Save Your Sole
Foot & Ankle Specialists

# Patient Guide

## Mission Statement

Welcome to our clinic!  Our goal is to provide high quality foot and ankle care to our patients in a professional, caring, and personal atmosphere.

## Introduction

Podiatry is the broad based medical and surgical specialty dedicated to the prevention, diagnosis, and treatment of diseases and injuries of the foot and ankle.  Our scope encompasses treatment and/or service for:

- Achilles Tendonitis/Tendinopathy
- Ankle Pain
- Ankle Sprains and Injury
- Athlete's Foot
- Arthritis
- Bunions
- Burning Feet
- Calf Pain
- Children's Feet
- Corns and Calluses
- Diabetic Foot Care
- Diabetic Foot Infection
- Diabetic Shoe Prescription
- Drop Foot
- Fallen Arches
- Flat Feet
- Fractures, Foot and Ankle
- Fungal Nails
- Ganglion Cyst
- Gout
- Hallux Limitus
- Hammertoes
- Heel Pain
- Heel Spurs
- High Arches
- Ingrown Toenails
- Lisfranc Injury
- Neuroma, nerve damage
- Orthotics, Custom Made
- Pediatric Congenital Foot Deformities
- Peripheral Neuropathy
- Plantar Fasciitis
- Plantar Fibroma
- Platelet Rich Plasma Injections (PRP)
- Rheumatoid Arthritis
- Skin Conditions: Infections, Rashes, Corns, Calluses, Warts, Fungus, etc.

- Sports Medicine and Injuries
- Tarsal Tunnel Syndrome
- Tendonitis
- Trauma
- Turf Toe
- Warts
- Swollen Ankles

## Office Hours

Our Fort Collins office is staffed 8am to 5pm Monday through Friday.

## Locations

**Fort Collins clinic**
1927 Wilmington Dr unit 102
Fort Collins CO 80528
Phone (970) 416-9009
Fax (970) 416-9010

**Windsor clinic**
1220 West Ash St unit A
Windsor CO 80550
Phone (970) 416-9009

## Emergencies

If you experience a problem you consider an emergency, please call us at (970) 416-9009. The after hours message will give you the phone number for the current on-call physician who will be happy to assist you.

## Appointments

Please call (970) 416-9009 to schedule an appointment for either clinic location. Realizing you are in pain, we will make every effort to have you seen as soon as possible. If you are unable to keep a scheduled appointment, please call to cancel more than 24 hours ahead of your appointment time so that your allotted time may be offered to another patient. A $75.00 fee is charged if you do not show up for your appointment or cancel within 24 hours of your appointment. The $75.00 fee must be paid before another appointment can be scheduled for you.

Occasionally, emergencies arise that may result in a delay from your scheduled appointment. If possible, our staff will try to keep you informed in advance of such delays. In the event of an unanticipated delay, we ask for your patience and understanding.

## Initial Appointment

Your initial appointment will be more time-consuming than follow-up appointments. Quality medical care requires knowledge of your general health and a thorough history of your current foot and/or ankle condition.

**Please bring:**

- Your health insurance card(s)
- A referral if required by your insurance
- A list of your current medications and allergies
- Medical records pertinent to your treatment at our clinic.
- Worker's compensation claim number and referral number (if applicable)
- Motor vehicle accident claim number and policy number (if applicable)

## Referral

If your insurance requires a referral for you to be seen by a specialist, it is your responsibility to request a referral from your referring or primary care physician prior to your visit. Unless required by your insurance company, a referral is not always necessary.

We utilize a team approach to your medical care. If you are referred from another physician's clinic, we will strive to keep your referring physician informed of your progress.

## Prescriptions

Prescription refills are issued **only** during regular clinic hours. We suggest you call your pharmacy first for a refill at least 72 hours before you actually need the refill in order to ensure your medication can be taken without interruption. We cannot refill prescriptions on weekends, holidays, or after clinic hours because the on-call physician does not have access to your medical records and cannot determine the appropriate medication for your condition.

## Fees

The fee for your initial visit will vary depending upon the complexity of your condition. There may be additional charges for:

- X-rays
- Ultrasound
- Medical supplies: orthotics, braces, casts, splints, etc.
- Injections
- Procedures

## Insurance

We accept most insurance plans. It is imperative that we have your current insurance information so we can process your claim efficiently. Please notify our office of any changes to your insurance policy as soon as possible.

Currently, we participate with the following plans:

Aetna, Anthem Blue Cross/Blue Shield, AARP, Banner Health, CIGNA, Cofinity, GEHA, Great West, Humana, Kaiser Permanente, Medicare, Mutual of Omaha, MVP Health Care, Private Health Care Systems (PHCS), Rocky Mountain Health, Tricare, United Healthcare, and United Medical Alliance (UMA), United Medical Resources (UMR).

Please ask about other plans not on this list as this list may change.

## Financial Responsibility

All co-pays are due and will be requested at the time of service. We accept cash, check, debit, Visa, and MasterCard for payment. When your insurance "authorizes" or "covers" a service or medical supply, it does not guarantee your insurance company will pay. It is important for you to understand that you are ultimately responsible for payments to your account.

## About Our Physicians

**Emily Webb, DPM** received her Bachelor's degree from UCLA. She received her Doctor of Podiatric Medicine from New York College of Podiatric Medicine, Summa Cum Laude. Thereafter, she completed her surgical residency at Scripps Mercy Hospital in San Diego and Kaiser Permanente in Sacramento. She has been practicing in Fort Collins since 2000. Dr. Webb is Board Certified with the American Board of Foot and Ankle Surgery and is a Fellow of the American College of Foot and Ankle Surgeons. She is a staff physician at Poudre Valley Hospital, and Banner Fort Collins Medical Center. Dr. Webb has served on the Colorado Podiatry Board.

**Evie Plummer, DPM** completed her Bachelor's degree in Health and Exercise Science from Colorado State University. She received her Doctor of Podiatric Medicine medical degree from Des Moines University College of Podiatric Medicine and Surgery. She then returned to Colorado to pursue her surgical residency training at North Colorado Medical Center Podiatric Medicine and Surgical Residency. Dr. Plummer is a community member of Medical Center of the Rockies Hospital. She has been practicing with Save Your Sole Foot and Ankle Specialists since 2013. She is passionate about enhancing her patients' quality of life by providing professional and thorough foot and ankle care.

**Tucker Worthen, DPM** received his Bachelor's degree from Utah Valley University in 2007. He then received his Doctor of Podiatric Medicine medical degree from Arizona College of Podiatry at Midwestern University in Glendale, AZ in 2012. Following this he completed his extensive three year podiatric surgical training at Legacy Health and Kaiser

Permanente Podiatric Surgical Residency in Portland, OR. During his training, Dr. Worthen gained a special interest in Reconstructive foot and ankle surgery, foot and ankle trauma, and ankle joint replacement. Dr. Worthen is an associate member of the American College of Foot and Ankle Surgeons. He is a staff physician at Poudre Valley Hospital, Medical Center of the Rockies Hospital, and Banner Fort Collins Medical Center.

## About Our Staff

We have a dedicated staff to assist you in all aspects of your medical concerns.

Lauryn and Nicole: Administrative Assistant
Angelica, Melissa, and Eli: Medical Assistant
Nicole: Surgery Coordinator
Sammi: Billing
Lauryn: Compliance

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# PRIVACY PRACTICES

Our clinic is committed to protecting the confidentiality of information about you, and is required by law to do so. This notice describes how we may disclose your information to others.

**Treatment:** Our clinic may use the information about you to provide you with services and supplies. We may also share information with others that need information to treat you such as: surgery centers, other specialist's, testing centers, or other medical facilities that you are sent for treatment or to obtain supplies. This includes information provided to your insurance company from our office for any treatment or testing that your physician may order.

**Payment:** Our clinic may use and disclose information about you to get paid for medical services and supplies that we have provided to you. Your health insurance company may request to see parts of your medical record before they will pay us for treatment and supplies.

**Legal:** There are other circumstances when our clinic may have to give out your information such as court requests, workers compensation, and state and federal required government reporting.

**Third Party:** If you request your records be released to a third party such as your spouse, friend or relative, we will need a written release on file that authorizes us to do so.

# WHAT ARE YOUR RIGHTS

You have the right to request:

- A copy of your health record. (There may be a charge for this).
- We communicate with you in a confidential way.
- We add or amend information about you that you believe is incorrect or incomplete.
- A paper copy of this information.
- An accounting of disclosures.

# OUR COMMITMENT TO RESPECT YOUR PRIVACY

Our clinic is committed to respecting your privacy. We are dedicated to keep your health information private and only share it with those parties that need it for treatment of your health condition. At any time that you feel that you would like more information on our clinic's privacy practices or you have a concern, please let your provider know so that we may take actions to rectify the situation. We truly value our patients and are committed to helping them achieve the best outcome.

I, _____ hereby consent to the use, access, and disclosure of my protected health information to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

____ No one.

*I acknowledge that I have read (or had the opportunity to read if I so chose) and understood the Notice.*

Signature:_____ Date:_____

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## Personal Information

Name: _____ Birth date: _____ Today's date: _____
Address: _____ City: _____ State: ____ Zip: _____
Home phone: _____ Cellular phone: _____
Email address: _____
Ethnicity: African American / Asian American / Caucasian / Hispanic / Native American /
Pacific Islander (Hawaiian) / Other: _____
Preferred spoken language: _____
Age: _____ SS# last 4 digits: _____ Sex: M / F Occupation: _____
Employer: _____ Work phone: _____
Preferred pharmacy: _____ Location: _____
Primary family physician: _____
How did you hear of our clinic? _____
Marriage status (circle): Single Married Widowed Divorced Other
Emergency contact (list parent if minor):Name _____
Relationship: _____ Phone number: _____

Today, my foot/ankle complaint is: 1. _____
(if time allows) 2. _____
The condition(s) has existed for (how long)?_____
Is this related to a specific injury? _____ Date of injury? _____
Have you had this problem before? _____ How long ago? _____
Previous treatment(s)?_____
**Allergic to latex? ___Yes ___No What reactions do you get if "yes"?**_____
**Height:**_____ **Weight**:_____ **Shoe Size**:_____

**Review of Systems**: (check all that applies)
____ In general good health ____Recent significant weight gain ____Recent significant weight loss
**Eyes**: ___ Does not apply ___Wear glasses/contact lenses ____Cataracts ____Glaucoma ____Macular deg.
**Ears/Nose/Mouth/Throat**: ___Does not apply ____Sinusitis ____ Swollen lymph nodes
_____Difficulty hearing _____Using hearing aids _____Others (please describe)
**Cardiovascular:** ____Does not apply ___History of heart attack ___DVT ___High blood pressure
____History of stroke ____Heart murmurs _____Others (please describe)
**Gastrointestinal**: ____Does not apply ___History of stomach ulcer ____IBS ___Heartburn/reflux
____ Hiatal hernia ____ Hepatitis (A/B/C) ____Cirrhosis _____Others (please describe)
**Genitourinary:** ____Does not apply ____Kidney stones ____Benign prostate hypertrophy (in men)
____ Overactive bladder ____ Frequent UTI _____Others (please describe)

Please turn over →

**Musculoskeletal:** ____Does not apply ____Rheumatoid arthritis ____Psoriatic arthritis ____Osteoporosis
____Osteopenia ____Lower back pain/arthritis/herniated disc/pinch nerve
____Osteoarthritis( where? _____) ____Sciatica_____Others (describe)
**Skin:** ____ Does not apply ____Eczema ____History of Athlete's foot _____Others (describe)
**Neurological:** ____Does not apply ____Migraine headache____Numbness of hands ____Seizures
_____Numbness of feet ____Multiple sclerosis ____ Charcot-Marie-Tooth disease
**Psychiatric:** _____Does not apply ____Depression ____Anxiety ____Bipolar disorder ____ADHD
_____Others (describe)
**Endocrine:** ___Does not apply ____Gout ____Diabetes____Thyroid problems_____Others(describe)
**Hematologic:** ___Does not apply ___Bleeding disorder ____ Anemia _____Others(describe)
**Allergic/Immunologic:** ____Does not apply ___ Auto-immune disease ___ HIV positive

What operations or surgeries have you had? _____

_____

___**Yes** ___**No** Do you smoke tobacco? If **yes**, how much? _____ Smoking how long? _____
If **no**, did you smoke in the past? _____ When did you quit? _____
___**Yes** ___**No** Do you use recreational drugs? If **yes**, how much? _____ Using how long? _____
If **no**, did you use in the past? _____ When did you quit? _____
___**Yes** ___**No** Do you drink alcohol? How much do you drink? _____
___**Yes** ___**No** Do you exercise on a regular basis? If yes, please describe. _____
Does anything significant run in your family? (i.e. heart disease, diabetes, foot deformities) Please list all conditions. _____

_____

**If there's anything else in your medical history that may be important for your physician to know in order to facilitate your treatment? Please describe**: _____

_____

## RELEASE OF MEDICAL INFORMATION

*I authorize Save Your Sole Foot and Ankle Specialists to release and obtain medical information as required for my treatment and processing of my insurance claim. I realize that it is my responsibility to pay for any services rendered. A monthly billing charge will be added to all accounts over sixty days. I understand if any balance is unpaid after 60 days, it will be sent to collections. I will also be responsible for the cost of collections, plus attorney and court fees, which may amount to 50% of the original owed amount.*

*I request that payment of authorized insurance or Medicare benefits be made on my behalf to Save Your Sole Foot and Ankle Specialists for the services rendered to me.*

*I authorize Save Your Sole Foot and Ankle Specialists to release any information needed to determine these benefits or the benefits payable for related services.*

*I authorize release of medical information to my primary care physician or other specialty physicians related to my treatment.*

Signature:_____ Date:_____

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# Clinic Policies

In order to best serve our patients and families, the following policies have been implemented:

## Financial Policy

All co-pays are due and will be requested at the time of service. We currently accept cash, checks, or credit cards for payment.

Insurance is designed to cover some of the costs of health care. Because there are so many insurance companies and plans, it is impossible for us to have complete knowledge of them all.

Insurance is a contract between you and your insurance company. We are **not** a party to this contract. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, or other matters regarding reimbursements. Your insurance benefits depend upon what you or your employer has negotiated with the insurance company and the amount you choose to pay in premiums. When your insurance "authorizes" or "covers" a service or medical supply, it does not guarantee your insurance company will pay. It is your responsibility to know your insurance coverage and benefits.

If your insurance carrier denies reimbursement, you will be financially responsible for the full amount. If your insurance carrier does provide partial reimbursement, you will be financially responsible for any unpaid deductible, co-insurance, or balance as stipulated in your plan provisions.

If your insurance changes and we do not have your new insurance information, you will be billed for all charges until we receive a copy of your new insurance card. If your insurance requires a referral for you to see a specialist, it is your responsibility to make sure that the referral is in place before your visit with us.

It is important for you to understand that you are ultimately responsible for payments to your account.

## Medical Records Authorization

I authorize Save Your Sole Foot and Ankle Specialists to access and use the protected health information from UC Health and/or Banner Health systems. Protected health information includes your complete health record including but not limited to: chart notes, radiology images, MRI images, lab test results and medication list.

## Medical Records Policy

A minimum of seven working days is needed to release medical records or x-rays from the request date. All requests must be in writing. Please refer to our Medical Records Release Form for detailed information on costs and instructions.

## Prescription Refill Policy

We request three working days on all prescription refills. We do not refill prescriptions on holidays or weekends as the on-call physician may not have your medical record.

## Colorado Prescription Drug Monitoring Program (PDMP)

If you receive a prescription for a "controlled" (Schedule II through V) drug, most commonly used for post-op pain management, this information will be entered into the Colorado PDMP database. This information is shared and may be accessed by the health providers who will and have prescribed you these medications.

## Appointment Policy

Appointments are scheduled at times mutually convenient to the patient and doctor. We understand that urgent or emergent situations arise which may prevent you from keeping an appointment. If you are unable to keep a scheduled appointment, please call to cancel more than 24 hours ahead of your appointment time so that your allotted time may be offered to another patient. Patients who are more than 10 minutes late may need to be rescheduled. Our staff reserves the right to reschedule appointments.

A $75.00 fee is charged if you do not show up for your appointment or cancel within 24 hours of your appointment. The $75.00 fee must be paid before another appointment can be scheduled for you.

If you have a contagious symptom such as a cold or flu, if possible, please call to reschedule your appointment. We want to be considerate of other patients' well being as many of our elderly patients may have a weaker immune system. Thank you for your understanding.

Emergencies do arise in a medical clinic. We apologize for any inconvenience or delays should they occur. We will attempt to notify our patients in a timely manner should your appointment be delayed or changed. Your understanding and patience is greatly appreciated.

## Treatment Policy

We think it is important that you follow the instructions given by your doctor. Incompliance or lack of proper follow-up leads to problems and complications that can be prevented. Compliance and appropriate feedbacks are crucial for successful treatment.

## Communication Policy

Please call our office with questions you have. Even though our EHR, Practice Fusion has messaging ability, we do not read or respond to Practice Fusion messages.

## Mutual Respect Policy

Our staff performs tasks to the best of their ability. They make a sincere effort to treat every patient with respect and professionalism. Please treat all members of our staff with the same courtesy you would expect from them. We reserve the right to terminate any patient who we feel has violated this policy.

By signing this form, I acknowledge and agree to the *clinic policies*.

Patient name (print): _____

Signature: _____ Date: _____

Relationship to Patient (if minor or incapacitated): _____

**Patient Name:**_____ **Date:**_____

## Medications

| Medication Name | Dosage and Frequency | For what purpose? |
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## Drug Allergies

| Drug Name | Please describe drug reaction |
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