South Denver Podiatry, PLLC

Patient Registration

Patient Last Name:_____Patient First Name:_____

Address:_____City:_____State:_____Zip:_____

Cell Phone:_____Home Phone:_____

Social Security Number:_____Date of Birth:_____

**Email**:_____Sex:_____Race:_____Marital Status:_____

Employer Name:_____Phone:_____

Preferred Pharmacy/ location:_____Phone:_____

**Primary Insurance Information:**

Insurance Name:_____Policy Number:_____

Phone:_____Name of Insured/ relationship:_____

Billing Address if Different from Home Address:_____

**Secondary Insurance Information:**

Insurance Name:_____Policy Number:_____

Phone:_____Name of Insured/ relationship:_____

**Referring Physician Name:**_____Phone:_____

**Primary Care:**_____Phone:_____

**Emergency Contact/ relationship:**_____Phone:_____

**If you chose not to provide SS# please be aware that your claim may be denied. If it is subsequently denied you may be held financially responsible for your charges. I acknowledge and agree to the statement above.**

**Patient release: I hereby consent to the release of information to my primary care provider, referring physician, physical therapist, attorney, insurance carriers, occupational medicine providers or any other party with a personal interest. Information may be transmitted by verbal, written, fax or email communication. Patient assignment: I hereby assign medical benefits otherwise payable to me to South Denver Podiatry, PLLC. I understand and agree that I am financially responsible for any unpaid balance for services rendered along with legal fees incurred in collecting payment from me. If applicable, I understand that I am responsible for all copays, deductibles, coinsurance and balances. Verification: I hereby verify that all of the information is true and correct as of the date signed below.**

Patient /Guardian Signature:_____Date:_____

# Patient Medical History Form

Patient Name: _____ Date of Birth:_____

Age:_____Height:_____Weight:_____

How did you hear about us:_____

Primary Care Physician:_____ Physician Contact:_____

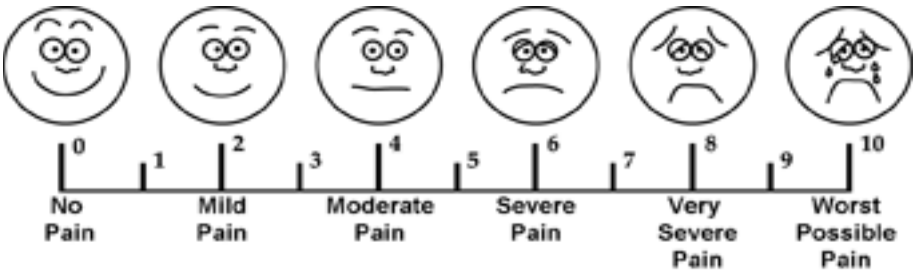
Reason for today's visit:_____

Location of Pain:_____Date of Onset:_____

Was this related to an accident? ____Y ____N ____Workers Comp ____Auto

Have any images been taken of your foot/ ankle (X-ray/MRI/CT)?_____

Pain Level (Please circle a number 0-10):




Pain Quality: ____Sharp ____Dull ____Burning ____Radiating ____Constant

Have you had any prior treatments for this problem? ____No.
If yes please explain: _____

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Social History:

Do you drink alcohol? ____Y ____N How many drinks per day? _____

Tobacco Use: ____Y ____N Packs per day:___Years Smoked:___Year Quit:_____

Are you currently pregnant?____Y ____N Due Date:_____

What is your occupation?_____

Do you participate in any sports/ activities?_____

_____

Are you married?____Y ____N Who do you live with?_____

Please indicate if you have any of the following:

| | | | |
|---|---|---|---|
| | Arthritis | | Rheumatoid Arthritis |
| | Anxiety | | Stomach Ulcers |
| | Asthma | | Varicose Veins |
| | Alcoholism | | Kidney Disease |
| | Anesthesia Problems | | Blood thinner |
| | Birth Defects | | Leg Cramps |
| | Bleeding Disorder | | Lung Disease |
| | Blood clots | | Liver Problems |
| | Cancer | | Lupus |
| | Chronic Back Pain | | Murmur |
| | Congestive Heart Failure | | Neurological Disorder |
| | Poor Circulation | | Numbness/ Tingling |
| | Severe Allergies | | Osteopenia / osteoporosis |
| | Thyroid Problems | | Colitis |
| | Diabetes | | Phlebitis |
| | Depression | | Seizures |
| | Foot Ulcer | | Stroke |
| | Artificial joints | | Irregular Heartbeat |
| | Heart Attack | | Heart disease |
| | Hepatitis | | Leg swelling |
| | High Blood Pressure | | Sleep apnea |
| | HIV | | Use of oxygen at home |
| | Pulmonary Embolism | | Pregnancy |

Please list any previous surgeries and dates (month/year):

_____

_____

_____

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Please list any Allergies:_____

_____

____None ____Metals ____Latex ____Adhesive tape

Current Medications: Please list any prescription and / or over the counter medications including **dosage and frequency**:

| Medication Name | Dosage/frequency |
| --- | --- |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

South Denver Podiatry, PLLC

**Consent to Disclose Personal Information**

In order to help us communicate with you better please use this form to tell us when you would like us to leave a message or discuss your health with you and others, and how we should contact you with non-urgent news, such as lab results or appointment reminders.

Who is it okay to discuss my health with:

_____No one

_____Any of the people listed below

_____/_____/_____

_____/_____/_____

_____/_____/_____

Name Relationship Phone

Can we leave basic information such as appointment reminders by:

_____Text

_____Email

This consent will remain in effect until revoked by patient, or in the case of a minor on the date the minor becomes an adult under state law. Please advise us of any changes to your preferences.

Signature:_____Date:_____

**ACKNOWLEDGMENT OF RECEIPT**
**OF**
**NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____
Patient Name (please print) Date

_____
Parent or Authorized Representative (if applicable)

_____
Signature

South Denver Podiatry, PLLC

# Payment Policy

Thank you for choosing us for your foot and ankle needs. We are committed to providing you with quality and affordable health care. Our payment policy was created in an effort to address any questions you may have regarding patient and insurance responsibility for services rendered. Please read thoroughly and ask any questions which you may have prior to signing below. A copy may be provided upon request.

- **Insurance:** Your insurance coverage is a contract between you and your insurance company to help you meet medical expenses. It is not possible for us to provide services on the basis that your insurance will pay all the charges because coverages very so greatly. Please feel free to discuss charges with us at any time.

  We participate with most insurance plans, including Medicare. If you are not insured by a plan we do business with then payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card then payment in full for each visit is required until we can verify your coverage.

- **Referrals:** If your insurance requires a referral from your primary care provider it is your responsibility to obtain the referral prior to your appointment.

- **Copayments and deductibles:** All copayments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure to do so on our part can be considered fraud. Please help us in upholding the law by paying your copayment at each visit.

- **No insurance:** If you have no insurance a cash discount may be offered. Complete payment is due upon services rendered.

- **Noncovered services:** Please be aware that some and perhaps all of the services you receive may be non covered or not considered medically necessary by Medicare or other insurers. You must pay for these services in full at the time of the office visit. We will do our best to try to let you know prior to if we know the service offered will not be covered.

- **Proof of insurance:** All patients must complete our patient information form before seeing the provider. We must obtain a copy of your driver's license and current valid insurance. If you fail to provide us with the correct insurance information you may be responsible for the balance of the claim.

- **Claims submission:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility

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# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.**

## *Our Legal Duty*

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect **<insert date>**, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

## Uses and Disclosures of Protected Health Information

We will use and disclose your protected health information about you for treatment, payment, and health care operations.

Following are examples of the types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

**Treatment:** We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Health Care Operations:** We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

**Sale of Health Information:** We will not sell or exchange your health information for any type of financial remuneration without your written authorization.

**Fundraising Communications:** We may use or disclose your health information for fundraising purposes, but you have the right to opt-out from receiving these communications.

**Fundraising Communications:** We may use or disclose your health information for fundraising purposes, but you have the right to opt-out from receiving these communications.

**Uses and Disclosures Based On Your Written Authorization:** Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice.

**Others Involved in Your Health Care:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

**Marketing:** We may use your protected health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities. If we are paid by a third party to make marketing communications to you about their products or services, we will not make such communications to you without your written authorization. Except as stated above, no other marketing communications will be sent to you without your authorization.

**Research; Death; Organ Donation:** We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

**Public Health and Safety:** We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

**Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

**Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

**Food and Drug Administration:** We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make

repairs or replacements; or to conduct post marketing surveillance, as required.

**Criminal Activity:** Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

**Required by Law:** We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

**Process and Proceedings:** We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

**Law Enforcement:** We may disclose limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

## Patient Rights

**Access:** You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you **25¢** for each page, **$15.00** per hour for staff time to locate and copy your protected health information, and postage if you want the copies mailed to you. If the Practice keeps your health information in electronic form, you may request that we send it to you or another party in electronic form. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

**Accounting of Disclosures:** You have the right to receive a list of instances in which we or our business associates disclosed your non-electronic protected health information for purposes other than treatment, payment, health care operations and certain other activities during the past six (6) years. For disclosures of electronic health information, our duty to provide an accounting only covers disclosures after January 1, 2011 [January 1, 2014] and only applies to disclosures for the three (3) years preceding your request. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

**Restriction Requests:** You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. Except as noted herein, we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). We are required to accept and follow requests for restrictions of health information to insurance companies if you have paid out-of-pocket and in full for the item or service we provide to you. Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

**Confidential Communication:** You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

**Amendment:** You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your

request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of that information.

**Electronic Notice:** If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

**Notice of Unauthorized Disclosures:** If the Practice causes or allows your health information to be disclosed to an unauthorized person, the Practice will notify you of this and help you mitigate the effects.

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## Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below.

If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Name of Contact Person:

Telephone:

Address:

whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

- **Coverage changes:** If your insurance changes please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

- **Nonpayment:** If your account is over 90 days past due you will receive a letter stating that you have to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if the balance remains unpaid we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that time our physician will only be able to treat you on emergency basis.

- **Missed appointments:** Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed to you. Please help us to serve you better by keeping your regularly scheduled appointment. A charge of $40 dollars will be billed to you for a missed appointment not cancelled within a reasonable amount of time.

- **Payment:** We accept payment by cash, checks or credit card. We charge a return check fee of $25 per check for any check returned unpaid by your bank for any reason.

South Denver Podiatry, PLLC is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

I have read, understand and agree to the payment policy of South Denver Podiatry, PLLC. I understand that charges not covered by my insurance company as well as applicable copayments and deductibles are my responsibility.

I authorize my insurance benefits to be paid directly to South Denver Podiatry.

**Patient Name:**_____

**Signature:**_____**Date:**_____