FOOT AND ANKLE
INSTITUTE OF COLORADO

Patient Information ***Today's Date_____***

Name _____ Birth Date _____/_____/_____ Age_____

Home Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____City: _____State: _____Zip: _____

Email Address:_____

Marital Status _____ SS# _____-____-_____ Male ( ) Female ( )

Home Phone (____)_____-_____Work Phone (____)_____-_____Other Phone (____)____-_____

Occupation _____ Employer _____

Emergency Contact Name:_____ Phone Number:_____

Person Responsible for the Account (if different than above)

Name _____ Relationship _____

Birth Date _____/_____/_____ SS#_____-____-_____ Male ( ) Female ( )

Address: Street_____ City_____ State_____ Zip _____

Home Phone (____)_____-_____Work Phone (____)_____-_____Other Phone (____)____-_____

Occupation _____ Employer _____

Insurance Information

Primary Insurance Company _____

Claims Address and phone # _____

Policy Holder's Name/ D.O.B./SSN: _____

ID# _____

Group# _____

Secondary Insurance Company _____

Claims Address and phone # _____

Policy Holder's Name/D.O.B./SSN:_____

ID# _____

Group# _____

Name of Family Doctor _____***Date of last visit***_____

WE NEED DATE OF LAST VISIT FOR MEDICARE TO PROCESS CLAIMS

How Did You Learn Of Our Office? (Who May We Thank?)

Friend/Family: _____ Yellow Pages: ( ) Insurance Company: _____

Practice Website: ( ) Doctor Referral:_____ Other: _____

Health History: Height ____ft.____inches Weight _____ lbs.

Please circle any illness you have had, or currently have: High blood pressure, Heart Attack, Leg cramps, Varicose veins, Blood clots, Poor circulation, Stroke, Asthma, Shortness of breath, Emphysema, Swelling, Hepatitis (A, B, or C) Acid reflux or stomach ulcers, Heart Kidney or Liver problems, Diabetes (Type I or Type II), Rheumatic Fever, Arthritis, Gout, Thyroid Disease, HIV, Cancer, Epilepsy, Numbness, Depression, Anxiety.

Other:_____

Past Surgeries/Hospitalizations:_____

_____

Current Medications:_____

Medication Allergies:_____

Flu Shot Date:_____

Vision Test Date:_____

Tobacco: ____packs/day for ____years, quit date _____, Alcohol: _____drinks per week,

Drug use:_____

Family History: Diabetes, Heart Disease, Rheumatoid arthritis, Other: _____

Describe your foot/ankle problem: _____

_____

I acknowledge that I was offered or provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Also, may we leave phone messages regarding your Protected Health Information with the following:

Your home phone answering machine?	YES	NO	N/A
Your work phone voice mail?	YES	NO	N/A
Your cell phone voice mail?	YES	NO	N/A
Your spouse (name) _____	YES	NO	N/A
Other (name) _____	YES	NO	N/A

Patient Name (please print) _____

Patient Signature (adult) __ _____

Date _____

Parent or Authorized Representative (if applicable) _____

Office Policies

Photo Identification: We require that each patient present a photo ID issued by a local, state or federal government agency (drivers license, passport, military ID, etc). 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.
Insurance information: Please provide us with your insurance card(s), referral and worker's compensation information upon registration at the front desk. If further information is requested, please fax the requested documents to us at 719-488-4667 within 24 hours.

Payment Policies

Method of payment: We accept the following forms of payment: cash, personal and bank checks, Visa, Mastercard, Discover and American Express credit cards. All returned checks will have a $30.00 return check fee in addition to the full amount of the original check.
Surgery patients: We will authorize your insurance for surgery. It is the patient's responsibility to check their insurance for coverage and to know their policy before surgery.
Patients without insurance coverage: Payment for medical services and dispensed items are due at the time of service. We are pleased to provide an estimate of costs for services and offer a 30% discount for medical services provided on your visit and will outline a cost plan for future services.
Patients with insurance coverage: Your insurance is a contract between **you and your insurance company**. While we cannot guarantee that your insurance company will pay your claim, we will provide information to them if requested and the above data is accurate and complete. I understand that I am responsible for any **CO-PAYMENTS, DEDUCTIBLES OR BALANCES not covered by my insurance.**

COLLECTION POLICY:

In the event our office is not contacted within 30 days of you receiving our last billing statement, your account will be turned over to our collection agency. Any collection fees, court costs, reasonable attorney fees or returned check fees are the responsibility of the adult person(s) named on the account. A monthly service fee of 1.5% per month or 18% per annum will be assessed on all past due accounts.

Signature:_____

Insurance Authorization and Assignment of Benefits

I hereby authorize treatment of the above patient or minor patient. I hereby authorize Foot and Ankle Institute of Colorado, P.C. to furnish information to insurance carriers regarding my illness and
treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself and my dependents

Signature: _____ Date: _____

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_____

HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: *Relationship:*

_____ _____

Contact information: _____

_____

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**

B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS) Alcohol/drug abuse
- ☐ treatment
- ☐ Other (please specify):

_____

_____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐ An electronic record or access through an online portal
- ☐ Hard copy

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event:_____ unless I revoke it.

(NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____ _____

Print Name of the Individual Giving this Authorization Date of birth

_____ _____

Signature of the Individual Giving this Authorization Date