FOOT AND ANKLE
INSTITUTE OF COLORADO

PATIENT INFORMATION

Patient's Last Name First Middle		Marital Status (Circle One) Single / Married / Divorced / Separated / Widowed
Name I preferred to be called	Date of Birth	Sex (Circle One) Male Female
Street Address	Social Security Number	Home Phone Number ( )
City State Zip Code	Email	Mobile Phone Number ( )
Occupation	Employer	Work Phone Number ( )
Primary Care Physician	Primary Care Physician Phone Number ( )	Date of Last Visit / /
Cardiologist	Cardiologist Phone Number ( )	

IN CASE OF EMERGENCY

Emergency Contact Name	Phone Number

PERSON RESPONSIBLE FOR BILL (IF DIFFERENT THAN ABOVE)

Name of Person Responsible for Bill	Date of Birth / /	Sex (Circle One) Male Female	Relationship to Patient
Street Address	Social Security Number		Home Phone Number ( )
City State Zip Code	Email		Mobile Phone Number ( )

INSURANCE INFORMATION

Primary Insurance	Policy Number	Group Number
Subscriber Name	Date of Birth / /	Social Security Number
Secondary Insurance	Policy Number	Group Number
Subscriber Name	Date of Birth / /	Social Security Number

REFERRAL

How did you learn about us? (Circle One)

Family/Friend: _____ Doctor: _____ Other:_____

Hospital/ER Insurance Plan Internet Website

PATIENT PORTAL

Would you like to have access to our patient portal? Patient Portal integrates with Kareo and lets us securely communicate with our patients, post eLab results and health information.

YES _____ ***NO*** _____

APPOINTMENT REMINDER

For your upcoming appointment, would you like to be reminded by:

Text_____ Call_____ Email_____

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HEALTH HISTORY

Height: _____ ft. _____ inches **Weight:** _____lbs.

Medical History: Have you ever been treated for:

- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Hepatitis
- ☐ Arthritis
- ☐ Gout
- ☐ Thyroid Disease
- ☐ HIV
- ☐ Numbness
- ☐ Liver Disease
- ☐ Vascular Disease
- ☐ None of the above
- ☐ Stroke
- ☐ TIA
- ☐ Diabetes (Type I or Type II)
- ☐ Depression
- ☐ Anxiety
- ☐ Acid Reflux
- ☐ Stomach Ulcers
- ☐ Cancer
- ☐ Kidney Disease
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ CRPS
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Poor Circulation
- ☐ Shortness of Breath
- ☐ Fibromyalgia
- ☐ Alzheimer's
- ☐ Heart Condition
- ☐ Multiple Sclerosis

Other: _____

Surgical History:

_____

_____

Family History:

- ☐ Diabetes
- ☐ Heart Disease
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Bleeding Disorder
- ☐ COPD
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Stroke

Other: _____

SOCIAL HISTORY:

Tobacco: ____ packs/day for _____ years, quit date _____; Alcohol: ____ drinks per week; Drug use: _____

Current Medications and Dosage:

_____

_____

Preferred Pharmacy: _____

Location: _____

Allergies:

- ☐ Latex
- ☐ Antibiotics: _____
- ☐ Codeine
- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Other Narcotics: _____
- ☐ Other Anesthetics: _____
- ☐ Iodine or Betadine

Additional medication or food allergies: _____

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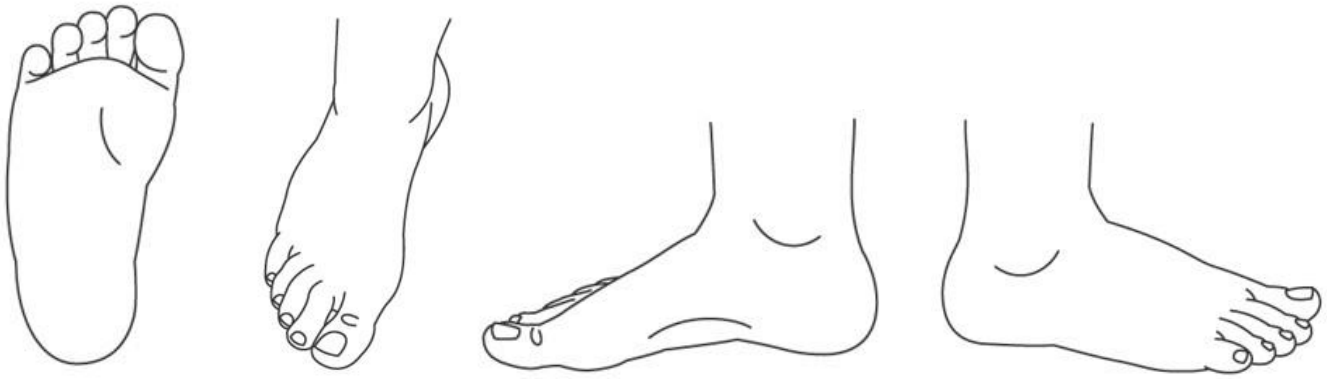
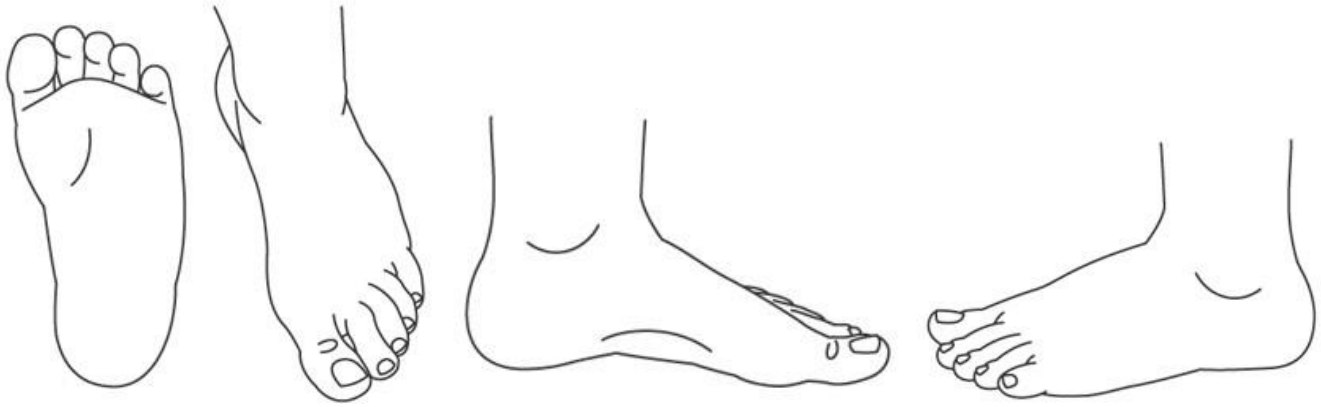
Foot/Ankle Problem: Put an "X" where your pain is located

Right Foot/Ankle



Left Foot/Ankle



Describe your foot/ankle problem:

_____

_____

Does the pain radiate anywhere else on the foot/leg?

_____

_____

Indicate the severity of pain/discomfort:

☐ None ☐ Light ☐ Moderate ☐ Strong ☐ Severe

How long did the pain/discomfort start?

☐ ____ years ☐ ____ months ☐ ____ weeks ☐ ____ days

Pain occurs while:

☐ Walking ☐ Standing ☐ Running ☐ Wearing Shoes

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____ Date of Authorization: _____

I authorize Foot and Ankle Institute of Colorado to contact me in the manner below:

☐ - Phone _____ Leave a detailed message YES / NO

☐ - Email _____

☐ - Address on file

I authorize Foot and Ankle Institute of Colorado to disclose protected health information to:

Name _____ Relation _____ Phone _____

Name _____ Relation _____ Phone _____

Name _____ Relation _____ Phone _____

The following health information.

☐ - All of my health information

☐ - Messages to return clinic call only

☐ - My health information relating to the following treatment condition:

_____

Patient Rights:

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission, I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of the authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of the authorization after I have signed it. A copy of the authorization is as valid as the original.

Signature of Patient _____ **Date:** _____

☐ - Patient is a minor ☐ - Patient is unable to sign because: _____

Authorized Representative: _____ **Date:** _____

FINANCIAL POLICY/CONSENT TO TREAT/APPOINTMENTS

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1. Co-payments are due at the time of visit per your contract with your insurance. Per our policy, unmet deductibles and co-insurance are collected at time of service. Co-Insurance and unmet deductibles are due prior to scheduled surgeries. Patient Initial _____
2. In accordance with your insurance policy, it is your responsibility to ensure our physicians are in your insurance network. It is your responsibility to provide accurate insurance information and present your insurance ID card at the time of your visit. If you do not have insurance or do not present a valid insurance card, you will be responsible for payment at the time of service. We will provide you with a copy of our billing form so that you can obtain reimbursement from your insurance company. Patient Initial _____
3. It is your responsibility to obtain all referrals if your insurance requires one. We will do all we can to assist you, but it is ultimately your responsibility. If a required referral is not in place prior to your appointment, we may reschedule the appointment until it is received. Patient Initial _____
4. There is a service fee of $30 for each time a check is returned. The bank may return your check up to three times before considering it nonnegotiable. Your insurance company does not cover this fee. Patient Initial _____
5. There is a $10.00 fee for copies of medical records, and a $5.00 fee per X-Ray disc. Please call office to request medical records and allow 48-72 hours to be completed. Patient Initial _____
6. FMLA/Disability Forms: There is a fee of $30.00 for each disability/FMLA form to be completed by our office. The fee is due at time the form is turned in. Please allow 7 business days for the form to be completed. Patient Initial _____
7. SELF-PAY: We offer a discounted rate for patients with no insurance. To receive the discount, payment is due at time of service. Patient Initial _____
8. I give consent to Foot and Ankle Institute of Colorado, their doctors, assistants, and other qualified medical personnel to treat me and to recommend and/or order laboratory test or other specialized tests as indicated for diagnosis for my medical condition. I understand the right to refuse any procedure or treatment. Patient Initial _____
9. I understand if I no-show my appointment 3 times, I will be released from the practice. I also understand if I am late to my appointment 3 times, I will be automatically rescheduled. Patient Initial _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have coverage with the insurance company(ies) disclosed and assign directly to Foot and Ankle Institute of Colorado and its Podiatrists, all insurance benefits, if any, otherwise payable to me for service(s) rendered. I understand that I am financially responsible for any co-payments, deductibles, co-insurance or balances whether or not paid by my insurance. I agree that should my account become delinquent and is referred to a collection agency, I will be responsible for any collection fees, court costs, reasonable attorney fees or returned check fees.

OFFICE POLICIES

Photo Identification: Patients must present a photo ID issued by a local, state or federal government agency (drivers license, passport, military ID, ect). The request is to protect against identity theft for medical services.

Minor patient authorization: All minors are required to have a parent or guardian present for each appointment. By law, we are required to have a consent for treatment from a legal guardian to provide treatment to a minor. Guardians must have a Power of Attorney or written notice from a parent giving permission for guardian to approve care of the minor.

I acknowledge by initialing and signing my name below, as the patient or guardian of the patient, that I have read all of the above financial disclosures and understand and will comply.

_____ _____ _____

Name of Individual/Legal Representative (Print) Signature of Individual/Legal Representative Date