PODIATRY ASSOCIATES, P.C.

CASTLE PINES PHYSICAL THERAPY

www.footdoctorscolorado.com
www.castlepinesphysicaltherapy.com
Phone: 303-805-5156
Fax: 303-805-5157

Castle Pines Foot and Ankle Clinic, P.C.
7505 Village Square Dr., Ste. 101
Castle Pines, CO 80108

Parker Foot and Ankle Clinic, P.C.
9397 Crown Crest Blvd., Ste. 311
Parker, CO 80138

Podiatry Associates at Cherry Creek, P.C.
300 S. Jackson St., Ste. 310
Denver, CO 80209

Podiatry Associates at Aurora
1444 S. Potomac St., Ste. 230
Aurora, CO 80012

PERMISSIONS

I hereby give my permission for any physician, physician's assistant or physical therapist employed by Podiatry Associates, P.C. to release any necessary information, including but not limited to: office notes, lab/test results, operative reports, etc. to my primary physician, any specialist I am being referred to, or any outpatient facility that may require my personal or medical information (i.e. physical therapy facility, outpatient surgery centers, radiology facilities, etc.).

I authorize Podiatry Associates, P.C.; Castle Pines Physical Therapy, P.C. to furnish a copy of medical or other information of any claims under Title XVIII of the Social Security Act and its intermediaries, or to an authorized person.

I understand that if I am seen on a referral, the physician may require the treatment notes to be sent to them in order to extend or renew my referral.

I authorize treatment for services rendered and ordered by the physician, physician's assistant or physical therapist.

X_____ **Date:** _____

I authorize the release of any medical information necessary to process this bill to my insurance company and request payment of benefits to Podiatry Associates, P.C. I acknowledge that I am financially responsible for payment whether or not the procedure is covered by my insurance.

X_____ **Date:** _____

NOTICES OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices or was given the opportunity to read the Notice of Privacy Practices and understand the notice.

X_____ **Date:** _____

CONFIDENTIALITY POLICY

I understand that all health information that I have disclosed and/or all information discussed in office visits with the physician, physician's assistant or physical therapist is confidential and can only be released with my permission.

I give my permission to speak with, and give detailed information to, the person(s) indicated below. Please select all that are applicable and fill in the required information:

( ) **Self:** You may leave a detailed voicemail at the following **phone number**: _____

( ) **Authorized (secondary) contact:** _____ **Relationship:** _____

Phone number: _____ May we leave a detailed message on this voicemail? O Yes O No

Signature: _____ **Date:** _____

PODIATRY ASSOCIATES, P.C.

CASTLE PINES PHYSICAL THERAPY

www.footdoctorscolorado.com
www.castlepinesphysicaltherapy.com
Phone: 303-805-5156
Fax: 303-805-5157

Castle Pines Foot and Ankle Clinic, P.C.
7505 Village Square Dr., Ste. 101
Castle Pines, CO 80108

Parker Foot and Ankle Clinic, P.C.
9397 Crown Crest Blvd., Ste. 311
Parker, CO 80138

Podiatry Associates at Cherry Creek, P.C.
300 S. Jackson St., Ste. 310
Denver, CO 80209

Podiatry Associates at Aurora
1444 S. Potomac St., Ste. 230
Aurora, CO 80012

AUTHORIZATION FROM PATIENT OR LEGAL REPRESENTATIVE

Podiatry Associates, P.C. (Herein after collectively referred to as "PA")

1. Consent to treat: The undersigned consents to any initial or follow-up evaluations, examinations, x-rays, laboratory procedures, other tests, medications, medical treatment, surgery, physical therapy, home instructions, orthotics, other durable medical equipment, photographing and/or videotaping and/or other services rendered to the patient by PA and its providers. The undersign agrees that it is their responsibility to contact and/or schedule with PA for any follow up visits, other services, prescriptions and items ordered for the patient. The undersigned also understands that PA providers exercise their care with reasonable skill and diligence, but make no guarantee as to the results or cure that will be attained.

2. Assignment of benefits: I hereby irrevocably assign, transfer and convey to PA and any practitioner providing care and treatment to me/my child, any and all benefits and all interest and rights (including causes of action, the right to enforce payment and the right to appeal an adverse benefit determination) to which I am entitled under an employee benefit plan sponsored by my employer, all insurance policies, benefits, any third-party reimbursement, or prepaid health care plan for services rendered or products I received from PA.

3. Medicare assignment: I certify that the information given by me in applying for payment under XVIII of the Social Security Act is correct and agree to complete the Medicare screening form annually. I authorize the release of information concerning me to the Social Security Administration or its intermediaries as well as any information needed for filing a Medicare claim; I request that payment and authorized benefits be made on my behalf. I assign benefits payable for services to PA.

4. Authorization to release information: I consent and authorize PA and its agents to release my health information for payment, treatment, and healthcare operations to any of the following: insurance company and its affiliates, any practitioner, support staff or facility involved in my plan of care or transfer of care. In addition, I understand that the potential uses and disclosures of my Health Information are detailed in the Privacy notice. The HIPAA Notice of Privacy Practices are available online at www.footdoctorscolorado.com. Individual copies are also available in the office upon request and posted in the hallway adjacent to Reception. I have read/had the opportunity to read my HIPAA rights, which include PA's fees for records.

5. Designation of authorized representative: I designate and appoint PA (and its agents) as my authorized representative and authorize it to act on my behalf to 1) request and receive a copy of the summary plan description, 2) pursue a benefit claim, 3) appeal and adverse benefit determination, and/or 4) file a legal/equitable action to recover benefits from my employee benefit plan, insurance policy, and any third-party reimbursement or prepaid health care plan. I understand and agree that my authorized representative shall have full authority to act, and receive notices, on my behalf with respect to an initial determination of the claim for health benefits relating to treatment and health care services received by me/my child at PA, any requests for documents relating to this claim and appeal of an adverse determination of the claim.

6. Financial agreement: I hereby promise to pay for all products received or services rendered to me/my child to the extent I am legally responsible for such payment. According to the language of the physician's insurance contract, I understand that I am responsible for all health insurance copayments, deductibles, coinsurances, OTC- over the counter convenience items and non-covered services and any other amounts that apply at the time of service or at the pre-operative appointment. Regardless of the assignment of benefits, should the insurance misrepresent their coverage or delay payment of a claim greater than 60 days, as the designated responsible party, I am responsible for all monies owed to PA. I also understand that the insurance policy is a contract between me and the insurance company; therefore, the policy holder should contact the insurance carrier first when there are questions regarding explanation of benefits. The benefits and determination of Durable Medical Equipment (DME) may vary greatly from plan, policy, and group contract. **Although we will call for predetermination and authorization when necessary, your eligibility for coverage and amount of benefits, at times, cannot be determined until a claim is received.** Should your insurance company decide that this DME is not a covered benefit, you do not have a valid referral, or they will not reimburse PA for these services, you will be fully responsible for these charges.

Therefore, you are requested to sign this waiver of financial responsibility, attesting that you understand that **you will be held financially responsible for the charges if they are not covered by your insurance,** or lack thereof.

I consent to the performance of the procedures necessary for my treatment rendered by the PA. **I fully understand I will be held financially responsible for the DME if my insurance, or lack thereof, fails to reimburse PA for the services.** The undersigned certifies that he/she has read and understands the foregoing statements 1-6, and is either the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accepts its terms. This document shall remain in force until a written revocation by me is delivered to PA.

Print name of patient or legal authorized representative | **Relationship to patient** | **Date**

Signature

PODIATRY ASSOCIATES, P.C.

CASTLE PINES PHYSICAL THERAPY

www.footdoctorscolorado.com
www.castlepinesphysicaltherapy.com
Phone: 303-805-5156
Fax: 303-805-5157

Castle Pines Foot and Ankle Clinic, P.C.
7505 Village Square Dr., Ste. 101
Castle Pines, CO 80108

Parker Foot and Ankle Clinic, P.C.
9397 Crown Crest Blvd., Ste. 311
Parker, CO 80138

Podiatry Associates at Cherry Creek, P.C.
300 S. Jackson St., Ste. 310
Denver, CO 80209

Podiatry Associates at Aurora
1444 S. Potomac St., Ste. 230
Aurora, CO 80012

Reading the following policies and procedures annually will keep you informed about our office:

1. **Appointments:** Physicians are available by appointment during posted hours. During a medical emergency, patients should seek care at the nearest emergency room or call 911. Other critical calls should page the on-call physician after hours.
2. **Refills and Medication:** Refills are completed via a pharmacy request. Contact your local pharmacy. Prescription refill requests can take up to 48 hours to be authorized.
3. **Messages**: Phone messages received before 3 PM are usually returned daily.
4. **Benefits:** Podiatry Associates, P.C. will reiterate the benefits that were disclosed to us by your insurance plan. We will then collect, based on the benefit level, all applicable copays, deductibles, coinsurances and balances that apply at the time of service or at the pre-operative appointment.
5. **Payment:** Podiatry Associates, P.C. accepts VISA, MasterCard, Discover, Cash or Check.
6. **Insurance Claims:** Podiatry Associates, P.C. files claims electronically for the patient's primary contracted plan and accepts payment via the patient's assignment. Podiatry Associates, P.C. files secondary claims if provided at time of service. If not provided patients may request itemized statements to file to multiple carriers.
7. **Multiple Policies:** When multiple policies exist, it is the policy holder's responsibility to inform Podiatry Associates, P.C. of their primary plan. Delayed filing to the primary plan can result in violating timely filing limits, resulting in a denial of service and full patient financial responsibility.
8. **Insurance Networks:** Podiatry Associates, P.C. only files claims to carriers whom we have a contractual relationship; our in-network list is available upon request or on our website.
9. **Liability Claims:** Podiatry Associates, P.C. does not accept personal injury protection, letters of protection or other liability claims. These types of claims are to be paid in full by the patient.
10. **Non-Covered Services:** Podiatry Associates, P.C. will not submit claims for non-covered items including, but not limited to cosmetic services and over the counter convenience items (OTC e.g. Biofreeze, Coban, Powerstep, Superfeet, Mycomist, etc…)
11. **Referrals:** Podiatry Associates, P.C. may refer patients to other providers, facilities, and labs. Podiatry Associates, P.C. is not responsible for these entities. The patient should contact these non- Podiatry Associates, P.C. providers, facilities or labs directly regarding any billing questions. The policy holder is also responsible for all insurance prior authorizations and/or managed care referrals necessary for payment to Podiatry Associates, P.C.
12. **Missed Appointments:** A $35 charge will apply for appointments missed or canceled without 24 hours advanced notice.
13. **Appointment Hold:** Repetitive broken appointments, non-compliance, hostile behavior, and/or financially deficient accounts will result in appointment hold and/or the termination of the Podiatry Associates, P.C. Doctor-Patient relationship. 30 days advance notice will be given should the situation result in a transfer of the patient's care.
14. **Delinquent Accounts:** Past due accounts are subject to collection proceedings and are reported to the credit bureau. All collection fees, interest, attorney fees and court fees shall become the patient/guarantor's responsibility in addition to the balance due the office.
15. **Returned Checks:** A $25.00 fee will be assessed on all returned checks. Any NSF or Closed Account will result in future services on a pre-pay cash or credit basis. The District Attorney's Office will prosecute unresolved checks.
16. **Refunds:** Podiatry Associates, P.C. issues patient refunds within 30 days of a completed investigation of the potential overpayment, as long as other outstanding charges have been resolved.
17. **Returns:** Only unworn and non-custom items are returnable within 3 days of receipt, if no visible signs of wear, tear, or odor. Custom items are tailored to meet individual needs; custom items are non-returnable, non-refundable.
18. **Medical Records:** The cost for copied medical records and completion of disability forms will be charged to the patient and collected prior to replicating. The fees for these services are regulated by HIPAA and Colorado state law. If a records request is submitted, Podiatry Associates, P.C. will make every effort to complete this request in a timely manner, but Podiatry Associates, P.C. does have up to 30 days to respond to this request.

The undersigned certifies that he/she has read and understands the foregoing 1-18 statements, and is either the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accepts its terms.

Print name of patient or legal authorized representative | **Relationship to patient** | **Date**

Signature

PODIATRY ASSOCIATES, P.C.

CASTLE PINES PHYSICAL THERAPY

www.footdoctorscolorado.com
www.castlepinesphysicaltherapy.com
Phone: 303-805-5156
Fax: 303-805-5157

Castle Pines Foot and Ankle Clinic, P.C.
7505 Village Square Dr., Ste. 101
Castle Pines, CO 80108

Parker Foot and Ankle Clinic, P.C.
9397 Crown Crest Blvd., Ste. 311
Parker, CO 80138

Podiatry Associates at Cherry Creek, P.C.
300 S. Jackson St., Ste. 310
Denver, CO 80209

Podiatry Associates at Aurora
1444 S. Potomac St., Ste. 230
Aurora, CO 80012

Date: _____

PATIENT INFORMATION

Last name: _____ **First name:** _____ **M.I.** _____

SSN: _____ **Date of birth:** _____ **Age:** _____ **Gender:** O M O F

Ethnicity:
O Not Hispanic/Latino
O Hispanic/Latino
O Unknown

Race:
O African American
O Asian
O Caucasian
O Hispanic
O Native American
O Other

Preferred language:
O English
O Spanish
O Other: _____

Employment:

O Disabled O Student O Full-time Employer name: _____

O Retired O Unemployed O Part-time Occupation: _____

O Self

Marital status: O Single O Married O Significant other O Separated O Divorced O Widowed

CONTACT INFORMATION

Mailing address: _____

City: _____ State: _____ Zip Code: _____

Phone: Home ( ) _____ Cell ( ) _____ Business ( ) _____

Preferred phone number: O Home O Cell O Business

E-mail: _____

Emergency contact: _____ Relationship: _____ Phone: ( ) _____

IMPORTANT INFORMATION

Is your visit due to a job related injury? O Yes O No Is your visit due to an automobile accident? O Yes O No

***If you answered yes to either of these questions, please notify the receptionist.**

PODIATRY ASSOCIATES, P.C.

CASTLE PINES PHYSICAL THERAPY

www.footdoctorscolorado.com
www.castlepinesphysicaltherapy.com
Phone: 303-805-5156
Fax: 303-805-5157

Castle Pines Foot and Ankle Clinic, P.C.
7505 Village Square Dr., Ste. 101
Castle Pines, CO 80108

Parker Foot and Ankle Clinic, P.C.
9397 Crown Crest Blvd., Ste. 311
Parker, CO 80138

Podiatry Associates at Cherry Creek, P.C.
300 S. Jackson St., Ste. 310
Denver, CO 80209

Podiatry Associates at Aurora
1444 S. Potomac St., Ste. 230
Aurora, CO 80012

Name: _____ **Date:** _____

In order for us to file a claim on your behalf, this section must be completed in its entirety

RESPONSIBLE PARTY FOR ACCOUNT (if different than patient)

Name: _____

Date of birth: _____ SSN: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip code: _____

Phone: Home ( )_____ Cell ( )_____ Business ( )_____

INSURANCE INFORMATION

Primary insurance name: _____ Plan type: O HMO O PPO O Other: _____

Policy#: _____ Group#: _____ Effective date: _____

Insured name: _____ Employer: _____

Date of birth: _____ SSN: _____ Relationship to patient: _____

SECONDARY INSURANCE

Secondary insurance name: _____ Plan type: O HMO O PPO O Other: _____

Policy#: _____ Group#: _____ Effective date: _____

Insured name: _____ Employer: _____

Date of birth: _____ SSN: _____ Relationship to patient: _____

PRIMARY CARE

Primary Care Physician: _____ Physician phone: ( )_____

Do you want us to provide your PCP with documentation of your visits? O Yes O No

REFERRAL

How did you hear about us?

O Physician reference: referring Physician's name and phone number: _____

O Google O Website O Facebook O Insurance directory O Yellow pages O Twitter O Pinterest O LinkedIn

O Patient or friend's name: _____ O Other (please specify): _____

PODIATRY
ASSOCIATES, P.C.

www.footdoctorscolorado.com
Phone: 303-805-5156
Fax: 303-805-5157

Castle Pines Foot and Ankle Clinic, P.C.
7505 Village Square Dr., Ste. 101
Castle Pines, CO 80108

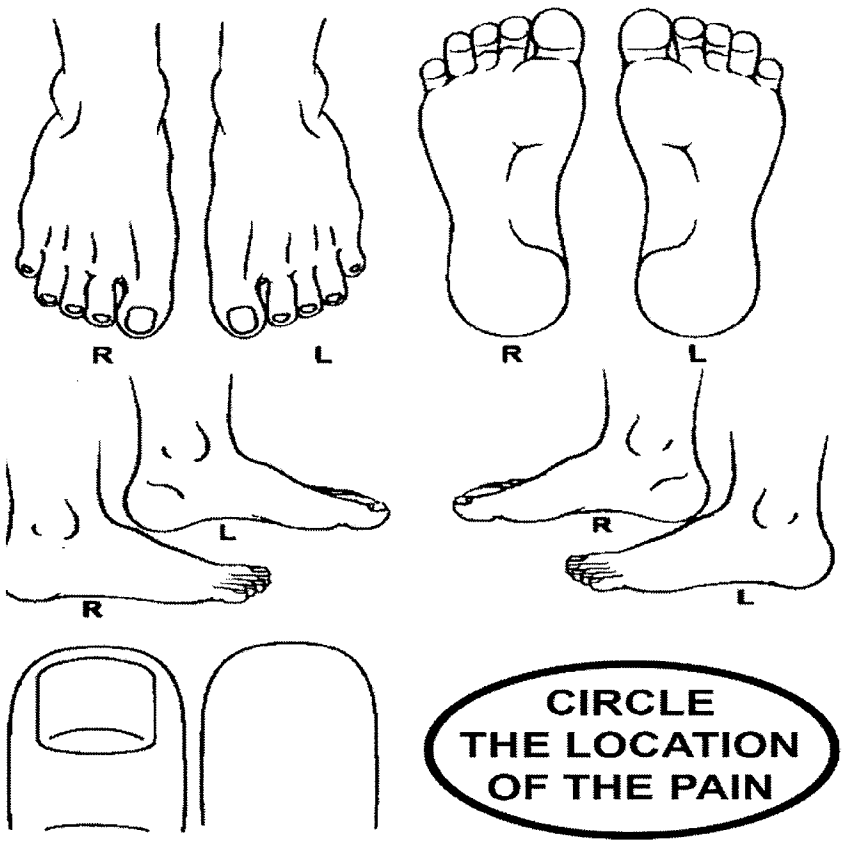
Parker Foot and Ankle Clinic, P.C.
9397 Crown Crest Blvd., Ste. 311
Parker, CO 80138

Podiatry Associates at Cherry Creek, P.C.
300 S. Jackson St., Ste. 310
Denver, CO 80209

Podiatry Associates at Aurora
1444 S. Potomac St., Ste. 230
Aurora, CO 80012

Name: _____ **Date:** _____

INITIAL PODIATRIC HISTORY



Description of symptoms: _____

_____

Injury? **O Yes.** Date of injury: _____ **O No.** When did your pain/disability start? _____

What treatments have you tried? _____

What makes it hurt? _____

What makes it better? _____

Do you have any additional problems with your feet or ankles that you would like treatment for? _____

_____

Name: _____ **Date:** _____

FAMILY HISTORY: Select all that apply.

CONDITION	RELATIVE	CONDITION	RELATIVE
O Arthritis		O Heart disease	
O Congenital deformity of foot *Specify:*		O Hypertension	
O Cancer		O Kidney disease	
O Deep venous thrombosis (blood clot in vein- usually in leg)		O Liver disease	
O Diabetes mellitus		O Malignant hyperthermia due to anesthesia	
O Drug allergy *Specify:*		O Mental disorder	
O Gout		O Pulmonary embolism (blood clot in lungs)	

PERSONAL HISTORY: If options are given, please indicate appropriately.

Height: _____ **Weight:** _____ **Shoe size:** _____ **Shoe width:** _____

Marijuana use: O No O Yes **Recreational drug use:** O No O Yes: *Please specify:* _____

Tobacco use: O Former O Current: *How many years and how much per day?* _____ O Never

Alcohol use: O Social drinker O Moderate: 1-2 per day O More than 2 per day O Never

Exercise: O Occasionally O Moderate: 1-3 times a week O Exercise regularly O Never

Pregnant? O No O Yes: *Expected delivery date:* _____

Current Medications: List ALL medications you take. Include all prescriptions, over-the-counter medications, herbal and vitamin/mineral/dietary (nutritional) supplements.

MEDICATION (name)	DOSAGE (mg, cc, ml, etc.)	FREQUENCY (daily, twice daily, weekly, etc.)	ROUTE (oral, injection, topical, etc.)

**Please attach additional sheet if needed.*

Pharmacy: _____ **City/Phone#:** _____

Name: _____ **Date:** _____

Allergies: Select all that apply.

ALLERGEN	REACTION
O Adhesive tape	
O Anesthesia	
O Aspirin	
O Codeine (pain medication)	
O Iodine	
O Latex	
O Morphine	
O NSAIDs	
O Penicillin	
O Sulfa drugs	
O Antibiotic(s) (not already listed):	
O Other:	

MEDICAL HISTORY: Please tell us about your medical history and any recent/current symptoms you've been experiencing. Select all that apply and fill in the blank as needed.

List any serious injuries and the age at which they occurred: _____

_____

List all surgeries in the last 5 years: _____

_____

Cardio-vascular:

O Calf pain on walking
O Chest pain
O Edema (swelling from excess fluid)
O Heart attack
O Heart murmur
O Hypertension (high blood pressure)
O Night sweats
O Other heart problem(s): _____
O Orthopnea (shortness of breath when lying flat)
O Pacemaker
O Palpitations
O Stroke
O Syncope (fainting)
O Varicose veins

Constitutional:

O Recent: chills diarrhea fever general fatigue general weakness nausea vomiting

Name: _____ **Date:** _____

Ears/Nose/Throat:

O Dentures O Recent difficulty with smelling O Ringing of ears O Sinusitis
O Difficult hearing O Recent loss of hearing O Postnasal drip O Sore throat
O Frequency of infection: ear(s) nose throat sinus

Specify location(s): O Bleeding: _____ O Discharge: _____ O Sore(s): _____

Endocrine:

O Gout O Hyperthyroidism (high) O Hypothyroidism (low)

O Diabetes, Type 1
O Diabetes, Type 2
Treating doctor: _____

Eyes:

O Blurring O Double vision O Pain O Wear corrective lenses
O Cataract O Floaters O Recent (significant) visual change
O Discharge O Glaucoma O Retinopathy

Gastrointestinal:

O Abdominal pain O Food intolerance O Recent change in: appetite bowel habit
O Blood in stool O Gall bladder problems O Recent difficulty with: swallowing tasting
O Constipation O Hernia O Stomach ulcer
O Dyspepsia (indigestion/GERD) O Painful swallowing

Genitourinary:

O Discharge with urination O Hematuria (blood in urine) O Prostate problem
O Dysuria (painful urination) O Incontinence O Urgency of urination
O Frequency of urination O Kidney function problem(s)

Hematologic:

O Anemia O HIV/AIDS
O Bleeding disorder: _____ O PE (blood clot in lungs)
O DVT (blood clot in vein- usually in leg) O Take blood thinner: *Please list:* _____

Specify location(s): O Bleeding: _____ O Bruising: _____

Integument:

O Eczema O MRSA O Psoriasis O Skin cancer (feet and/or legs)

Specify location(s): O Hives: _____ O Itching: _____ O Skin rash: _____

Liver:

O Hepatitis, Type: A B C D E G O Jaundice O Liver problem(s): _____

Name: _____ **Date:** _____

Musculoskeletal:

O Bursitis
O Club foot: ___right ___left
O Deficiency: calcium vitamin D
O Low back pain
O Osteoarthritis
O Osteopenia
O Osteoporosis
O Rheumatoid arthritis
O Sciatica

O Other congenital foot deformity: _____

Specify location(s):

O Fracture(s) of foot and/or leg: _____
O Metal and/or implants in body: _____
O Muscle pain: _____
O Recent sprain(s): _____
O Stiffness: _____
O Swelling: _____
O Weakness: _____

Neurologic:

O Convulsions
O Fainting
O History of falls
O Incoordination (balance problems while walking)
O Migraines
O Multiple Sclerosis
O Neuropathy
O Other neurologic condition: _____
O Paralysis
O Speech problems
O Weakness

Specify location(s): O Numbness: _____ O Tingling: _____ O Burning: _____

Psychosocial:

O Anxiety
O Depression
O Recent change in lifestyle: *Please specify:* _____
O Recent stressors: *Please specify:* _____

Respiratory:

O Asthma
O Bronchitis
O Emphysema
O Hemoptysis (coughing blood)
O Persistent cough
O Shortness of breath
O Sleep apnea
O Sputum production (coughing up mucus)
O Wheezing

O Other lung problems: _____

Do you have any other medical conditions, not indicated above? _____

_____

_____

Signature: _____ **Date:** _____

Name: ____ **Date:** ________________________________

CURRENT MEDICATIONS

MEDICATION (name)	**DOSAGE** (mg, cc, ml, etc.)	**FREQUENCY** (daily, twice daily, weekly, etc.)	**ROUTE** (oral, injection, topical, etc.)