20______

First Visit Information

PLEASE PRINT CLEARLY

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	Condition
Y N	Y N	Anemia? ____________
Y N	Y N	Arthritis? Type ____________
Y N	Y N	Asthma? ____________
Y N	Y N	Cancer? Type ____________
Y N	Y N	Diabetes? Date of diagnosis ____________
Y N	Y N	Excessive bleeding? ____________
Y N	Y N	HIV or AIDS? ____________
Y N	Y N	Healing problems? ____________
Y N	Y N	Heart attack? Date ____________
Y N	Y N	Heart failure? ____________
Y N	Y N	Hepatitis? A, B, C or other ____________
Y N	Y N	High Blood Pressure? ____________
Y N	Y N	Kidney problems? ____________
Y N	Y N	Liver problems? ____________
Y N	Y N	Lung disease? Circle type: COPD Emphysema

Self	Family	Condition
Y N	Y N	Neurologic disorders? Type ____________
Y N	Y N	Osteoporosis? ____________
Y N	Y N	Phlebitis / Blood clots / Pulmonary embolus ____________
Y N	Y N	Psychiatric disorders? Type ____________
Y N	Y N	Rheumatic fever? ____________
Y N	Y N	Murmur? ____________
Y N	Y N	Stomach ulcers / peptic ulcers? ____________
Y N	Y N	Stroke? ____________
Y N	Y N	Thyroid disease? ____________
Y N	Y N	Do you have any metal implants, plates, pins or screws? ____________

Please list any other medical condition you have not listed above (i.e., High Cholesterol): ______________________

____

____

Please answer the following questions:

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:

____

____

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

Patient Information Sheet

Personal Information: (PLEASE PRINT CLEARLY)

Name ______________________ SS# ______________ Birthday ______________ Age ________

Address ______________________________ City ______________________

State ________ Zip Code __________ – ________ Home Phone ______________ Cell Phone ______________

E-mail Address ____

Employer ______________________ Occupation ______________________

Address ______________ City ____________ State _____ Zip ________ Phone ______________

Marital Status ______________________ Sex: ❑ Male ❑ Female

In an emergency contact ______________ Relationship ______________ Phone ______________

Referred By ______________________ ❑ Physician ❑ Patient ❑ Insurance Company ❑ Hospital ❑ Phone Book ❑ On-Line

Primary Care Physician: ______________________ Phone: ______________

First Name Last Name

Responsible Party: (If patient is a minor)

Name ______________________ SS# ______________ Relationship ______________

Address ______________ City ____________ State _____ Zip ________ Phone ______________

Employer ______________________ Occupation ______________________

Insurance Information:

We will make a copy of your insurance card for our records. If you do not have your card with you, you will need to provide a copy of your insurance card (front and back) and fax it to us at 303-423-2536 within 24 hours.

We will make a copy of your referral (if required) for our records. If you do not have a referral, please ask the front office staff for additional information before seeing the doctor.

Please provide policy holder's date of birth. ______________________

Payment Policy

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

If you do not have insurance, then payment is due in full at the time of service.

Insurance Authorization and Assignment

I hereby authorize Rocky Mountain Foot & Ankle Center to furnish information to insurance carriers regarding my illness and treatments, and I hereby assign to the physician all payments for medical services rendered to myself and my dependents. I understand that I am responsible for any CO-PAYMENTS, DEDUCTIBLES OR BALANCES not covered by my insurance. I authorize use of this form and all my insurance submissions, and I permit a copy of this authorization to be used in place of the original. By signing this form I am consenting to treatment by the doctor in this office and agree to the terms indicated above.

Acknowledgement of Receipt of Privacy Practices

I have reviewed a copy of Rocky Mountain Foot & Ankle's Notice of Privacy Practices with an effective date of April 14, 2003.

Signature ______________________________ Today's Date ______________

____

Parent's printed name and signature if patient is a minor.

Matthew H. Paden, DPM, FACFAS
Barbara Y. Paden, DPM, FACFAS
Brett D. Sachs, DPM

WHEAT RIDGE EVERGREEN

Financial Policy

Thank you for choosing Rocky Mountain Foot and Ankle Center, PC for your foot and ankle needs. Our physicians are committed to the highest standards of excellence in your treatment. The following is an explanation of our office policies which we require you to read and sign prior to treatment. All patients must also complete our patient information sheet before seeing our providers.

Initial _____ Photo Identification:

We require that each patient present a photo Id issued by a local, state, or federal government agency (e.g. a drivers license, passport, military Id, etc). The request is to protect the patient against identity theft for services.

Initial _____ Insurance:

We cannot bill your insurance company without a completed form and a copy of your insurance card. We will bill only insurance companies that we are contracted with or that we have prior approval from.

Initial _____ Insurance Plans We Do Not Participate With:

If your insurance company is one that we are NOT contracted with, full payment is expected at the time of service. We will be happy to give you a copy of your bill with the appropriate information regarding your visit for you to submit to your insurance company.

Initial _____ Canceled or missed appointments:

For missed appointments not canceled 24 hours prior to your scheduled appointment time, our policy is to charge $25.00. This charge is solely your responsibility and not your insurance company's. Additionally, if you arrive 15 minutes late for a scheduled appointment we reserve the right to reschedule. Please help us serve you better by keeping scheduled appointments and arriving on time.

7615 W. 38th Avenue, B133 • Wheat Ridge, CO 80033 • Phone 303 423-2520 • Fax 303 423-2536
www.rockymountainfootandanklecenter.com

Initial _____ Payments:

We accept the following forms of payment: cash, personal checks, Visa, MasterCard, Discover and American Express. All returned checks will have a $30.00 return check fee, in addition to the full amount of the original check.

Initial _____ Late Fees:

We reserve the right to charge a late fee of $8.00 for every 30 days a payment is not made on your outstanding balance unless the claim is under insurance review.

Initial _____ FMLA / Disability / Work Forms:

After the first two forms are filed we will charge $10.00 for each additional form.

Initial _____ Surgery Patients:

We will verify coverage on out-patient surgery procedures for your convenience. Verification from your insurance carrier is not a guarantee of benefits or payment. After verification if you have not met your annual deductible a deposit (which will vary by patient) will be collected when you sign the consent form for surgery.

Initial _____ Minor Patients:

All minors are required to have a parent or guardian present with them for each appointment. By law we are required to have a consent from a legal guardian to provide treatment to a minor. If a parent or guardian is unable to attend the appointment with the minor, then a signed Authorization to Treat a Minor is required prior to the appointment. If a minor comes to the office unattended and we do not have a signed and dated authorization from the parent or guardian for a specific day(s) of treatment, we will be unable to see the patient at that time, and the appointment will have to be rescheduled.

By signing below I agree that I have read and understand the Financial Policy and agree to it.

____ Date: __________________

Signature of Patient or Responsible Party