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Rocky Mountain Foot & Ankle Center

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PERMISSION TO COMMUNICATE PROTECTED HEALTH INFORMATION

PLEASE COMPLETE SECTIONS ONE AND TWO

Patient Printed Name: _____ DOB: _____

I grant permission to Rocky Mountain Foot & Ankle Center to disclose health information in the following manner(s):

SECTION ONE: COMMUNICATION OPTIONS (Choose any/all that apply)

☐ ***For email consent, initial here*:_____***"I recognize that electronic mail (i.e. email) is **NOT** a secure form of communication" **Note: Your email information will NOT be used to communicate specific personal health information, it will NOT be sold to any 3rd parties. We will only use your email for Patient Portal notifications to alert you when you have information available to view/print from your secure Patient Portal, OR for newsletter and event communication(s).***

Email address): _____

☐ Leave a message on my voice mail/answering machine at (phone#) **home** _____

☐ Leave a message on my voice mail/answering machine at (phone#) **work** _____

☐ Leave a message on my voice mail on my **mobile** phone _____

☐ Information may be left with the following other person(s):

Name: _____ Relationship: _____ Number: _____

Name: _____ Relationship: _____ Number: _____

SECTION TWO: TYPE OF INFORMATION AUTHORIZED FOR DISCLOSURE

(Choose any/all that apply)

☐ Laboratory Results ☐ Prescription drug information ☐ Radiology Results (x-ray, ultrasounds, etc)

☐ Medical instructions or advice

☐ Appointment information, including confirmation or cancellation of an appointment and/or reason for an appointment.

☐ Do **NOT** leave any information on voice mails or answering machines.

By signing this form I understand that protected health information may be left on an answering machine as I have indicated above.

_____ _____

Signature of Patient or Authorized Representative **Date**

This consent form expires: (1) when revoked by the patient or representative in writing, and (2) in the case of a minor, when revoked by the minor's representative in writing or on the date the minor becomes an adult under state law, whichever occurs first.

20_____

First Visit Information

PLEASE PRINT CLEARLY

How did you hear about us?

☐ Referring Dr. _____ ☐ Friend/Family (name) _____ ☐ Online Search Engine ☐ Other: _____

Name: _____

Why are we seeing you today? _____

How long has this been a problem? _____ Which foot: right left both

Shoe size: _____ Height: _____ Weight: _____

Medical / Family History

Please circle to indicate "Y" (yes) or "N" (no). **Please describe details of any "Yes" answer.**

Self	Family		Self	Family	
Y N	Y N	Anemia? _____	Y N	Y N	Neurologic disorders? Type _____
Y N	Y N	Arthritis? Type _____	Y N	Y N	Osteoporosis? _____
Y N	Y N	Asthma? _____	Y N	Y N	Phlebitis / Blood clots / Pulmonary embolus
Y N	Y N	Cancer? Type _____			_____
Y N	Y N	Diabetes? Date of diagnosis _____	Y N	Y N	Psychiatric disorders? Type _____
Y N	Y N	Excessive bleeding? _____	Y N	Y N	Rheumatic fever? _____
Y N	Y N	HIV or AIDS? _____	Y N	Y N	Murmur? _____
Y N	Y N	Healing problems? _____	Y N	Y N	Stomach ulcers / peptic ulcers? _____
Y N	Y N	Heart attack? Date _____	Y N	Y N	Stroke? _____
Y N	Y N	Heart failure? _____	Y N	Y N	Thyroid disease? _____
Y N	Y N	Hepatitis? A, B, C or other _____	Y N	Y N	Do you have any metal implants, plates, pins or screws? _____
Y N	Y N	High Blood Pressure? _____			
Y N	Y N	Kidney problems? _____			Please list any other medical condition you have not listed
Y N	Y N	Liver problems? _____			above (i.e., High Cholesterol): _____
Y N	Y N	Lung disease?			_____
		Circle type: COPD Emphysema			_____

Please answer the following questions:

(Women) Are you pregnant? yes no Are you breastfeeding? yes no

List all allergies to medications, adhesive tape, or latex:

_____

_____

Please list any medications you take and dosage:

_____

_____

Please list surgeries and hospitalizations:

_____

_____

Do you or have you ever used tobacco products? yes no Type _____ Packs per day____ Years____ Quit _____

Do you drink alcohol? yes no Amount per day _____

Do you drink caffeinated beverages? Amount per day _____

Any recreational drug use? _____

Please list any physicians who have treated your feet, and when:

_____

_____

Patient Information Sheet Date_____

Personal Information: (PLEASE PRINT CLEARLY)

Name_____SS#_____Birthday_____Age_____

Marital Status_____ Sex: ❑ Male ❑ Female ❑ Transgender

Address_____City _____

State_____ Zip Code _____ Home Ph#_____ Cell Ph#_____

E-mail _____

Employer_____ Occupation _____

Employer Address_____City_____State _____ Zip_____ Phone _____

Our office participates in Federal programs (Medicare/Medicaid), so we must ask the following:

- **(Circle One) Race:** White Hispanic Asian Black/African American American Indian/Alaskan Native Other Decline
- **(Circle One) Language:** English Spanish Russian Indian Other Decline
- **(Circle One) Ethnicity:** Not Hispanic Hispanic/Latino Decline

PHARMACY & EMERGENCY CONTACT INFORMATION:

Pharmacy Name: _____ Street/Cross Streets _____

City: _____ Phone: _____

Emergency Contact_____ Relationship_____ Phone _____

Referred By: ***(Check one)*** ❑ Physician ❑ Patient ❑ Insurance Company ❑ Hospital ❑ Phone Book ❑ On-Line

Primary Care Physician:_____Phone: _____
First Name Last Name

Acknowledgement of Receipt of Privacy Practices (Check one):

❑ I have reviewed a copy of Rocky Mountain Foot & Ankle's *Notice of Privacy Practices*.
❑ I have opted not to receive a copy of Rocky Mountain Foot & Ankle's Notice of Privacy Practices.

Patient Signature_____ Date _____

Responsible Party: *(For Minor Patients ONLY):*

- *Please note that by signing below as the parent or legal guardian of the minor receiving treatment, you indicate that you authorize Rocky Mountain Foot & Ankle Center to provide treatment to the minor. You also indicate that you understand that you will be the responsible party for all billing charges related to the treatment of the minor.*

Parent/Legal Guardian Name (Printed)_____Signature _____

SS#_____Relationship _____

Address_____

City_____State _____ Zip_____Phone _____

Employer_____Occupation _____

Rocky Mountain
Foot & Ankle Center

Patient Consent Form

Patient's Full Name:_____

I, the patient or guardian, hearby consent to the following treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medications
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I, the patient or guardian, understand the following financial policies:

- It is solely your responsibility to obtain referrals and pre-authorizations from your Primary Care Physician (PCP) before scheduling your appointment with us.
- Co-pays are due at the time of service. We reserve the right to reschedule your appointment without your co-pay. We accept cash, credit card and checks.
- If you no-show for your appointment or do not cancel within 24 hours you may be charged a $25 fee.
- All returned checks will result in an additional $30 fee that will be billed directly to the patient.
- If your payment is delinquent we have the right to charge you interest at 18% and a $5 late fee and we will send delinquent accounts to a collection agency.
- Patients must present all current insurance cards and ID cards prior to every appointment. Without current proof of insurance or ID cards, patients cannot be seen by our providers, and their appointments will be re-scheduled.
- We cannot guarantee any benefits or your insurance coverage, it your responsibility to know your benefits and coverage.
- If you have a change in insurance, please notify us immediately so we can bill the appropriate insurance.

By signing below you certify that you have read, fully understand and agree to the above statements and give Rocky Mountain Foot and Ankle Center consent to treat.

Patient Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____