



**Patient Name:** \_\_\_\_\_ **Minor:** Y / N **DOB:** \_\_\_\_\_  
**Sex:** M / F **SSN#:** \_\_\_\_\_ **Marital Status:** Single Married Separated Widow Divorced  
**Mailing Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_  
**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_  
**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

**Are you a nursing home resident:** Y / N  
**If Yes, where:** \_\_\_\_\_

**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:** \_\_\_\_\_



Patient Health History

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Shoe size and width: \_\_\_\_\_

Do you smoke? [ ] Yes [ ] No \_\_\_\_\_ packs per day \_\_\_\_\_ years smoking \_\_\_\_\_ years stopped

Do you drink alcohol? [ ] Yes [ ] No Amount per day/week/month \_\_\_\_\_

Do you have any allergies to medications/foods? \_\_\_\_\_

Do you have a durable medical power of attorney? [ ] Yes [ ] No

Do you have a living will? [ ] Yes [ ] No

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

Have you had a Flu Shot this season? [ ] Yes [ ] No

List any Medications you take now and the dosage: (If you have a printed list, please give it to the receptionist to copy)

Table with 4 columns: Name of Medication, Reason, Dose, Frequency. Includes three rows of blank lines for entry.

Who is your primary care doctor? \_\_\_\_\_ Date last seen: \_\_\_\_\_ Fitness

Activities you participate in and frequency: \_\_\_\_\_

Have you ever had any of the following?

[ ] 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

[ ] Stroke [ ] Nerve Disorder [ ] Stomach Ulcers [ ] Kidney Trouble [ ] Thyroid Problems [ ] Liver Trouble

Have you ever broken your Leg/Foot/Ankle/Toe? [ ] Yes [ ] No

Side? [ ] Right [ ] Left

When? \_\_\_\_\_ Treatment: \_\_\_\_\_

List any surgeries you have had, and the dates: (If you have a printed list, 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 \_\_\_\_\_



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?

---

---

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

---

---

7. Are there any activities that you cannot do because of your condition?  Yes  No  
If so, what are they?

---

---

8. Are there shoes that you cannot wear because of this?  Yes  No

---

---

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

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

---

---

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

---

---

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

---

---



## 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. Once products are taken from our facility, i.e. braces, orthotics, splints, etc., they cannot be returned or refunded.

\*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



## 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 **Health 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 (Printed)

Patient Name (Signature)

\_\_\_\_\_

\_\_\_\_\_

Date \_\_\_\_\_

Patient/Guardian Signature

\_\_\_\_\_

Date \_\_\_\_\_