Cynthia Oberholtzer-Classen, DPM, FACFAS
Adam Toren, DPM, MBA, AACFAS
Paul Fawson, DPM
Jennifer Molner, PT, DPT
www.footdoctorscolorado.com
www.castlepinesphysicaltherapy.com

Castle Pines Foot and Ankle Clinic, PC
Castle Pines Physical Therapy and Spa, PC
7505 Village Square Drive, Suite 101, Castle Pines, CO 80108
P: 303-805-5156

Podiatry Associates at Cherry Creek
Cherry Creek Physical Therapy and Spa
300 S. Jackson St, Suite 310
Denver, CO 80209

Parker Foot and Ankle Clinic, PC
9397 Crown Crest Boulevard, Alpine Bldg., Suite 311
Parker, Colorado 80138
Fax: 303-805-5157

Patient Information:

Date: _____

First Name:_____ Last Name:_____ M.I._____

Suffix (Jr., Sr., III):_____ SS#_____ Age:_____ Date of Birth:_____

Marital Status: ◯Married ◯Single ◯Domestic Partner ◯Divorced ◯Separated ◯Widowed ◯Minor

Gender: ◯M ◯F Preferred Language: ◯English ◯Spanish ◯Other _____

Ethnicity: ◯Not Hispanic/Latino ◯Hispanic/Latino ◯Unknown

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

Address:_____ City: _____ State: ____ Zip Code: _____

Contact Information: Home ( )_____ Cell ( )_____ Business ( )_____

Preferred contact: ◯Home ◯Business ◯Cell May we leave a detailed message at that number?: ◯Yes ◯No

E-mail: _____

Employed: ◯Yes ◯No Employer Name: _____ Occupation: _____

Emergency Contact: _____ Relation: _____ Phone: ( )_____

Primary Care Physician: _____ Physician Phone #: ( )_____

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

---

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: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Contact Information: Home ( )_____ Cell ( )_____ Business ( )_____

Insurance Information:

Primary Insurance Name: _____ Plan Type: ◯ HMO ◯ PPO ◯ Other: _____

Policy#: _____ Group#: _____ Effective Date: _____

Insured Name: _____ Employer: _____

Date of Birth: _____ SSN: _____ Relationship to Patient: _____

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Name: _____

Date: _____

Secondary Insurance:

Secondary Insurance Name: _____ Plan Type: ◯HMO ◯PPO ◯Other: _____

Policy#: _____ Group#: _____ Effective Date: _____

Insured Name: _____ Employer: _____

Date of Birth: _____ SSN: _____ Relationship to Patient: _____

Referral:

How did you hear about us?

◯Physician Reference - -*Please complete the following:*

Referring Physician Name:_____ Physician Phone#: _____

◯Google+ ◯Website ◯Facebook ◯Insurance Directory ◯Yellow Pages ◯Twitter ◯Pinterest ◯LinkedIn

◯Patient or Friend's Name:_____ ◯Other (please specify): _____

Important Information:

Is your visit due to a job related injury? ◯Yes ◯No

Is your visit due to an automobile accident? ◯Yes ◯No

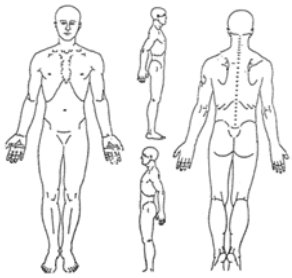
***If yes please notify the receptionist**

CASTLE PINES
PHYSICAL THERAPY

Jennifer Molner, PT, DPT
www.castlepinesphysicaltherapy.com

Medical Questionnaire – Physical Therapy

Patient Name: _____ Date: _____
Date of Birth: _____ Age: _____ Height: _____ Weight: _____
Occupation: _____ Employer: _____ Hrs / Wk: _____
What problem or diagnosis brings you here today? _____
Side of Injury: ☐R ☐L Date of Injury: _____ Who referred you to PT: _____
Briefly describe your symptoms: _____
Describe how your condition or injury occurred: _____



Please rate your pain on the scale below from 0 to 10:
(0 = no pain; 10 = worst pain imaginable / emergency room pain)

Pain at rest: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Pain with activity: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
What is the frequency of your pain? ☐Constant ☐Intermittent
Does your pain awake you at night? ☐Yes ☐No

What eases your symptoms: _____
What aggravates your symptoms: _____
Are your symptoms getting: ☐Better ☐Same ☐Worse Is your pain worse in the: ☐AM ☐PM ☐Mid-Day
Are you currently working: ☐ Yes ☐ No Are you currently on: ☐ Light Duty ☐Normal Duty
What activities at home, work or recreational are you unable to perform? _____
Have you had a similar condition before? ☐ Yes ☐ No If yes, when? _____
Have you had tests for this condition? ☐ Yes ☐ No If yes, results: _____
Check tests: ☐ X-ray ☐ MRI ☐ Bone Scan ☐ CT Scan ☐ Nerve Tests (EMG) ☐ Other: _____
Have you had any other treatment for this condition? ☐Yes ☐No If yes, what? ☐PT ☐OT ☐Chiropractic ☐Massage
What goals do you hope to accomplish with physical therapy? _____

Medical History (check all that apply)

☐ Angina / Chest Pain
☐Asthma
☐Arthritis
☐Blackouts
☐Bliindness
☐Blood Clot
☐Bowel or Bladder Problems
☐Carpel Tunnel Syndrome
☐Chest / Abdominal Surgery
☐Coronary Artery Disease
☐Cancer
☐Depression
☐Diabetes
☐Diverticulitis
☐Ear Infections
☐Endometriosis
☐Fibroids
☐Fibromyalgia
☐Fractures
☐Frequent Falls
☐Hearing Problems
☐Heart Disease
☐Hepatitis
☐High Blood Pressure
☐High Cholesterol
☐Hypoglycemia
☐Menopause
☐Migraine Headaches
☐Major Spinal Injury
☐MRSA
☐Osteoporosis
☐Pacemaker / Nitroglycerin
☐Poor Circulation / Raynaud's
☐Polio
☐Seizures
☐Stroke
☐TB
☐Traumatic Injury / MVA

Are you pregnant: _____ Do you smoke tobacco? ☐ Yes ☐ No If yes, how much? _____

Medications

List all medications (including name, dosage, frequency, and route of administration): _____
_____
List current allergies: _____
List all surgeries: _____

Signature: _____ Date: _____

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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 Associate's, 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 Associate's, P.C. accepts VISA, MasterCard, Discover, Cash or Checks.

6. Insurance Claims: Podiatry Associate's, P.C. files claims electronically for the patient's primary contracted plan and accepts payment via the patient's assignment. Podiatry Associate's, 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 Associate's, 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 Associate's, 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 Associate's, 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 Associate's, 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 Associate's, P.C. may refer patients to other providers, facilities, and labs. Podiatry Associate's, P.C. is not responsible for these entities. The patient should contact these non- Podiatry Associate's, 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 Associate's, 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 Associate's, P.C. Doctor-Patient relationship. 30 days' advance notice will be given should the situation result in a transfer of the patient's care.

15. 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.

16. 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.

17. Refunds: Podiatry Associate's, P.C. issues patient refunds by check within 30 days of a completed investigation of the potential overpayment, as long as other outstanding accounts have been resolved.

18. Returns: Only unworn and non-custom items are returnable within 3 days of receipt, and unused. Custom items are tailored to meet individual needs; custom items are non-returnable, non-refundable.

19. 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 Associate's, P.C. will make every effort to complete this request in a timely manner, but Podiatry Associate's, 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 1-19 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

1.17.14

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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 the purpose of 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 physicians 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 you 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

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PERMISSIONS

I hereby give my permission for Dr. Cynthia Oberholtzer-Classen, DPM or Dr. Adam Toren, DPM or Dr. Ronnie Pollard, DPM or Dr. Jennifer Molner, DPT 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, PC; Castle Pines Physical Therapy, PC 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 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 or will be discussed in office visits with the doctor or physical therapist is confidential and can only be released with my permission.

I give my permission to speak with and give detailed information with the name of the person provided below and give permission for detailed messages to be left at the number provided below.

Name: _____ Relationship: _____

Phone number: _____

X_____ Date: _____

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully. The privacy of your medical information is important to us. This notice takes effect November 15, 2013, and will remain in effect until we replace it.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

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Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

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In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.
Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.
Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services
We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your health insurance plan to coordinate payment for your medical serivces.
Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.
Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.
Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

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Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Marketing

I authorize the above named clinics to use or disclose the protected health information in my health or treatment record to notify me of health-related or of non-health-related products, treatments, services or opportunities.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.