SOUTH DENVER PODIATRY
PLLC

Patient Registration

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

Preferred Name: _____

Address (Please Make Legible): _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Social Security Number: _____ Date of Birth: _____

Email: _____ Sex: _____ Race: _____ Marital Status: _____

Employer Name: _____ Phone: _____

Preferred Pharmacy/ Location: _____

Primary Insurance: _____ Policy Number: _____

Group Number: _____ Name of Insured/relationship: _____

DOB Insured: _____ Billing Address if Different from Home: _____

Secondary Insurance: _____ Policy Number: _____

Group Number: _____ Name of Insured/relationship: _____

DOB of Unsured: _____

Referring Physician Name: _____ Phone: _____

Primary Care: _____ Phone: _____

If you choose 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: _____

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Patient Medical History Form

Patient Name: _____ Date of Birth: _____ Age: _____

Height: _____ Weight: _____ Shoe Sz: _____

How did you hear about us: _____

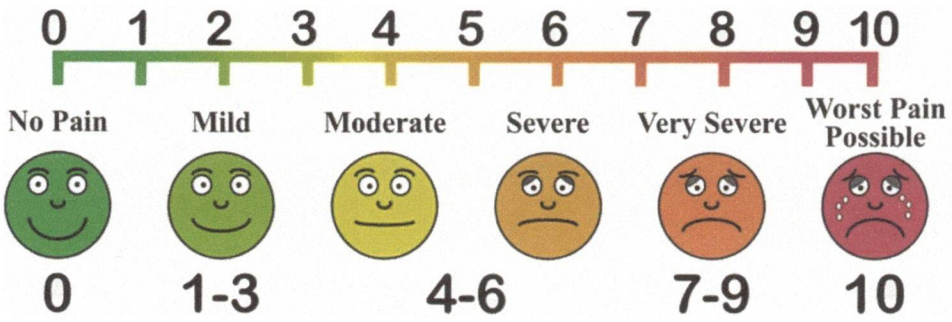
Reason for today's visit: _____

Location of Pain: _____ Date of injury: _____

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 1-10):



Pain Type: _____Sharp _____Dull _____Burning _____Radiating _____Constant

Have you had any prior treatments for this problem? _____ No.

If yes please explain: _____

(FOR OFFICE USE) Blood Pressure: _____ Temp: _____

Social History: (on next page)

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Social History

Do you drink alcohol?_____Y _____N
How many drinks per day?_____

Do you use tobacco?_____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?_____

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Medical History

Please CIRCLE who is your family has had any of the conditions listed below:
M- Mother, F- Father, B- Brother, S- Sister, I- Yourself

Arthritis	M	F	B	S	I
Anxiety	M	F	B	S	I
Asthma	M	F	B	S	I
Alcoholism	M	F	B	S	I
Anesthesia Problems	M	F	B	S	I
Birth Defects	M	F	B	S	I
Bleeding Disorder	M	F	B	S	I
Blood clots	M	F	B	S	I
Cancer	M	F	B	S	I
Chronic Back Pain	M	F	B	S	I
Congestive Heart Failure	M	F	B	S	I
Poor Circulation	M	F	B	S	I
Severe Allergies	M	F	B	S	I
Thyroid Problems	M	F	B	S	I
Diabetes Type I or Type II	M	F	B	S	I
Depression	M	F	B	S	I
Foot Ulcer	M	F	B	S	I
Artificial joints	M	F	B	S	I
Heart Attack	M	F	B	S	I
Hepatitis C	M	F	B	S	I
High Blood Pressure	M	F	B	S	I
HIV	M	F	B	S	I
Pulmonary Embolism	M	F	B	S	I
Rheumatoid Arthritis	M	F	B	S	I
Stomach Ulcers	M	F	B	S	I
Varicose Veins	M	F	B	S	I
Kidney Disease	M	F	B	S	I
Blood thinner	M	F	B	S	I
Leg Cramps	M	F	B	S	I
Lung Disease	M	F	B	S	I
Liver Problems	M	F	B	S	I
Lupus	M	F	B	S	I
Heart Murmur Arrhythmia	M	F	B	S	I
Neurological Disorder	M	F	B	S	I
Numbness/ Neuropathy	M	F	B	S	I
Osteopenia osteoporosis	M	F	B	S	I
Colitis/IBS/Crohn's disease	M	F	B	S	I
Phlebitis	M	F	B	S	I
Seizures	M	F	B	S	I
Stroke IA	M	F	B	S	I
Irregular Heartbeat	M	F	B	S	I
Heart disease	M	F	B	S	I
Leg swelling	M	F	B	S	I
Sleep apnea	M	F	B	S	I
Use of Oxygen at home	M	F	B	S	I
Currently Pregnant	M	F	B	S	I

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Medical History Continued

Please List any **CURRENT** medical history **NOT** Listed on Previous Page:

_____

_____

_____

Please List any Previous Surgeries and Dates (Month/Year):

_____

_____

_____

Please List any Allergies: _____

_____

_____None _____Metals _____Latex _____Adhesive Tape

Please List any Medical Conditions for which you are **CURRENTLY** or have **RECENTLY** been treated:

_____

_____

_____

_____

Current Medications; Please List any Prescription and/or over the counter medications including the **DOSAGE and FREQUENCY:**

Medication Name	Dosage/Frequency

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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 reminds.

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 minor on the date the minor becomes an adult under state law. Please advise us of any changes to your preferences.

Signature: _____

Date: _____

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Credit Card Authorization

Dear Patients, Parents and/or Legal Guardians:

South Denver Podiatry is instituting the Credit Card Authorization Policy. This policy is meant to supplement and be consistent with the existing South Denver Podiatry Payment policy, specifically the section outlined regarding Account Balances. (Please see back of this letter South Denver Podiatry Payment Policy.)

Under this policy, every patient, parent, responsible party and/or legal guardian with Commercial Insurance will be required to provide South Denver Podiatry with a Credit Card Authorization for co-pays and outstanding balances for services/supplies deemed to be the patient's responsibility per your selected insurance policy. South Denver Podiatry is adopting this policy to mirror emerging standards in medical practices.

Having health insurance is not a guarantee of payment for services. Non-payment from insurance companies occurs for many reasons, including but not limited to:

- Amount due for your chosen annual deductible/coinsurance
- Visit co-pays
- No coverage for specified services and/or exclusions under your chose policy
- Terminated Benefits

South Denver Podiatry will continue to accept your contracted insurance plans, and file timely claims on your behalf. When your plan has assessed a patient responsibility, South Denver Podiatry will run the Credit Card Authorization, 15 days after we are notified by your insurance company. South Denver Podiatry will wait these 15 days to give the patient/responsibility party time to:

- Reconcile your Explanation of Benefits to your patient statement
- Discuss with your insurance plan if the claim needs to be reprocessed
- Discuss other billing arrangements with our internal billing office

Rest assured that your Credit Card Authorization is encrypted in our system, inaccessible to any of our staff or any party at Merchant Services — Clover. Our medical records and billing system is also secured to the standards required by the Health Information Technology for Economic and clinical health ("HITECH") requirements established by the US Department of Health and Human Services. In short, your credit card information is as secure as your protected health information (PHI) that you've entrusted in us.

You are very important to us. Thank you for your continued trust in us as your partners in your healthcare.

Kind regards,

South Denver Podiatry

Patient Signature: _____

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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 gave 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 vary so greatly. Please feel free to discuss charges with us at any time.

If your benefits reset at the beginning of the calendar year, unless you can furnish proof that your deductible has been met, we will be collecting cost for visits and procedures at time of service.

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.
Failure to inform us of any **changes made to insurance** may result in denied claims and increased patient responsibility.

- **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 each visit.

- **No Insurance:** If you have no insurance a cash rate 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/Identity:** All patients must complete our patient information form before seeing the provider. We must obtain a copy of your drivers 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.**

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Payment Policy Continued

- **Claim 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 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.

- **CREDIT/DEBIT CARD ON FILE: We are now requesting a credit card on file if we will be billing insurance for you. The information will be held securely. When your portion of the bill is determined (following a review of your copay, co-insurance, and deductible) we will charge your card for the remaining balance and a copy of the receipt will be emailed to you. You can remove your card on file by giving written notice.**

- **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 an 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 cancelled 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 $68.00 dollars will be billed to you for missed appointments not cancelled within a reasonable amount of time (24 hours' notice).

- **Payment:** We accept payment by checks or credit card. We charge a return check fee of $25.00 dollars 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.

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Payment Policy Agreement

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:** _____

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ACKOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTIVES

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 chose) and understand the Notice.

_____ _____

Patient Name (Please Print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

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