Elevation Foot and Ankle

3445 E. 28th Ave., Denver, CO 80205 (303)-388-0976, Fax 303-388-0978

NEW PATIENT/ INSURANCE INFORMATION

Last Name:_____First Name_____Middle Initial____ Birth Date_____

Street_____City_____State_____Zip_____Preferred Phone_____

Email_____ Appt. Reminder: (Circle One) Phone E-Mail

Marital Status (Circle One) Single Married Separated Divorced Widowed Sex: M F

Ethnicity_____ Primary Language_____

Employer_____Occupation_____Length at this job_____

IN CASE OF EMERGENCY, CONTACT

Name_____Relationship_____Phone Number_____

Primary Care Doctor_____ Date of Last Visit_____

How Referred: (Circle One) Doctor: By Whom _____ Friend/Family: By Whom _____ Internet Insurance

Insurance Information

Who is responsible for the payment of this account: _____ Relationship of this person to you_____

INSURANCE

Name of Insured: _____ Name of Insurance Company _____

Member ID _____Group Number _____ Ins Phone Number_____

Secondary Insurance

Name of Insured_____ Name of Insurance Company _____

Member ID _____ Group Number _____ Ins Phone Number_____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Elevation Foot and Ankle all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all insurance submissions.

Signature _____ Date _____

Medicare Authorization

I request that payment of authorized Medicare benefits be made on my behalf to Elevation Foot and Ankle for any services furnished to me by that physician. I authorize any holder of medical information about me to release to Elevation Foot and Ankle and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCJA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

Beneficiary Signature: _____ Date _____

Confidential Communications

I request that all written/oral communications to me (by telephone, mail, or otherwise) by Elevation Foot and Ankle and/or its staff be handled by using the above address and telephone number. I am responsible to notify the office of any change of above.

May we leave a message? YES_____ NO:_____

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Name _____ Age _____ Height _____ Weight _____

Other Specialists/Doctors you see: _____

Allergies: (Circle those that apply)

Tape	Rubber/latex	Metal/nickel	Seafood/shellfish
Penicillin	Iodine	Aspirin	Sulfa
Codeine	Local anesthetics	Other_____	

List of Medications you are currently taking:

Name of Medication	Dose	Frequency	Reason for taking	Who Prescribed

List Pharmacy that you use: _____ Pharmacy Location _____-

SURGERY – Indicate what type and year

_____

_____

_____

HOSPITALIZATION – (not for surgery) List reason and year

_____

_____

_____

Other General Important Health Questions:

Do you smoke? **YES/NO**
How many packs per day? _____
Do you drink alcohol? **YES/NO**
How many drinks per day? _____
Do you drink caffeinated beverages? **YES.NO**

Have you experienced 2 falls OR any falls with injury in the last year? **YES/NO**
Have you received an influenza vaccination this year? **YES/NO**
Have you received a pneumonia vaccination this year? **YES/NO**

FOOT AND ANKLE HISTORY

What problems bring you to the doctor today? _____

Have you ever broken a bone in your foot or ankle? YES NO Which bone _____ When _____

Have you had problems with this area since that time? YES NO What problem _____

What do your symptoms feel like?
Aching Burning Cramping Dull Itching Pressure Like Pulling Sharp Shooting Sore Stabbing Tender Tingling/Numbness

What makes the symptoms worse?
Standing Walking Running Sitting Lying Down Certain Shoes Other _____

What makes the symptoms better?
Nothing Rest Ice Heat Ibuprofen Changing Shoes Periodic Footcare Other: _____

What prior treatment has been attempted?
None Rest Ice Heat NSAID's Physical Therapy OTC Arch Supports Changing Shoes Periodic Footcare Custom Orthotics Topical RX Prescription RX OTC Topical

Do you have any **Back Pain**? Yes No **Knee Pain**? Yes No **Hip Pain?** Yes No

What is your normal shoe size _____ Have you ever been to a podiatrist before? YES NO

PLEASE CIRCLE ANY OF THE FOLLOWING DIAGNOSES THAT YOU HAVE HAD:

Anemia
Arthritis
Asthma
Back Pain
Bleeding Disorders
Cancer
Diabetes
Gout
Heart Disease
Hepatitis
High Blood Pressure
High Cholesterol
Kidney Disease
Liver Disease
Lung Problems
Neck Pain
Numbness in Feet
Poor Circulation
Stroke
Other _____

FAMILY HISTORY

What illnesses/conditions/diagnoses are in your family?

	Father	Mother	Sibling	Grandparent
No Known Problems				
Anemia				
Arthritis				
Asthma				
Blood Clots				
Cancer				
Dementia				
Diabetes				
Gout				
Heart Disease				
Hepatitis				
High Blood Pressure				
High Cholesterol				
Kidney Disease				
Liver Disease				
Lung Disease				
Mental Illness				
Numbness in Feet				
Poor Circulation				
Stroke				
Thyroid				
Other----				

ELEVATION FOOT AND ANKLE OFFICE POLICIES

INSURANCE POLICY
Due to recent changes in insurance policies, we have had a few claims denied due to lack of referrals from primary care doctors and not being in-network with your particular policy. Please check with your insurance to find out if we are "in-network" with your policy and if you need a referral.
Your insurance policy is a contract between you and your insurance company; therefore, you are responsible for payment whether or not your insurance company pays. If proper authorizations or referrals are not obtained, this may reduce the benefits paid by your insurance company making this patient responsibility.
Definition of "**covered":** The insurance company "covers" the service of item. Remaining fees with co-insurance and deductibles apply to the patient.

SELF PAY
Payment in full is due at the time of service if you do not have health insurance or a health plan we participate with.

NEW PATIENT AND PROCEDURE DEPOSITS
Based on your deductible and amount met, we may take a deposit for your visit. This deposit will be applied to your billed responsible amount. Any refund owed will be re-issued via our billing department at the end of the billing month.

COPY FEE
We reserve the right to charge a $25.00 fee for work leave/disability forms over five pages in length.

COLLECTIONS POLICY
In case of default payment, you agree to pay any and all costs of collecting this account including, but not limited to, attorney fees, court costs, and collection agency fees.

NO SHOW POLICY/CANCELLATION POLICY
If you cannot keep your appointment time, please call our office at 24 hours prior to your scheduled appointment time. We reserve the right to charge for appointments cancelled or broken without the requisite notice. There may be a $25.00 fee for any appointment canceled or rescheduled within 24 hours of the scheduled time and a missed appointment time. If you miss 2 or more appointments, you may be required to pay a $50.00 deposit to hold any future appointment time slots. If you arrive late for an appointment, we may need to reschedule your appointment to another time or day. Repeated missed or late appointments may result in dismissal from our practice.
If your scheduled appointment was for **SURGERY** outside our office, you will be charged **$200.00** for your missed surgery. (If notice is received less than 48 hours prior to surgery)

PRIVACY STATEMENT
Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing the highest quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

DURABLE MEDICAL EQUIPMENT
These items include, but are not limited to: Walking Boots, Night Splint, Braces, Custom Orthotics, and Ped Pillow Inserts and any accommodative over the counter items. These **MAY** be able to be submitted to your insurance. Items listed above are NON-RETURNABLE. We are restricted from re-selling items that have been taken from this office due to health regulations.

Most insurance companies do cover the cost of medically necessary walking casts. However, some insurance policies have restrictions which are usually specified in your booklet of insurance benefits. If you have benefits, the fee will be billed to your insurance carrier. **Should the insurance company deny payment, it is your responsibility to pay $150.00 for the walking cast.**

PROTECTED HEALTH INFORMATION
Elevation Foot and Ankle wants to ensure your privacy. This form is intended to give you the opportunity to release medical information to designated parties (this does not apply to minors under the age of 18).

You may release pertinent medical information related to diagnosis and treatment from my office visits to the following parties:

Name_____ Relationship_____ Phone_____

Name_____ Relationship _____Phone _____

Your name: _____ Signature: _____ Date: _____

SUMMARY OF NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices contains a detailed description of how our office will protect your health information as set forth by HIPAA, 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 may 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.

- 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 law

Patient Rights

- To have access to and/or a copy of your health information
- To receive and 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 we amend your health information
- To receive notice of our privacy practices.

By signing this document you acknowledge having read and understood the above information. You also understand that there is a copy of the APMA HIPAA Manual available to you at the front desk of Elevation Foot and Ankle and that you have access to view it at any time. Please contact the Privacy Office of Elevation Foot and Ankle at 303-388-0976 with any questions.

CONSENT FOR TREATMENT

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Elevation Foot and Ankle, PLLC all insurance benefits payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, co-insurance, non-covered services and other fees AT THE TIME OF SERVICE. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I understand that my agreement with the insurance company is between me and the insurance company and that my doctor will bill them as a courtesy to me. I further understand that I am responsible for any unpaid balance on my account. I also understand that it is my responsibility to ensure that the doctor I see is a provider for my insurance and that I can be held accountable if they are not. I authorize Release of Medical Information to my insurance carrier or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions. I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information and acknowledge I was provided with a copy of the Notice of Privacy Practices and understand and accept its terms.

I hereby give my permission to Elevation Foot and Ankle, PLLC and Dr. Ronnie Pollard to administer treatment with proper informed consent and to perform the necessary procedures in the diagnoses and treatment of my condition:

PRINT Patient Name: _____ Signature: _____

If patient is under 18, please complete the following for the FINANCIALLY RESPONSIBLE PARTY:

PRINT Name: _____Signature: _____

Relationship to Patient: _____ Date: _____