# Castle Rock Foot & Ankle Care

2352 Meadows Blvd #270, Castle Rock, CO 80109
8671 S. Quebec St. #230, Highlands Ranch, CO 80130
(303)814-1082

## INTAKE PAPERWORK

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

Mailing Address: Street:_____Apt#_____ 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:_____ Primary:_____ Secondary:_____

Birth Date of Insured:_____ Address of Company:_____

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

Secondary Group and Policy:_____

**Confidential Communications**

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.
May we leave a message? YES:_____ NO:_____

**Assignment and Release**

I, the undersigned, certify that I (or my dependent) 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 Tuberculosis
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 Abdominal Pain
Bleeding Disorder
Hemophilia
Sickle Cell Anemia
HIV Positive
Other_____
Change in Appetite

**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

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**

Ulcer in Stomach
Hiatal Hernia
Nausea or Vomiting
Constipation
Diarrhea
Frequent Infections
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**

**Diabetic YES NO**
**Year Diagnosed_____**

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

**GENITOURINARY**
Difficulty Urinating

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

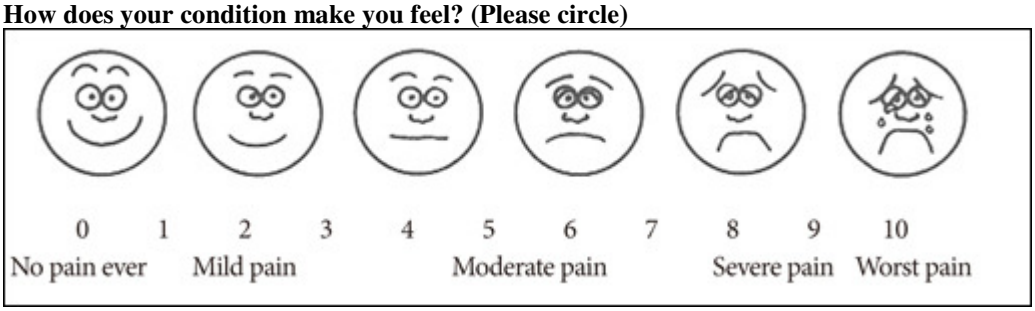
**What makes the symptoms worse?**
Standing Walking Running Sitting Lying down Certain shoes Other:_____

**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

**CONSENT FOR HEALTH CARE SERVICES**

I authorize physicians, their assistants and/or designees to administer any treatment as may be necessary or advisable in my diagnosis and treatment at Castle Rock Foot and Ankle Care. This authorization includes, but is not limited to, medical services, diagnostic imaging, procedures, injections and other services. I understand Castle Rock Foot and Ankle Care practice may release my medical records to other medical practices, physicians and medical companies for treatment as permitted by law. I understand that my rights and responsibilities with regard to my care are described in more detail on the Patient Bill of Rights document.

**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.
- I hereby authorize this provider and its employees, agents, and assignees to contact me via e-mail and text messaging and to my cellular devices.

# CASTLE ROCK FOOT & ANKLE CARE OFFICE POLICIES CONTINUED

**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 $600. This does NOT include the office visit. If these are covered, we will reimburse you after we have been paid by your insurance. 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.**)

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge Castle Rock Foot and Ankle Care has offered me a copy of its Notice of Privacy Practices. I understand that the Notice of Privacy Practices is also electronically available on the web-site. I understand acknowledgment in no way affects the care I shall receive.

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

I_____have reviewed the above policies.

Signature_____Date_____