_____

Prim Phone_____ Sec Phone _____ Third Phone _____

Birthday_____ Age_____ Patient SS#_____

E-mail Address_____

By providing my cell number and/or email address, I am consenting to electronic marketing communications from CFA.

Whom may we thank for referring you? _____

II. Emergency Contact

Name_____ Relationship_____

Home Phone_____ Cell Phone_____

III. Insurance & Billing

Who is responsible for this account? (Self, Parent, or POA's name) _____

Relationship to Patient_____

Primary Insurance Company _____

ID #_____ Group #_____

Subscriber: Name_____ Birthdate_____ SS# _____

Secondary Insurance Company_____

ID #_____ Group #_____

Subscriber: Name_____ Birthdate_____ SS# _____

IV. Basic Health Information

Primary Care Provider_____ Date Last Seen_____

Preferred Pharmacy Name and Location_____

*Preferred Language_____

Height_____ Weight_____ Shoe Size_____ Men's/Women's/Children's (Circle one)

*Please Select Your Race: American Indian / Alaskan Native / Asian / African American / Caucasian / Pacific Islander / Other / Declined

*Please Select Your Ethnicity: Hispanic / Non-Hispanic / Declined

***Requirement of our Government's Health Information Technology for Economic and Clinical Health Act (HITECH)**

V. Podiatric History **(Are you currently or have you been treated in the past for any of the following conditions? Please circle)**

Ankle pain	Athletes foot	Bunions	Corns and Calluses	Cramps or numbness
Flat feet	Foot or leg cramps	Heel pain	Ingrown Toenails	Plantar warts

What is the reason for your visit today? _____

_____

Have you been to a Podiatrist before? If yes, whom? _____ Last Visit _____

VI. Medical History **(Are you currently or have you been treated in the past for any of the following conditions? Please Circle)**

Alcohol chemical dependency	COPD	Heart disease	Liver disease
Anemia	Depression	Heart Murmur	Menopause
Arthritis (type):_____	Diabetes-Type I or Type II	Hepatitis (type):_____	Migraines
Asthma	Emphysema/Bronchitis	High Cholesterol	Osteoporosis
Bipolar disorder	Epilepsy/Seizure Disorder	HIV Status: + - unknown	Prostate problems
Bleeding disorders	Fibromyalgia	HTN/High blood pressure	Rheumatic fever
Blood clots/DVT/PE	GERD/Reflux	Hyperthyroidism	Sleep apnea/difficulties
Cancer (type):_____	Glaucoma	Hypothyroidism	Stroke/TIA
Cardiac arrhythmia	Gout	Hypotension	Stomach ulcers
Crohn's/Ulcerative Colitis	Heart attack- MI	Kidney disease	Tuberculosis

Others:_____

VII. Surgeries & Hospitalizations **(List all procedures, locations, and any complications.)**

_____

_____

_____

VIII. Medications **(List all prescriptions or over-the-counter meds that you currently take, including dosage and frequency.)**

_____

_____

_____

IX. Allergies **(List the medication and the reaction that if has caused.)**

_____

_____

X. Social History

Marital Status: ___Single ____Married ___Widowed ___Divorced

Employed? ____yes ____no Type of work? _____

Smoking Status: ___never ____current smoker ____former smoker ____social smoker

Smoking amount: ½ pack/day 1 pack/day 2 pack/day 3 pack/day 4 or more pack/day How long? _____

Tobacco Exposure at your home? ____yes ____no If yes, smoker in home smokes: ____inside ____outside

Do you drink alcohol? ____yes ____no ____Rare ____Occasional ____Social ____Daily ____Former ____Recovering Alcoholic

Drinking Amount: None 1-2/day 3-4/day 5-6/day 7+/day 0-2/Week 3-4/Week 5-6/Week 7+/Week

Do you use recreational drugs? ____yes ____no If yes, how often? _____

Do you exercise routinely? ____yes ____no If yes, what activities? _____

XI. Family History **(Do you have any Blood-Relatives being treated for the following medical condition(s)? If so, who and for what?)**

If you list a grandparent, please indicate if they are on your mother's or father's side (Maternal/Paternal)

Anemia ____yes ____no Who? _____

Arthritis ____yes ____no Who? _____

Asthma ____yes ____no Who? _____

Cancer ____yes ____no Who? _____

Diabetes ____yes ____no Who? _____

Heart Disease ____yes ____no Who? _____

High Cholesterol ____yes ____no Who? _____

Hypertension ____yes ____no Who? _____

Kidney Disease ____yes ____no Who? _____

Neurologic ____yes ____no Who? _____

Stroke/TIA ____yes ____no Who? _____

Thyroid Disease ____yes ____no Who? _____

Vascular Disease ____yes ____no Who? _____

XII. Review of Systems (Please circle any of the following symptoms that you are currently experiencing.)

Nausea	Vomiting	Fevers	Chills	Night Sweats
Dizziness	Light headiness	Headaches	Hearing loss	Ringing in ears
Blurred vision	Dry eyes	Itchy eyes	Sinus congestion	Sneezing
Cough	Dry mouth	Sore throat	Difficulty swallowing	Shortness of breath
Wheezing	Chest pain	Heart Palpitations	Heartburn	Constipation
Diarrhea	Bloody Stool	Abdominal Pain	Incontinence	Frequent urination
Leg swelling	Calf or leg cramps	Foot cramps	Muscle pain	Back pain
Weakness	Abnormal sensation	Numbness	Tingling	Burning
Tremors	Memory loss	Speech difficulties	Confusion	Disorientation
Skin ulcers	Rashes	Skin sores	Warts	Calluses
Dry skin	Changes in toenails	Varicose veins	Hair loss	Excessive sweating
Increased thirst	Increased hunger	Weight gain	Weight loss	Heat intolerance
Cold intolerance	Depression	Irritability	Mood swings	Sleep problems
Bruises easily	Bleeding issues	Swollen lymph nodes	Recurring infections	Chronic fatigue

Joint pain/swelling/stiffness (list locations)_____ Chronic pain affecting work or home life

XIII. Consent to Treat

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations.

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been given an opportunity to review the office's *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Colorado Prescription Drug Monitoring Program

IF YOU RECEIVE A PRESCRIPTION FOR "CONTROLLED" (SCHEDULE II THROUGH V) DRUG, YOUR IDENTIFYING PRESCRIPTION INFORMATION WILL BE ENTERED INTO COLORADO'S ELECTRONIC PRESCRIPTION DRUG MONITORING DATABASE (PDMP) WHEN THIS DRUG IS DISPENSED TO YOU. YOUR PRESCRIPTION INFORMATION IN THE DATABASE IS A PROTECTED HEALTH RECORD AND CANNOT BE ACCESSED BY NON-CAREGIVERS EXCEPT AS PART OF AN AUTHORIZED INVESTIGATION

YOU HAVE A RIGHT TO ACCESS YOUR INFORMATION IN THE PDMP THROUGH THE COLORADO BOARD OF PHARMACY. YOU MAY SEEK CORRECTIONS TO THE INFORMATION AS YOU WOULD YOUR OTHER MEDICAL RECORDS

_____ _____/ _____/ _____

Patient/Parent or Guardian Signature **Date**

Designation for Release of Medical Information to a Family Member, Friend or Legal Representative

Introduction

It is the physicians' responsibility to ensure that the physician-patient relationship is confidential. The Health Portability and Accountability Act (HIPAA) allows physicians to use their professional judgement on disclosing certain personal health information to family, friends, etc. without an authorization. This form is an aid to the physicians in making a determination on disclosing such information. Colorado Foot and Ankle realizes that there are times when you, the patient, may want another person to be knowledgeable about your medical condition or medical needs. Your doctor wants you to be able, if you so desire, to name a person to whom you want the office staff to speak with about your medical condition. To enable that, we would ask that you **please select one option below**. Please note the following points:

- **Only one person can be designated for this role.**
- **The designation is valid until you cancel it in writing.**
- **If you designate no one, Colorado Foot and Ankle will not release information to any family member, friend, or legal representative.**

Designation Statement

I, (patient or responsible party) _____, designate the following person to be able to speak to a physician at Colorado Foot and Ankle, or other staff member, should it be necessary, on my behalf. I hereby give permission to Colorado Foot and Ankle through its physicians and staff to release to my designee any information about my medical condition or medical needs or the status of my account and I release Colorado Foot and Ankle its physicians and staff, from any claim of confidentiality in connections with the release of this information.

***OPTION 1: Name of Designated Person: _____**

Relationship: _____ Best Phone Number: _____

Patient's Name (if different than shown above): _____

Patient or Responsible Party Signature: _____ Date: _____

***OPTION 2:** ☐ **I decline to designate another person to speak with my physician or clinical staff.**

Patient's Name (if different than shown above): _____

Patient or Responsible Party Signature: _____ Date: _____

Office Staff Witness: _____

If you have health insurance coverage: As a courtesy to our patients, we will submit your insurance claim(s), however, **we must emphasize that as medical providers, our relationship is with you and not your insurance company.** Although we attempt to verify benefits with your insurance policy, please be advised any quote of benefits provided by your insurance company is considered a general overview, and only a guideline until final coverage determinations are made and payment is received. **If the claim is denied as a non-covered service by your insurance carrier and/or the charges are not paid (or only partially paid) by your insurance carrier, you will be financially responsible for the balance.**

This office makes **NO** guarantee of benefits.

- It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified prior to your appointment.
- Not all services provided in our office are a covered benefit under all insurance plans.
- If your insurance policy requires a referral of any type, it is your responsibility to have that referral sent to our office prior to your appointment. Without an appropriate referral you are solely responsible for payment.
- It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under your insurance policy. You are responsible for any non-covered or denied service(s) by your insurance policy.
- Most insurance companies require preauthorization before you have a surgical procedure. Failure to obtain preauthorization may result in refusal of payment by insurance and becomes your responsibility.
- We do not enter into disputes over insurance benefits. We bill insurance in accordance with all federal, state and other contractual requirements in cases where we have an agreement, or we are a participating provider.
- Our office does participate with some insurance plans, and out of network and benefits may be different from in network benefits.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, please do not hesitate to ask us. **We are here to help you.**

I have read and understand the above Patient Payment Policy and agree to meet all financial obligations as outlined regardless of my insurance status. I acknowledge that these policies do not obligate Colorado Foot and Ankle to extend credit.

_____ _____

Patient Name (Please print) Patient or Responsible Party Signature

_____

Date

Patient Payment Policy

Dear Patient:

The doctors and staff at Colorado Foot and Ankle would like to welcome you to our practice. Below are the financial responsibilities of our patients.

Payments: We accept cash, check, Visa, Mastercard, American Express, or Discover. A credit card will be requested and placed on file. All insurance co-payments, co-insurance, and deductibles will be collected at the time of service prior to treatment. If you do not have your payment(s), your appointment may be rescheduled, and a cancellation fee charged.

No Insurance: All services will be billed according to the current self-pay charge sheet and all transactions will be completed prior to leaving the office. (Note: there may be additional charges to your office visit if x-rays or procedures are required.)

Outstanding Balances: We may refuse to see patients with balances over $250 who have not made prior arrangements with our billing department. Any and all balances, regardless of insurance coverage, are **due within 60 days** of the date of service, unless prior arrangements are made. Any unpaid balances older than 60 days may be subject to account maintenance and finance charges of $35 per month. Returned checks will result in a $30 service charge and payment of all fees incurred resulting from the returned check. Disputes resulting from unpaid balances are agreed to be settled by mediation at your expense and request. If the account is referred to a collection agency, you the patient (or guarantor of the patient) shall pay an additional collection fee of at least 50% of the principal balance plus reasonable attorneys' fees and all court costs of the other party incident to any action brought to enforce this agreement.

Refunds: Refunds due to overpayment will be issued within 4-6 weeks from the date requested. Refunds will be held until all outstanding insurance claims or balances are paid in full. Any refund amount under $25 will not be refunded due to the overhead cost involved. All products and orthotics purchased from our office are medical grade, Non-refundable, and are not returnable.

Cancellations: Please notify us at least 24 hours in advance if you need to cancel or change your regular appointment (5 business days for surgery). There will be a $75 charge for regular appointments and a $250 charge for surgical appointments in the event that you do not show up at your scheduled appointment time, cancel or change your appointment without 24 hours' notice (5 business days for surgery). If you cancel or reschedule two appointments back-to-back, you will need to pre-pay a $250 "guarantee fee" in order to schedule again. After insurance pays (if applicable), this amount will be applied towards any balance due, and you will be refunded anything that isn't due based on the services you have received. Proper notification allows the doctor to care for another patient during that time.

Late Arrivals: Patients who are late for their scheduled appointments may have to be rescheduled to another date. Because we were unable to utilize your appointment slot for another patient, if your appointment needs to be rescheduled due to a late arrival, you will be responsible for the late cancellation fee stated above.

Forms/Letters/Medical Records: There is a $30 charge for the completion of paperwork (ex: disability, FMLA, work releases etc.). We charge a $25 copy fee for medical records requested for personal use and $25 copy fee for x-rays. Letters completed on your behalf will be charged at a rate consistent with the doctor's time spent creating the letter. Please allow up to 5 business days for the completion of your disability, FMLA, or work release paperwork.

Workers' compensation: If your claim is denied you will be responsible for payment in full. Outstanding balances follow the same rules and timeframes as above. Out of State claims will be handled only if first approved by the physician rendering treatment.

Auto Accidents/Personal Injury: Payment is due in full at the time of service.