Castle Rock Foot & Ankle Care

2352 Meadows Blvd #270, Castle Rock, CO 80109 (303)814-1082

INTAKE PAPERWORK

Last Name:_____ First Name:_____ Middle Initial:____ Birth Date:_____ Age:_____

Mailing Address: Street:_____ City: _____ State: _____ Zip: _____

Contact # _____ Home/Cell Patient's SS#:_____

Marital Status (Circle One): Single Married Separated Divorced Widowed Sex: M F Email_____

Race:_____ Ethnicity:_____ Preferred Language:_____

Would you like to receive notification of our office special and/or discounts? (please provide email above) Yes_____ No_____

Employer:_____ Occupation:_____ Length at this job:_____

Employer Address:_____ City:_____ State:_____ Zip:_____ Work Ph:_____

Name of Spouse or Parent:_____ Birth Date:_____

Spouses Employer:_____ Work Ph:_____ Cell Ph.:_____

In case of emergency, contact

Name:_____ Relationship:_____ Home Ph:_____

Street:_____ City:_____ State:_____ Zip:_____ Cell Ph:_____

Insurance Information:

Who is responsible for payment of this account:_____ Relationship of this person to you:_____

Insurance 1

Name of Insured:_____ Name of Company:_____

Birth Date of Insured:_____ Address of Company:_____

Patient's SS#:_____ Group #:_____ Policy#:_____

Confidential Communications / HIPAA

I request that all written or oral communications to me (by telephone, mail or otherwise) by Castle Rock Foot & Ankle Care and /or its staff be handled by using the above address and telephone number. I am responsible to notify the office of any change of above.
I have been offered a copy of the Privacy Practice Notification of Castle Rock Foot & Ankle Care and have read and understand the Notice.
May we leave a message? YES:_____ NO:_____

Assignment and Release

I, the undersigned, certify that I (or my dependant) have insurance coverage with_____ and assign directly to Castle Rock Foot & Ankle Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all insurance submissions.

Responsible Party Signature:_____ Relationship:_____ Date:_____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Castle Rock Foot & Ankle Care for any services furnished to me by that physician. I authorize any holder of medical information about me to release to Castle Rock Foot & Ankle Care and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCJA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

Beneficiary Signature:_____ Date:_____

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Patient Health History

Name:_____ Age:_____ Height:_____ Weight:_____

Primary Doctor (first/last name):_____ Last Visit:_____ Office Number_____

Other Specialist / Doctors you see:_____

How did you hear about our office? Were you referred here by: Doctor:_____

Friend: _____ Internet Search:_____ Publication:_____

Allergies: Tape Metal/nickel Rubber/Latex Seasonal Foods:_____

Allergy to Medication?:_____ Reaction:_____

List of Medications you are currently on:

Name of Medicine	Dose	Frequency	Reason for Taking	Who Prescribed It

List Pharmacy that you use:_____ Pharmacy Phone #:_____

SURGERY – Indicate what type and year

_____

_____

_____

HOSPITALIZATION – (not for surgery) Indicate reason and year

_____

_____

_____

FOOT AND ANKLE HISTORY

Have you ever broken a bone in your foot or ankle? **YES NO**
Which bone?_____When?_____

Have you had a problem with this area since that time? **YES NO**
What problem?_____

What is your normal shoe size?_____
Have you ever been to a podiatrist before? **YES NO**
Why?_____

Circle any of these that you have had:

Ankle Pain	Foot Cramps
Athlete's Foot	Heel Pain
Bunions	Ingrown Nails
Corns	Plantar Warts
Calluses	Swollen Feet
Flat Feet	Tired Feet

What problem brings you to the doctor today?_Injury? Work Comp?_____

Other General Important Health Questions:

Do you smoke? **YES / NO** Type (Circle any that apply) **Cigarettes Cigars Other** Amt. Per day:_____ Years smoked:_____
Do you drink alcohol? **YES / NO** Type (Circle any that apply) **Hard Liquor Beer Wine** Amt. Per day_____ Mth._____ Yr._____
For how many years?_____

Does any one of your blood relatives have or have had any of the following conditions? (please circle)

Diabetes Cancer Gout Heart Disease High Blood Pressure Tuberculosis

ARE THERE ANY OTHER MEDICAL CONDITIONS THE DOCTOR SHOULD BE AWARE OF?

_____

PLEASE CIRCLE ANY OF THE FOLLOWING THAT YOU HAVE HAD:

EENT
Nose Bleeds
Difficulty Swallowing
Difficulty Chewing
Visual Problems
Glaucoma
Cataracts
Glasses
Contact Lenses
Hearing Problems
Sore in mouth that won't heal
Thyroid Problem
Other_____

NEUROLOGICAL
Numbness of Arms or Legs
Fainting
Dizziness
Seizures/ Epilepsy
Stroke
Headaches
Migraine headaches
Other_____

HEMATOLOGICAL
Anemia
Bleeding Disorder
Hemophilia
Sickle Cell Anemia
HIV Positive
Other_____

CARDIOVASCULAR
Chest Pain / Angina
Heart Attack
High Cholesterol
High Blood Pressure
Abnormal EKG
Swelling of the Feet or Ankles
Abnormal Heart Rhythm
Rapid Heart Rate
Artificial Heart Valve
Pacemaker
Blood Clot in Leg
Other_____

RESPIRATORY
Asthma
Emphysema
Lung Disease
Abnormal Chest X-Ray
Shortness of Breath
Use Oxygen at Home
Tuberculosis
Blood Clot in Lung
Chronic Cough
Blood in Sputum
Other_____

MUSCULOSKELETAL
Rash
Gout
Arthritis
Sore Not Healing
Limited Motion in Joint
Back Problems
Other_____

GASTROINTESTINAL
Abdominal Pain
Ulcer in Stomach
Hiatal Hernia
Nausea or Vomiting
Constipation
Diarrhea
Change in Appetite
Unexplained Weight Loss
Heart Burn
Gall Bladder Problems
Other_____

LIVER
Hepatitis
Yellow Skin / Jaundice
Other_____

MENTAL HEALTH
Depression
How Long_____
Medication_____
Anxiety
Panic Attack
Agoraphobia
Obsessive/Compulsive disorder
Schizophrenia
Chemical Dependency
Substance_____

CANCER
Where?_____
When?_____

OTHER DIAGNOSES OR CONDITION
Diabetic YES NO
Year Diagnosed_____

Have You Been Exposed to Any Infectious Diseases in the Last Month?
Which:_____

GENITOURINARY
Difficulty Urinating
Frequent Infections
Kidney Problems
Prostate Problems
On Dialysis – Hemo / Peritoneal
Abnormal Female Bleeding
Other_____

I certify that the above information is true and current to the best of my knowledge. I give my permission to the Doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet and ankles.

Signature:_____ Date:_____

PROTECTED HEALTH INFORMATION FORM

Castle Rock Foot and Ankle Care wants to ensure your privacy. This form is intended to give you the opportunity to release medical information to designated parties (this does not apply to minors under the age of 18).

You may release pertinent medical information related to diagnosis and treatment from my office visits to the following parties:

Name:_____ Relationship:_____Phone:_____

Name:_____ Relationship:_____Phone:_____

Your Name:_____Signature:_____Date:_____

PLEASE CIRCLE ALL THAT APPLY TO YOUR CONDITION:

What do your symptoms feel like?
Aching Burning Cramping Dull Ill-defined Itching Pressure-like Pulling Sharp Shooting Sore Stabbing Tender Tearing Throbbing Tingling/Numbness

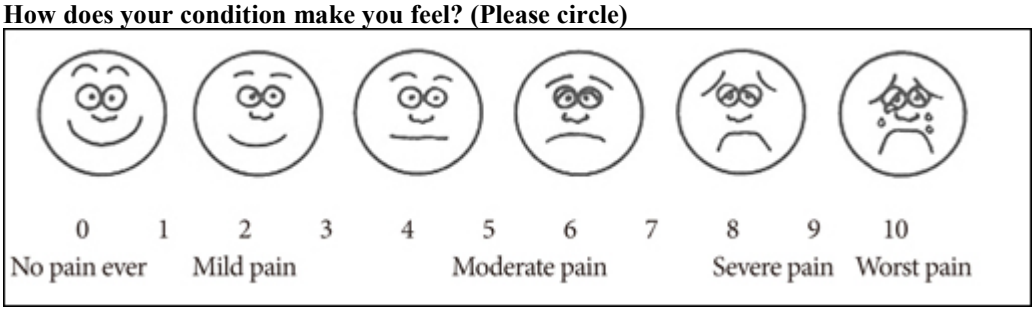
What makes the symptoms worse?
Standing Walking Running Sitting Lying down Certain shoes Other:_____

What makes the symptoms better?
Nothing Rest Ice Heat Ibuprofen Changing shoes Periodic footcare Other:_____

What prior treatment has been attempted?
None Rest Ice Heat NSAIDs Physical therapy OTC Arch supports Changing shoes Periodic footcare Topical Rx OTC Topical Rx Custom Orthotics Prescription Rx

Do you have any Back Pain? Yes No **Knee Pain?** Yes- R L No **Hip pain?** Yes- R L No

How does your condition make you feel? (Please circle)



THIS SECTION IS FOR THE DOCTOR:

Vascular- _____/4 Right _____/4 Left
Derm-
Neuro- Tinel's: R L DTR: 0 1 2 3 4 S-W: _____/10 R _____/10 L Vibratory diminished: R L
MSK-
ROM
Stability
Strength
Foot position: _____/10 R _____/10 L
RCSP
Ankle DF: Knee extended_____ Knee flexed_____
Limb length

CASTLE ROCK FOOT & ANKLE CARE OFFICE POLICIES

COLLECTIONS POLICY

- In the event your account is assigned to a collection agency, you agree to pay a collection fee in the amount equal to 30% of the balance due assigned to the collection agency.
- There is a returned check fee of **$50.00**. If for any reason you write a check to our office that does not clear, This fee will be added to your account and collected at next visit.

DURABLE MEDICAL EQUIPMENT

- These items include, but are not limited to:
  Walking Boots, Night Splint, Ankle & Trilok Brace, Custom Orthotic & Children's Orthotic Inserts, Ped Pillows Inserts, Vionic footwear, Any accommodative over the counter items
- Items listed above are NON-RETURNABLE. We are restricted from re-selling items that have been taken from this office due to health regulation.

ORTHOTICS

- Orthotics may be a self-pay item, and they cost $550. This does NOT include the office visit for casting. We require a $275 deposit before we can send these to be made. If these are covered, we will reimburse you after we have been paid by your insurance. The full balance will be due at the time of the orthotic dispensing. Insurance coverage varies for orthotics, and there is no guarantee of coverage.
- Benefits will only be known when claims are actually processed through your insurance carrier.
- You, as the patient are responsible for contacting your insurance to verify coverage as we do not do pre-authorizations for these.

INSURANCE POLICY

- Please check with your insurance to find out if we are "in-network" with your policy and if you need a referral.
- Your insurance policy is a contract between you and your insurance company; therefore, you are responsible for payment whether or not your insurance company pays. If proper authorizations or referrals are not obtained, this may reduce the benefits paid by your insurance company. This would be patient responsibility.
- Failure to inform us of any changes to insurance may result in denied claims, and responsibilities being 100% patients.

MEDICAL RECORDS/ X-RAYS

- Your records are the property of the office. The original copy must stay in the office. As a patient, you may request medical records and purchase copies per the State of Colorado fee schedule. We require a signed waiver and request 2 weeks' notice. We do not print or place your X-ray images on a CD. You must bring a USB drive into the office for X-rays.

NEW PATIENT, BOOTS, PROCEDURE & OA DEPOSITS

- Based on your deductible and amount met, we may take a deposit for the above-mentioned items. This deposit will be applied to your billed responsible amount. Remaining money will be re-issued via our billing department. If these services are non-covered by insurance they will be marked down as Self pay.

LATE/NO-SHOW POLICY

- If you are unable to keep your scheduled appointment, please notify us **at least 24 hours** in advance so we can accommodate our other patients.
- We strive to take time with each individual patient. Your punctuality affects your appointment, as well as others'. If you are **15 minutes late**, we may be able to work you into the schedule at a later time or we may ask you to reschedule.
- Our office strives to stay punctual- this is because we do not overbook appointments in anticipation of cancellations. However, certain medical circumstances may be allowed exceptions.
- A no-show or short notice cancellation will result in a charge of **$50.00**.
- On the second no-show or late cancellation appointment, it will be up to the Doctor's discretion as to whether a discharge letter will be sent disengaging you from the practice.
- For **CANCELED SURGERY**, you will be charged **$350.00** for cancelation. (**If less than 7 days prior to scheduled surgery date.**)

PLEASE SIGN BELOW THAT YOU HAVE READ AND UNDERSTAND OUR POLICIES:

I _____ have reviewed the above policies.

Signature_____Date_____

HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. Authorization

I authorize Castle Rock Foot & Ankle Care_____ (healthcare provider) to use and disclose the protected health information described below to _____ (individual seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. ☐ _____ to _____.

OR

b. ☐ all past, present, and future periods.

3. Extent of Authorization

a. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. □ I authorize the release of my complete health record with the exception of the following information:

□ Mental health records

□ Communicable diseases (including HIV and AIDS)

□ Alcohol/drug abuse treatment

□ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____

Signature of patient or personal representative

_____

Printed name of patient or personal representative and his or her relationship to patient

_____

Date