The Colorado Foot and Ankle Clinic

Robert M. Smith, DPM
630 Coffman St. Unit A
Longmont, Co 80501
Phone 303.974.7474 Fax 303.997.1085

PATIENT INFORMATION

(information kept confidential)

Name:_____ ☐ FEMALE ☐ MALE

Date of Birth ____/____/____ E-mail _____
By what name would you like to be addressed in our office? _____

Home Address: _____
(Street Address)

_____
(City) *(State)* *(Zip Code)*

Home Phone #: (_____)_____ -_____ Patient's SSN :_____-_____-_____

Patient's Employer _____ Patient's Work or Cell _____
(if applicable)

Name of Spouse _____Spouse's Employer_____
(if applicable)

Emergency Contact: Name: **Phone number:**

Name of Parents/Guardians (if patient is minor/child):
Mother's Name: _____Work Phone:_____
Father's Name: _____-_____Work Phone:_____

Whom may we thank for referring you to our office? _____

RESPONSIBLE FOR BILL:

☐SELF ☐ FATHER ☐WIFE ☐HUSBAND ☐ MOTHER ☐ OTHER_____

INSURANCE INFORMATION: Required- Please Fill Out!

Primary Insurance Carrier: (Insurance Company)

_____)_____

Primary Member Name_____Member's Date of birth: _____

Secondary/Supplemental Carrier: (Insurance Company)

_____

Member Name:_____Member's Date of birth:_____

==========

***Primary Care Physician:** _____Date of Last Visit_____

Has he/she requested that you be seen in our office? _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Specify

Race:
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Patient Declined to Specify

The Colorado Foot and Ankle Clinic

Robert M. Smith, DPM
630 Coffman St. Unit A
Longmont, Co 80501
Phone 303.974.7474 Fax 303.997.1085

MEDICAL INFORMATION
(CONFIDENTIAL)

Patient Name:_____ Age_____

Height _____ Weight_____ Shoe Size_____

What condition, or symptoms are you being seen for today?_____

WHERE is the problem? And on which foot? _____

How long have you had it?_____

How intense would you rate your pain? (please circle) 1 2 3 4 5 6 7 8 9 10

What aggravates it, or makes it worse?_____

What makes it feel better?_____

What treatments have you had or tried yourself?_____

MEDICAL HISTORY: Do **you** have a history of any of the following?

___Diabetes
___Heart Disease
___Rheumatic fever
___High Blood Pressure
___Gout
___Stroke
___Seizures
___Cancer(type?)_____
___Arthritis –___ Rheumatoid ___Osteoarthritis
___Stomach ulcers
___Hepatitis/Liver problems
___HIV Positive
___Kidney disease
___Tuberculosis
___Keloids
___Circulatory problems
___Phlebitis/blood clots

Any other Significant Health problems?_____

Have **you** had any of the following conditions **recently**?

___Excessive bleeding	___Poor healing	___Leg cramps	___Excessive fatigue
___Immune system problems	___Problems hearing	___Shortness of breath	___Frequent headaches
___Large weight change	___Chest pain	___Excessive coughing	___Frequent urination
___Frequent sore throat	___Digestive problems	___Neuropathy	___Frequent thirst
___Swollen glands	___Thyroid problems	___Skin rashes	___Anemia
___Varicose veins	___Back Pain	___Joint pain/stiffness	___Muscle weakness
___Swelling	___Depression	___Frequent anxiety	___Psychiatric history
___Neurologic problems	___Numbness	___Currently pregnant	

List any previous significant **injuries** and dates (broken bones, sprains, etc.) _____

_____

Other problems or conditions not listed above: _____

_____

Family doctor and other doctors you are currently seeing: _____

Date of last visit with them?_____

SURGERY:
PLEASE LIST ANY PREVIOUS SURGERIES AND DATES:

PLEASE LIST ALL ENVIRONMENTAL, FOOD AND DRUG ALLERGIES BELOW

Or check here if you have no known drug allergies ☐

ALLERGY	LOCATION	REACTION	SEVERITY (include approximate start date)

SOCIAL HISTORY
Exercise, Sports, or Recreational Activities _____
How many times per week? _____
Marital Status: Single Married Separated Divorced Widowed

Use of Alcohol: Never Occasional Moderate Daily

Street Drug Use: Never Rare Daily Previous

Smoking: Never Former/When quit _____Current/packs per day _____

FAMILY HISTORY
Please list diseases common to your family including heart disease, diabetes, rheumatoid diseases, arthritis, and genetic problems.
Grandparents: _____
Father: _____
Mother: _____
Siblings:_____

The Colorado Foot and Ankle Clinic

Robert M. Smith, DPM
630 Coffman St. Unit A
Longmont, Co 80501
Phone 303.974.7474 Fax 303.997.1085

CURRENT MEDICATIONS: PLEASE LIST BELOW

MEDICATION	HOW OFTEN?	STRENGTH	REASON FOR MEDICATION, COMMENT (include approximate start date)

SUPPLEMENTS: Please list any supplements you are currently taking (including herbal medications):

_____ _____ _____

_____ _____ _____

_____ _____ _____

The Colorado Foot and Ankle Clinic
Robert M. Smith, DPM
630 Coffman St. Unit A
Longmont, Co 80501
Phone 303.974.7474 Fax 303.997.1085

FINANCIAL POLICY

We welcome you to our practice and are glad you have chosen us for your care. Please understand that our credit and financial policies are a necessary part of the medical business to maintain the vital health care service for our patients.

Payment for services is due at the time the services are rendered. We accept most major private insurers and Medicare. If you have questions regarding this please ask. We accept Cash, Checks, Mastercard, Visa, American Express and Discover. The only exception to this policy is if you are a member of certain managed care insurance companies with whom our office has a participation agreement (please ask our office staff whether your insurance is included in these) or if previous written arrangements have been made with our office staff. Returned checks will incur a $25 service charge.

PLEASE NOTE: We do NOT accept MedicCAID as a primary carrier, and will only accept Medicaid as a secondary carrier to MediCARE. As a courtesy to our patients, if you have provided us with all appropriate insurance information, our billing service will contact supplemental plans for deductible amounts or co-insurance amounts, however, we will not bill to secondary plans for co-pay amounts less than $25.00.

Each patient is responsible for initiating and securing REFERRALS from his/her Primary Care Physician (if required) by your specific insurance policy. *This authorization by the patient's Primary* Care *Physician must be completed prior to the appointment date.* If the authorization has not been secured in advance, it may be necessary that the patient sign a waiver form, accepting responsibility for all charges incurred on that day's visit **or** patient may choose to reschedule appointment. ***Please keep us updated on all aspects of your insurance information.*** **Please have insurance card available with you at every office visit, as we may ask to copy it at any given time.**

Please be aware of any deductible you may have with your insurance company. Although we accept your insurance, some plans have yearly deductibles, and you may ultimately be responsible for charges if you have not met your plans deductible. We will make every effort to bill applicable insurers, but please be aware that we are not responsible for deductibles or coverage related to your policy specifics.

If unusual circumstances should make it impossible for you to meet our credit terms, we make every effort to help with a payment plan or financing. Contact us to avoid misunderstandings, and enable you to keep your account in good standing. Except when previous credit arrangements have been made, accounts which are 60 days past due may be referred to a collection agency.

Please feel free to contact our office or billing agency any insurance problems or questions. Our office staff would be happy to assist you. Thank you for your cooperation.

I agree to notify you of any changes in my health status or insurance information.

I understand and agree (regardless of my insurance status) that I am responsible for the balance on my account for any professional services rendered. I have read all the information on each page. I certify that this information is correct to the best of my knowledge.

Patient's Name (or Parent or Guardian) *Date*

The Colorado Foot and Ankle Clinic

Robert M. Smith, DPM
630 Coffman St. Unit A
Longmont, Co 80501
Phone 303.974.7474 Fax 303.997.1085

THE COLORADO FOOT AND ANKLE CLINIC, (ROBERT M.SMITH DPM, PC)

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for THE COLORADO FOOT AND ANKLE CLINIC, (ROBERT M.SMITH DPM, PC) to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (DBA The Colorado foot and ankle Center, Notice of Privacy Practices provides a more complete description of such uses and disclosures.) I have the right to review the Notice of Privacy Practices prior to signing this consent. THE COLORADO FOOT AND ANKLE CLINIC (ROBERT M.SMITH DPM, PC) reserves the right to revise the Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to THE COLORADO FOOT AND ANKLE CLINIC Privacy Officer at 14391 W. 2nd Pl, Golden, CO 80401.

With this consent, The Colorado foot and ankle clinic, Robert M. Smith DPM, PC, may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With this consent The Colorado foot and ankle clinic, Robert M. Smith DPM, PC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. With this consent The Colorado foot and ankle clinic, Robert M. Smith DPM, PC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that The Colorado foot and ankle clinic, Robert M. Smith DPM, PC restrict how it uses my PHI to carry out TPO. However, the practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement. By signing this form, I am consenting to The Colorado foot and ankle clinic, Robert M. Smith DPM, PC use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, The Colorado foot and ankle clinic, Robert M. Smith DPM, PC may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Patient's Name

_____

Print Name of Legal Guardian (if applicable)

The Colorado Foot and Ankle Clinic
Robert M. Smith, DPM
630 Coffman St. Unit A
Longmont, Co 80501
Phone 303.974.7474 Fax 303.997.1085

ACKNOWLEDGEMENT OF RECEIPT
of
NOTICE OF PRIVACY PRACTICES

I ACKNOWLEDGE that I can be provided a copy of the
Summary of Notice of Privacy Practices.
I may request and receive a copy of the full Notice of Privacy Practices anytime during normal business office hours or one may be sent to me. I agree to call or otherwise contact the office of The Colorado Foot and Ankle Clinic, PC, if I have any questions regarding these practices.

PATIENT NAME:_____**DATE:**_____
(PLEASE PRINT)

_____
PARENT or AUTHORIZED REPRESENTATIVE (if applicable)

_____
SIGNATURE