Four Corners Foot & Ankle

Patient Name:_____ **Minor:** Y / N **DOB:** _____

Sex: M / F **SSN#:** _____ **Marital Status:** ☐Single ☐Married ☐Separated ☐Widow

Mailing Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Physical Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Home Phone:_____ **Cell Phone:**_____

Preferred Method of Contact: ☐Phone Call ☐Text ☐Email: _____

****Is this a Work Comp Injury:** Y / N

Race: ☐American Indian or Alaskan Native ☐Native Hawaiian or Other Pacific Islander ☐Asian

☐Black or African American ☐White ☐Other Race ☐Declined

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Declined

***EMERGENCY CONTACT:**_____ **Relationship:**_____ **Phone:**_____

IF PATIENT IS A MINOR

Person Responsible for Account:_____ **DOB:**_____ **SSN#:**_____

Address (If Different than above):_____

Sex: M / F **Relationship to Patient:** _____ (If relationship is other than parent please provide court documents)

INSURANCE INFORMATION

Primary Insurance Name:_____ **Member / ID#:**_____

Secondary Insurance Name:_____ **Member / ID#:**_____

****Workman Comp Insurance Name:**_____

Adjustor Name:_____ Claim#:_____ Date of Injury:_____

Phone#:_____ Fax#:_____

Please Read and Sign: "The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I also authorize Four Corners Foot & Ankle or insurance company to release any information required to process my claims. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services."

Patient or Responsible Party Signature:_____ Date:_____

Four Corners Foot & Ankle

Patient Health History

Patient Name: _____ Date:_____

Height:_____ Weight: _____ Shoe size and width: _____

Is your general health: ☐ Good ☐ Fair ☐ Poor

Do you smoke? : ☐ No ☐ Yes _____packs per day ____ years smoking ____ years stopped

Do you drink alcohol? : ☐ No ☐ Yes Amount per day/week/month _____

Do you have any allergies to medications/foods?:_____

If you are 65 years or older, have you have a pneumonia vaccination this year? ☐ Yes ☐ No

Have you had a Flu Shot this season? ☐ Yes ☐ No

Please list any Medications you take now and the dosage (including vitamins, diet pills, aspirin, etc):
If you have a printed list of your medications, please give it to the receptionist to copy.

Name of Medication	Reason	Dose	Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Name of your Primary Care doctor:_____ Date last seen:_____
Fitness Activities you participate in and frequency: _____

Have you ever had any of the following: Yes No If yes, please indicate:

☐Diabetes : ☐Type I ☐Type II Is your diabetes under control? ☐ yes ☐ no Insulin: ☐ yes ☐ no
What is your average daily glucose level? _____

☐Arthritis ☐Asthma ☐Back Problems ☐Bleeding/Bruising Problems ☐Blood Disease

☐Cancer ☐Carpal Tunnel Syndrome ☐Circulatory Disease ☐Frostbite ☐Gout

☐Heart Trouble ☐High Blood Pressure ☐Kidney Trouble ☐Liver Trouble ☐Nerve Disorder

☐Stomach Ulcers ☐Stroke ☐Thyroid Problems

Have you ever had any broken bones? Yes No

☐ Arm/Wrist/Hand RT LT When? _____ Treatment:_____

☐ Leg/Ankle/Foot RT LT When? _____ Treatment:_____

☐ _____ When? _____ Treatment:_____

How many pregnancies have you had? _____ How many live births? _____

List any surgeries you have had, and the dates: (If you have a printed list of surgeries, please give it to the receptionist to copy)

_____

_____

Family History: please check if any of your relatives have or have had any of the following: (**Please indicate who, when**, and if they are deceased).

☐Cancer_____ ☐Circulation Problems_____ ☐Diabetes_____

☐Foot Problems _____ ☐Heart Problems_____

☐Other_____

Four Corners
Foot & Ankle

PATIENT EVALUATION

Patient name: _____ **Date:** _____

1. **What is your main foot/ankle problem today?**

2. **Rate your pain on a scale of 1 – 10; with 10 being the most severe:**

   1 2 3 4 5 6 7 8 9 10

3. **How can you best describe your pain?**

   ( ) Constant ( ) Intermittent ( ) Radiating ( ) Tingling ( ) Sharp ( ) Dull/Aching ( ) Numbness

4. **How long have you had this problem?**

5. **Do you ever recall injuring this area? When?**

6. **Do you have any swelling in your ankles/feet?**

   More in the morning? More in the afternoon?

7. **Are there any activities that you cannot do because of your condition?**

   If so, what are they?

8. **Are there shoes that you cannot wear because of this?**

   What type?

9. **Employment: ( ) Sit at job ( ) Stand at job ( ) Stands and walks at job ( ) Retired**

PATIENT HISTORY

1. **What have <u>you</u> tried in the past to relieve this problem (i.e.: insoles, new/different shoes medication, physical therapy, etc)?**

2. **Have you received professional care for foot/ankle problems?**

   What type and when?

3. **Is there anything else you would like the doctor to know?**

Four Corners Foot & Ankle

Financial Policy

Thank you for choosing our office for your foot & ankle health care needs. We are committed to your *treatment* being successful. Please understand that payment of your account is considered part of your treatment. If you have any questions regarding our financial policy, please contact our main office at 970-259-5303.

Charges for medical services are due and payable at the time services are rendered. Charges for medical care provided by this medical practice will be billed through our office and *should not be confused with charges for medical care provided by the hospital*. We accept Visa, MasterCard, Discover, American Express, and Care Credit as well as personal checks, money orders and cash.

*In accordance with guidelines set forth by the state of Colorado & New Mexico State Board of Medical Examiners, if further action must be taken on my account, I may be discharged from this practice and be required to seek further care elsewhere.

Contracted Insurance: If we are contracted with your insurance company you will be responsible for your co-pay, co-insurance, deductible, and any non-covered items/supplies *due at the time of service.* **Any balance remaining after the insurance payment is made is due to our office within 30-days.**

Non-contracted Insurance: Patients who have policies with non-contracted insurance companies will be responsible for payment in full for all office visits/procedures at the time service is rendered. We will bill your insurance company and you will be reimbursed directly.

Home Health Agencies / Nursing Home Rehab Centers: Our office requires that if a patient is in one of these facilities and cannot provide health information themselves they must have a family member accompany the patient so they can help the patient fill out new patient paperwork, provide copies of insurance cards, state issued identification card or driver license and medical history.

Self-Pay Patients: We offer a 30% discount of services rendered except for supplies. We make no long-term payment arrangements on patient balances.

***Returned Check Fee:** We will apply a $30.00 (thirty dollars), plus any additional charges allowed by CRS 13-1-109 for any returned check. All payments thereafter must be made with cash or debit/credit card.

***Outside Services:** I understand that certain services may be sent to an outside source such as lab, pathology, and diagnostic services and thus will be billed separately for those services.

***Cancelled & No Call / No Show Appointments:** Our office offers appointment reminders and as such we require that you give a 24-hour notice if you need to cancel your appointment for whatever reason. **You will only be allowed 3 failed visits then Four Corners Foot & Ankle has the right to discharge you from care at the discretion of their doctors.**

I understand that if, 45 days after billing my insurance they have not paid, my account will be due and payable by me. In the event my account becomes past due, my balance will accrue interest at the rate of 18 % per month. In addition, I will be responsible for collection costs, attorney fees, court costs, and any other miscellaneous fees. I consent to have the collection agency obtain my credit report for the purposes of collection on my account.

I have read the financial policy above and understand and agree to these arrangements.

_____	_____	_____
Print Patient Name	Signature of Responsible Party	Date

Four Corners Foot & Ankle

575 Rivergate Lane # 95
Durango, CO 81301
970-259-5303

2700 Farmington Ave., Ste. C-1
Farmington, NM 87401
505-326-2255

HIPAA

Special care is given by our office to protect your health information. Today the State and Federal laws also Attempt to ensure the confidentiality of your very sensitive information.

The Federal Government has published regulations designed to protect the privacy of your health information through the **Heath Insurance Portability and Accountability Act of 1996 (HIPAA)**. All health information including paperwork, oral communication, and electronic formats are protected by this rule.

Consent of Disclosure

I hereby give consent to Four Corners Foot and Ankle, and the office staff to use and disclose my Protected Health Information (**PHI**) for the purposes of Treatment, Payment, and general health care Operations (**TPO**).

I understand that I have the right to review the offices notice before I sign this consent. I further understand, that I have the right to obtain a copy of the office's Notice of Privacy Practices if I so choose; a copy may be obtained by contacting the main office at (970) 259-5303; we reserve the right to amend this notice at any time.

I have the right to request, in writing, restriction on the usage and discloser of my PHI. I further have the right to cancel this consent in writing except to the extent that Four Corners Foot & Ankle has already made disclosures in reliance upon my prior requests.

If this consent is not signed, I understand that Four Corners Foot & Ankle may decline to provide treatment.

_____

Patient Name

_____ _____

Patient/Guardian Signature Date