Centennial Foot and Ankle Specialists, P.C.

WELCOME TO OUR OFFICE! Please complete this form upon your first visit and sign. Notify us at future visits if any of the information changes.

DATE _____ REFERRED BY _____

PATIENT'S LEGAL NAME _____ **BIRTHDATE** _____

MALE ___ FEMALE ___ MARITAL STATUS _____ E-MAIL ADDRESS _____

MAILING ADDRESS _____
STREET APT/UNIT# CITY STATE/ZIP

HOME PHONE _____ CELL PHONE _____ SS# _____

PATIENT'S OR PARENT'S EMPLOYER _____ WORK PHONE _____

EMPLOYER ADDRESS _____ OCCUPATION _____

SPOUSE OR PARENT'S NAME _____

SPOUSE EMPLOYER _____ WORK PHONE _____

IN CASE OF EMERGENCY
EMERGENCY CONTACT

NAME _____ RELATIONSHIP _____ PHONE _____

NAME OF RESPONSIBLE PARTY _____ RELATIONSHIP TO PATIENT _____

PLEASE CIRCLE RACE: Asian, African American, Hispanic, White, Other _____ ❑ Declined

PLEASE CIRCLE ETHNIC GROUP: Hispanic/Latino or Non Hispanic/Latino

PREFERRED LANGUAGE SPOKEN: _____

INSURANCE INFORMATION
PRIMARY INSURANCE _____ SUBSCRIBER NAME _____

POLICY/GROUP# _____ SUBSCRIBER BIRTHDATE _____

SECONDARY INSURANCE _____ SUBSCRIBER NAME _____

POLICY/GROUP# _____ SUBSCRIBER BIRTHDATE _____

PRIMARY CARE/FAMILY PHYSICIAN _____ PHONE _____

PHARMACY NAME _____ PHONE _____

I certify that I, and/or my dependent(s), have insurance coverage with the above-named insurance company and assign payment of insurance benefits directly to Centennial Foot and Ankle Specialists, P.C. I understand that I am financially responsible for all charges whether or not they are paid by insurance.

I hereby authorize the doctor to release all information necessary for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____
Signed (Insured or authorized person)

Centennial Foot and Ankle Specialists, P.C.

Policy on Patient Responsibility for Fees

Thank you for choosing Dr. Robert S. Anderson and Dr. Erik J. Thelander as your health care providers. We are dedicated to providing the most beneficial treatment and believe that the greatest care for you and your family starts with good communication. We have created this financial policy which we require you to read and sign prior to any treatment. All patients must complete our information form and be prepared to present a **current insurance card** before seeing the doctors.

1. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE PLAN. WE WILL BILL YOUR INSURANCE COMPANY AS A COURTESY. YOUR INSURANCE PLAN IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE ARE NOT A PARTY TO THAT CONTRACT. IT IS YOUR RESPONSIBILITY TO UNDERSTAND YOUR POLICY AND KNOW WHAT BENEFITS YOU HOLD.

2. I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION TO FILE A CLAIM WITH MY INSURANCE COMPANY AND AUTHORIZE PAYMENT OF MY BENEFITS TO CENTENNIAL FOOT AND ANKLE SPECIALISTS, P.C. IN THE EVENT THAT MY ACCOUNT MUST BE SENT TO A COLLECTION AGENCY, I UNDERSTAND THAT I AM LEGALLY RESPONSIBLE FOR ALL COSTS INCURRED. A COPY OF THE BELOW SIGNATURE IS VALID AS THE ORIGINAL.

3. COPAYMENTS ARE DUE AT THE TIME OF SERVICE. IF YOU CANNOT PAY YOUR COPAY AT THE TIME OF SERVICE YOU WILL NEED TO RESCHEDULE. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER OR AMERICAN EXPRESS. RETURNED CHECKS WILL BE ASSESSED A $40.00 RETURNED CHECK FEE.

4. IF MY ACCOUNT BALANCE IS NOT PAID IN FULL WITHIN 30 DAYS AFTER THE INSURANCE COMPANY PROCESSES THE CLAIM, A $10.00 REBILLING FEE WILL BE ADDED TO MY ACCOUNT EVERY 30 DAYS UNTIL THE ACCOUNT IS PAID IN FULL. IF MY ACCOUNT IS NOT PAID IN FULL AFTER 120 DAYS MY ACCOUNT WILL BE SENT TO COLLECTIONS.

5. WE REQUIRE 24 HOURS NOTICE FOR CANCELLATION OF APPOINTMENT. FAILURE TO DO SO WILL RESULT IN A $25.00 "NO SHOW" CHARGE TO THE PATIENT. PATIENTS THAT ARE 15 MINUTES OR LATER FOR THEIR APPOINTMENT WILL NEED TO RESCHEDULE.

Please let us know if you have any questions.

I have read the policies presented above and agree to this Financial Policy.

_____ _____

Signature of Patient or Responsible Party Date

_____

Printed Name

Dr. Robert S. Anderson and Dr. Erik J. Thelander
Medical and Surgical Foot and Ankle Specialists / Diplomates, American Board of Podiatric Surgery
Cornerstar Healthcare Plaza / 15901 E. Briarwood Circle Suite 300 / Aurora, CO 80016
Phone: (303) 632-3668 / Fax: (303) 632-3669

Centennial Foot and Ankle Specialists, P.C.

Robert S. Anderson, D.P.M.
Medical and Surgical Foot and Ankle Specialist
Diplomate, American Board of Podiatric Surgery

Erik J. Thelander, D.P.M.
Medical and Surgical Foot and Ankle Specialist
Diplomate, American Board of Podiatric Surgery

Medical History

Has your physician requested you be seen in our office?_____

Would you allow our office to forward all clinical notes to family physician? Yes No (Circle one)

Former Podiatrist_____

What problems bring you to our office?_____

Have you previously had physical therapy for this condition?_____

Please list **all** current medications , dose and how taken:_____

_____

_____

Please list **all** drug allergies and reactions:_____

_____

_____

FOR WOMEN ONLY: Are you pregnant?_____If so, how many months?_____

Indicate which of your **immediate** relatives have had any of the following diseases:

Cancer_____ Diabetes_____

Heart Trouble _____ High Blood Pressure_____

Kidney Disease _____ Mental/Emotional Disease_____

Stroke _____ Arthritis_____

Please check "yes" or "no" and indicate the date you were diagnosed.

Yes	No	Date	Nature of Problem
			Cancer
			Headaches
			Cataracts / Glaucoma
			Hearing Impaired
			Hay Fever
			Asthma
			Allergic Reaction to Medication
			Hypo / Hyper Thyroid / Goiter
			Diabetes
			Eczema / Acne / Rash
			Anemia (recent)
			Heart Disease / MVP / Heart Murmur
			Multiple Sclerosis
			Parkinson's Disease
			Peripheral Vascular Disease
			High Blood Pressure
			Chest Pain / Pulmonary Embolus
			Pneumonia (recent)
			Shortness of Breath (Cough, Pleurisy, Wheezing)
			Liver Disease, Gall Bladder Disease (or Jaundice)
			Stomach Trouble / GERD / Ulcer
			Swelling in Feet or Ankles / DVT
			Arthritis / Lupus
			Kidney Disease or Stones
			Gout
			Bleeding Tendency

Yes	No	Date	Nature of Problem
			Scarring Tendency
			Joint pain or Stiffness / Fibromyalgia
			Numbness in Feet or Legs / Peripheral Neuropathy
			Cramps in Feet or Legs
			Low Back Pain
			Do you smoke? How much?
			Do you drink? How much?
			Depression
			Psychiatric Problems
			Fainting or Convulsions
			Strokes
			Tuberculosis
			Hepatitis A B C
			HIV Positive

Operations / Serious Injuries	Date

Patient Signature Date

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization: To family members or close friends who are involved in your health care; For certain limited research purposes; For purposes of public health and safety; To government agencies for purposes of their audits, investigations and other oversight activities; To government authorities to prevent child abuse or domestic violence; To the FDA to report product defects or incidents; To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders; When required by court orders, search warrants. subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights: To have access to and/or a copy of your health information; To receive an accounting of certain disclosures we have made of your health information; To request restrictions as to how your health information is used or disclosed; To request that we communicate with you in confidence; To request that we amend your health information; To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please ask to speak to our HIPAA Compliance Officer.

May we leave confidential information on Voice Mail or E-mail for you?

Home phone _____ yes no

Work phone _____ yes no

Cell phone _____ yes no

Email _____ yes no

Permission to Discuss Patient Information with Others:

_____ _____

Name and relationship Phone number

Prescription Drug Monitoring Program:

If you are given a prescription for a controlled substance; i.e Percocet, while under our care this information will be entered into the Prescription Drug Monitoring Program and may be questioned as to its validity and accuracy by authorized individuals.

_____ _____

Patient or Authorized Representative Signature Date