Save Your Sole Foot & Ankle Specialists

1927 Wilmington Dr., Suite 102
Fort Collins, CO 80528
(970) 416-9009 Fax (970) 416-9010

1220 W. Ash St., Suite A
Windsor, CO 80550
(970) 416-9009

Personal Information

Name: ____________________________ Birth date: ___________ Today's date: _______________
Billing Address: ____Apt #__________________
City: ____ State: _________ Zip: _______________
Home phone: __________________________ Cellular phone: _______________________________
Email address: ____
Preferred method of appointment reminders: ☐ Email ☐ Text ☐ Phone
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**:__________ **Wears custom orthotics?**__________

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 degeneration
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 ____High Cholesterol ______________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 →

Pulmonary: ____Does not apply ____COPD ____Emphysema ____Asthma ____History of pulmonary embolism

Musculoskeletal: ____Does not apply ____Rheumatoid arthritis ____Psoriatic arthritis ____Osteoporosis ____Osteopenia ____Lower back pain/arthritis/herniated disc/pinch nerve ____Sciatica
____ History of chronic ankle sprains ____Osteoarthritis(where? __________________)
____Ehlers-Danlos syndrome _____________________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 ____Type 1 Diabetes ____Type 2 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

Providing the best medical care possible and seeing patients in a timely manner are of the utmost importance to Save Your Sole Foot and Ankle Specialists. 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.

Due to the increased demand for appointments and having a long waiting list, we charge a $75.00 fee and document in your chart 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. Continuing to miss appointments or cancelling within 24 hours may result in dismissal from our practice.

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.

Photography, Audio and Video Recording Policy

Audio and video recording of any kind is not permitted within the premises of any Save Your Sole Foot and Ankle Specialists clinic. Photography including pictures, x-rays and ultrasound images are permitted by Save Your Sole Foot and Ankle Specialists for the purpose of providing patient care, diagnosis, treatment, quality improvement, education and reimbursement.

Photography by patients, patient's families or patient's friends are not allowed in any common area including but not limited to the waiting room, hallways, and x-ray room. Photography by patients, patient's families or patient's friends is only allowed of that patient in treatment rooms with patient's verbal consent. Photography by patients, patient's families or patient's friends of other patients or Save Your Sole Foot and Ankle Specialists' employees is not permitted. Photography is not permitted and must be discontinued if interfering with Save Your Sole Foot and Ankle Specialists' patient care, another patient's privacy, or efficient clinic operations. Save Your Sole Foot and Ankle Specialists' employees have the discretion and authority to require such photography be discontinued.

Treatment Policy

You need to 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 ☐ Check box if taking no medications		
Medication Name	Dosage and Frequency	For what purpose?

Drug Allergies ☐ Check box if no known allergies	
Drug Name	Please describe drug reaction

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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:____________________________