PATIENT INFORMATION SHEET

NAME _____ BIRTHDAY_____

PREFERRED NAME_____

ADDRESS_____ CITY_____

STATE_____ ZIP CODE_____ PHONE (_____)_____

MAILING ADDRESS_____CITY_____STATE_____

WORK PHONE (_____)_____ PATIENT'S SOCIAL SECURITY# _____

EMAIL ADDRESS _____

SEX: MALE_____ FEMALE_____

MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED SEPARATED

RACE: ASIAN WHITE AMERICAN INDIAN/ALASKA NATIVE BLACK/AFRICAN AMERICAN

NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

ETHNICITY: HISPANIC OR LATINO NOT HISPANIC OR LATINO

PREFERRED LANGUAGE: ENGLISH SPANISH OTHER_____

PATIENT'S EMPLOYER_____ OCCUPATION_____

In emergency, we should notify?_____

Relationship_____ Phone (_____)_____

RESPONSIBLE PARTY _____ RELATIONSHIP_____

ADDRESS_____CITY_____STATE_____

SOCIAL SECURITY#_____DATE OF BIRTH_____

HOW DID YOU FIND OUT ABOUT OUR OFFICE_____

DOCTOR REFERRAL (NAME)_____

PRIMARY CARE PHYSICIAN NAME _____

PRIMARY CARE PHYSICIAN ADDRESS _____

PRIMARY CARE PHONE NUMBER _____

When was the last time you saw your Primary Care Physician? _____

PHARMACY NAME _____ PHONE # (_____)_____

PHARMACY ADDRESS/LOCATION _____

WORKER'S COMPENASATION CLAIMS: DATE OF ACCIDENT_____

EMPLOYER_____PHONE_____CLAIM#_____

NAME AND ADDRESS OF INSURANCE CARRIER_____

PHONE#_____

I certify that the above information is accurate and complete. I understand that I am personally responsible for payment of all fees incurred by me in this office. I authorize Foot and Ankle Center of the Rockies, LLC, to release information as necessary for the treatment of my condition or processing my account.

I realize that photographs may be taken as a part of my treatment plan, and become part of my medical record.

By signing this form I am consenting to treatment by the doctors in this office and agree to the terms indicated above.

SIGNED _____ DATE_____

NOTICE AND ACKNOWLEDGEMENT OF PRIVACY POLICIES AND PROCEDURES

Patient Name _____ Date of Birth _____

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), The Foot and Ankle Center of the Rockies, LLC(Practice) may not use or disclose your personal health information without your authorization.

The Practice has policies and procedures to comply with HIPAA law. Every attempt has been made to keep the process for patients and staff as efficient as possible. However, the requirements are extensive and take time, effort and cooperation to process required tasks.

All patients are presented with certain notices and must sign certain forms. Depending on the course of treatment, some patients may be required to sign additional forms. The following is a summary of the most common notices and forms.

Notices of Privacy Practices – This notice describes how medical information about you may be used and disclosed and how you get access to this information.

Authorization for Use or Disclosure of Protected Health Information – The Practice may not use or disclose your health information for purposes other than health treatment, payment or health care operations, without your authorizations. Your signature on this form indicates that you are giving permission to the Practice for the use and disclosure of the health information listed on the form, for the purpose(s) listed on the form, to the people/organization(s) listed on the form. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning to this office.

Complaint – You have the right to make a complaint about the Practice's privacy policies, procedures or actions. The Practice will not engage in any discriminatory or other retaliatory behavior against you because of a complaint.

Request to Amend Protected Health Information – You have the right to request that health information that requires to be amended if you believe that it is incorrect or incomplete. The Practice will review your request and either grant your request or explain the reason why it will not be granted. In the event that your request is not granted, you have the right to submit a statement or disagreement that will accompany the information in the question for all future disclosures.

Request for Inspection of Protected Health Information – You have a right to request the opportunity to inspect and copy health information that pertains to you. The Practice will evaluate your request and will either grant it or explain the reason why the request will not be granted. In the event that your inspection request is not granted, you may request that someone other than the person who originally denied the request review the decision. If you request copies of your medical record, the Practice

reserves the right to charge you a reasonable fee for the expenses associated with copying the requested information.

Request for Accounting of Disclosures of Protected Health Information – You have a right to request an accounting of all non-routine disclosures of health information that pertains to you. Disclosures of health information associated with treatment, payment and healthcare operations or with prior patient authorization will not be accounted for.

Confidential Channel Communication Request – You have a right to request the communications concerning your personal health information be made through confidential channels. The Practice will do its best to accommodate all reasonable requests.

Designation of Personal Representative – You have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you by making this request, you are informing the Practice of your wish to designate the named person(s) as your personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form and returning it to this office.

Acknowledgement of Receipt of Notice of Privacy Practices:

I acknowledge that I have received and read the above Notice of Privacy Policy and Procedures and have had any questions regarding this notice answered to my satisfaction.

_____ _____

Patient/Patient Representative Signature Date

_____ _____

Print Name Practice Representative & Title

Contact Information:

It is permissible to contact me at (please list phone number(s) or the appropriate line):

Home (____) _____ Work (____)_____ Mobile (____)_____

It is permissible to leave voice messages at: _____Home _____Work _____Mobile

It is permissible to leave voice messages with other people who may answer at: __Home __Work

UNDERSTANDING OUR INSURANCE & FINANCIAL POLICIES

First, and most important, we are pleased you have chosen us to care for your foot problems. Our goal is to provide the best podiatric care possible. The status of medical insurance in our country is changing rapidly with many new forms of coverage appearing yearly. Many patients change insurance policies and/or companies just as frequently. For these reasons and to prevent misunderstandings, it is important to be "up front" with each other as to what our mutual responsibilities are.

If we are contracted with your insurance company, we will honor all of our provisions of that contract. To do this, however, we need your help. If you have changed companies and policies, we must be advised prior to the date we provide service, and given current insurance identification cards and address for insurance submission. Otherwise, insurance benefits may be denied or delayed by your insurance company, and you immediately become thereby, financially responsible for the provided services.

We will make every effort to help you determine your insurance coverage and benefits by contacting your insurance company whenever possible. However, in many instances, insurance will not advise or guarantee coverage or the amount of reimbursement for a certain condition or treatment.

We will process your claim based on the information provided to us by you and your insurance company. You need to be familiar with your policy coverage, benefits, and eligibility. Deductible amounts, co-payments and fees for non-covered services as determined by your insurance company are the financial responsibility of the patient, as well as, unpaid claims due to lapse or termination of coverage or delayed payments if incorrect information is provided or insurance company does not process the claims in a timely fashion.

Ultimately, the patient is financially responsible for the professional services provided by our Physicians. In the event the account becomes delinquent, (over 120 days) the patient account will be turned over to a collection agency for further debt recovery.

Any collection fees, court cost, reasonable attorney fees, or returned check fees are the responsibility of the adult person(s) named on the account. Monthly service fee 1.5% per month or 18% per annum will be assessed on all past due accounts. In the event our office is not contacted within 30 days of you receiving our last billing statement your account will be turned over to our collection agency.

We request that you give our office 24-hour notice in the event that you may need to cancel or reschedule your appointment. Failure to do so may result in a cancelation fee of $20. Your compliance with this will allow us to fill that spot with patients on our waiting list.

I have read and understand the above insurance policy.

Patient Signature_____Date_____

PATIENT SELF-HISTORY FORM

PATIENT'S NAME_____ DATE _____

DATE OF BIRTH _____

ALLERGIES – TYPE OF REACTION:

CURRENT MEDICATIONS: (NAME, DOSAGE, STARTED) or REVIEW LIST PROVIDED:

CHIEF COMPLAINT (Why are you here?):

DURATION (How long has the problem been present?):

HAVE YOU BEEN TREATED BEFORE FOR THIS PROBLEM? ☐ YES ☐ NO

When?	Where?	What was done?
_____	_____	_____

SURGICAL HISTORY (what operations, when, where?):

Operation?	When?	Where?

DO YOU SMOKE? ☐ YES ☐ NO HOW LONG_____ HOW MUCH_____

DO YOU DRINK? ☐ YES ☐ NO HOW LONG_____ HOW OFTEN _____

HAVE YOU BEEN TREATED FOR DRUG ABUSE? ☐ YES ☐ NO
(If yes, when, and what type of treatment did you receive?)

DATE OF LAST COMPLETE PHYSICAL EXAM? _____

HAVE YOU HAD ANY BLOOD TESTS WITHIN THE LAST 30 DAYS? ☐ YES ☐ NO

DO YOU HAVE A VISITING NURSE? ☐ YES ☐ NO
COMPANY NAME OF VISITING NURSE: _____

HEIGHT _____ WEIGHT _____ SHOE SIZE _____

MEDICAL/FAMILY HISTORY

	Self	Mother	Father		Self	Mother	Father
Diabetes	□	□	□	Gout	□	□	□
If yes, how long	_____			Poor Circulation	□	□	□
Last Blood Sugar	_____			Skin Ulcers	□	□	□
High Blood Pressure	□	□	□	Venous Insufficiency	□	□	□
Heart Disease	□	□	□	Varicose Veins	□	□	□
Stroke	□	□	□	Rheumatoid Arthritis	□	□	□
Cancer	□	□	□	Osteoarthritis	□	□	□
Kidney Disease	□	□	□	Loss of Skin Sensation	□	□	□
Liver Disease	□	□	□	Hepatitis	□	□	□
Lung Disease	□	□	□	HIV/AIDS	□	□	□
Seizure Disorder	□	□	□	Asthma	□	□	□
Stomach Ulcers	□	□	□				

If you have experienced any of these in the last year, please check all that apply:

General
□ Change in weight
□ Fever/Chills
□ Lack of energy

Cardiovascular
□ Chest pain
□ Shortness of Breath
□ Swelling
□ Irregular heartbeat

Endocrine
□ Excessive thirst
□ Fatigue
□ Unexplained weight loss

Ophthalmologic
□ Dry Eyes
□ Loss of Vision
□ Wears Glasses

ENT
□ Ringing in ears
□ Loss of Hearing
□ Difficulty swallowing

Gastrointestinal
□ Nausea/Vomiting
□ Diarrhea

Integumentary
□ Sores
□ Poor Healing
□ Itching/Rash

Lymphatic
□ Enlarged Glands
□ Lymphedema
□ Inability to stop bleeding

Musculoskeletal
□ Back Pain
□ Joint Pain
□ Muscle Pain

Neurologic
□ Seizures
□ Tingling
□ Numbness

Psychiatric
□ Anxiety
□ Depression
□ Paranoia

Respiratory
□ Shortness of Breath
□ Excessive coughing
□ Asthma

Consent to Allow Access to your Pharmacy and Medication History

The providers at Foot and Ankle Center of the Rockies, LLC use an electronic medical record system that allows electronic prescribing of medications. To optimize the use of this electronic capability, and coordinate your care between us, your family practice physician, and other specialists, we ask that patients allow us to access their external medication history through the Rx hub.

Please check only one of the following:

_____ I consent to allow Foot and Ankle Center of the Rockies, LLC to access all of my medication history through the Rx hub.

_____ I **DO NOT** consent that Foot and Ankle Center of the Rockies, LLC may access my medication history through the Rx hub.

Signature: _____

Printed Name:_____

FOOT AND ANKLE CENTER
OF THE ROCKIES

COVID-19 INFORMED CONSENT/QUESTIONNAIRE

***Patient First & Last Name: _____**

With community transmission of communicable diseases, you could be exposed anywhere to infectious diseases including, but not limited to Covid-19 (also called Coronavirus). Our office is following the State and Federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of communicable diseases. However, it is possible that these precautions will not always be successful in blocking the transmission of these diseases. Social distancing nationwide has reduced the transmission of COVID-19, however it is not possible to provide treatment with social distancing between the patient, staff and sometimes, other patients.

By presenting yourself for treatment, you assume and accept the risk that you may inadvertently be exposed to a communicable disease. If you have been exposed to a communicable disease prior to your podiatry appointment, you may spread the disease to the staff and to other patients in the practice. Therefore, prior to each appointment, we require you to confirm the following:

_____ I confirm that I do not have any of the following symptoms of COVID-19: fever, shortness of breath, dry cough, runny nose, sore throat currently, or for the last 14 days.

_____I confirm that I have not tested positive/been diagnosed with COVID-19 or been in contact with anyone who has within the last 14 days.

_____ I agree that, if I were to exhibit any symptoms of, or am diagnosed with, COVID-19, I will immediately contact my doctor so that proper steps can be taken to limit the spread of this contagion.

Do you acknowledge and accept the risk of exposure in our office to a communicable disease, included but not limited to Covid-19, and consent to treatment? **Yes** **No**

***Date:** _____

***Patient/Guardian Signature:** _____