ARVADA
FOOT AND ANKLE

New Patient Forms

DEMOGRAPHICS

Name: _____	**DOB**: _____/_____/_____	**Social Security**: _____
Phone Number: _____	**Sex**: Male / Female / Other	**Email**: _____

Address Line 1: _____ **City**: _____ **State**: _____ **ZIP**: _____

Address Line 2: _____

Emergency Contact:

Name: _____ **Relationship to Patient**: _____

Phone Number: _____ **Email**: _____

Financial Information:

Responsible Party: ☐ **Myself** ☐ **Someone Else**

If you selected "Someone Else," please fill out the following:

Name: _____ **Relationship to Contact**: _____ **Primary Phone**: _____

Method of Payment:

What will be your method of payment? ☐ **Insurance** ☐ **Self-Pay**

If you do not have your card on hand, please fill out the following:

Primary Insurance Company: _____ **Policy Number**: _____

Secondary Insurance Company: _____ **Policy Number**: _____

Primary Care Physician:

Name: _____ **Location**: _____

Pharmacy:

Name: _____ **Location**: _____

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MEDICAL HISTORY

Past Medical History:

- ☐ Acid Reflux
- ☐ Alzheimer's
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Diabetes – Type I
- ☐ Diabetes – Type II
- ☐ Depression
- ☐ Emphysema/COPD
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Condition
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Multiple Sclerosis
- ☐ Numbness
- ☐ Poor Circulation
- ☐ Shortness of Breath
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Transient Ischemic Attack
- ☐ Thyroid Disease
- ☐ Vascular Disease
- ☐ None of the Above

Other: _____

Surgical History:

_____

_____

Family History:

- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ COPD
- ☐ Diabetes
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Stroke

Other: _____

Allergies:

- ☐ Latex
- ☐ Penicillin
- ☐ Sulfa
- ☐ Iodine
- ☐ Narcotic

Other: _____

Social History:

Tobacco: _____ packs/day for _____ years. Quit date _____ ☐ Never smoker

Alcohol: _____ drinks/week. ☐ No alcohol consumption

Other drug use: _____ ☐ No other drug use

Current Medications:

_____ _____

_____ _____

_____ _____

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Financial Policy

1. Co-payments are due at the time of visit per your contract with your insurance. Per our policy, unmet deductibles and co-insurance are collected at time of service. Co-insurance and unmet deductibles are due prior to scheduled surgeries.
2. In accordance with your insurance policy, it is your responsibility to ensure our physicians are in your insurance network. It is your responsibility to provide accurate insurance information and present your insurance ID card at the time of your visit. If you do not have insurance or do not present a valid insurance card, you will be responsible for payment at the time of service. We will provide you with a copy of our billing form so that you can obtain reimbursement from your insurance company.
3. It is your responsibility to obtain all referrals if your insurance requires one. We will do all we can to assist you, but it is ultimately your responsibility. If a required referral is not in place prior to your appointment, we may reschedule the appointment until it is received.
4. There is a service fee of $30 for each time a check is returned. The bank may return your check up to three times before considering it non-negotiable. Your insurance company does not cover this fee.
5. There is a $10 fee for copies of medical records. Please call the office to request medical records and allow 48-72 hours to be completed.
6. FMLA/Disability Forms: There is a $30 fee for each disability/FMLA form to be completed by our office. The fee is due at the time the form is turned in. Please allow 7 business days for the form to be completed.
7. SELF-PAY: We offer a discounted rate for patients with no insurance. To receive the discount, payment is due at time of service.
8. Should your account become delinquent and assigned to a collection agency, you agree to pay an additional collection charge of 35% of the outstanding balance or a minimum of $40, whichever is greater to offset in part the collection agency's fee charged to this practice. Should legal action be initiated by the collection agency, I agree to pay a collection charge of 50% of the outstanding balance as well as all costs and reasonable attorney fees incurred in such collection efforts by this office or our assignee.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of Arvada Foot and Ankle Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the notice.

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have coverage with the insurance company(ies) disclosed and assign directly to Arvada Foot and Ankle and its podiatrists, all insurance benefits, if any, otherwise payable to me for service(s) rendered. I understand that I am financially responsible for any co-payments, deductibles, co-insurance or balances whether or not paid by my insurance. I agree that should my account become delinquent and is referred to a collection agency, I will be responsible for any collection fees, court costs, reasonable attorney fees, or returned check fees.

Photo Identification: Patients must present with a photo ID issued by a local, state, or federal government agency (driver's 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. Guardians must have a Power of Attorney or written notice from a parent giving permission for guardian to approve care of the minor.

Patient Name (printed): _____
Signature of Patient: _____ **Date:** _____
or
Signature of Authorized Representative: _____
Date: _____
(legal guardian, power of attorney)

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Authorization for Disclosure of Protected Health Information

(This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy standards)

Name of Patient: _____ **Date of Birth**: _____

I authorize Arvada Foot and Ankle to contact me in the manner below:

- ☐ Phone
- ☐ Email
- ☐ Mail

I authorize Arvada Foot and Ankle to disclose protected health information to:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

The following health information:

- ☐ All of my health information
- ☐ Messages requesting a call-back from the patient only
- ☐ My health information relating to the following treatment condition:

_____

Patient Rights:

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission, I may not be ablet to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA privacy standards.

I understand that treatment by any party may not be conditioned upon my signing of the authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of the authorization after I have signed it. A copy of the authorization is as valid as the original.

Signature of Patient: _____ **Date**: _____

or

Signature of Authorized Representative _____ **Date:** _____

(legal guardian, power of attorney)

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Credit Card Authorization

This page is optional

The undersigned agrees and authorizes Arvada Foot and Ankle PLLC to save the credit card(s) indicated below on file.

Card Type: Mastercard / Visa / American Express / Discover / Other
(circle one)

Card Number: _____

Expiration Date: ____ /____

CVV: _____

Billing Address:

☐ same as previously stated

_____ _____ _____ _____
Address City State ZIP

☐ I authorize Arvada Foot and Ankle PLLC to process above credit card as "Card on File" and charge in accordance with the agreed upon payment plan between the practice and me (e.g. one time charge, monthly payment plan, etc). I understand this authorization will remain in effect until the expiration of the credit card account. Patient may also revoke this form by submitting a written request to the medical practice.

☐ By checking this box, I agree to use electronic records and signatures and I acknowledge that I have read the related consumer disclosure.

Patient Name: _____
(Printed)

Signature of Patient: _____ **Date:** _____
(or Authorized Representative)