Dr. Lee Fleming, DPM
Dr. Matthew Thomas, DPM
Dr. Michael Peck, DPM
Dr. Teague Gearhart, DPM

Patient Information

Full Name: _____ Today's Date: _____/_____/_____
Address: _____ City: _____ State: _____ Zip: _____
SS#: _____- _____- _____ DOB: _____/_____/_____ Age: _____ Gender: ☐ Male ☐ Female
E-mail Address: _____
Home Phone: _____ Work Phone: _____Cell: _____
Circle preferred phone number: Home / Work / Cell
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Race: ☐ Asian ☐ American Indian or Alaska Native ☐ African American
☐ Caucasian ☐ Native Hawaiian or Other Pacific Islander ☐ Hispanic ☐ Other: _____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Employer: _____ Employer Phone: _____

Responsible Party *(if not patient)*

Spouse/Guardian Name: _____ SS#: ____- ____- _____ DOB: ____/____/____
Address: _____ City: _____ State: _____ Zip: _____

Additional Information:

Emergency Contact: _____Relationship_____ Phone: _____
Do you have a Power of Attorney? ☐ Yes ☐ No Do you have a Living Will? ☐ Yes ☐ No
How were you referred to us? ☐ Friends/Family ☐ Google ☐ Our Website ☐ Insurance ☐ Other: _____

Insurance Information:

We MUST have a copy of your insurance card(s) in order to file your insurance. Please provide to the front desk.
Please notify us if you will be using third party coverage for an accident or workman's compensation.
Primary Insurance: _____ Are you the insured: ☐ Yes ☐ No
Policy ID#: _____ Group #: _____
Subscriber Name: _____ DOB: ____/____/_____
Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____
Secondary Insurance: _____ Are you the insured: Yes No
Policy ID#: _____ Group #: _____
Subscriber Name: _____ DOB: ____/____/_____
Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

To the best of my knowledge, I have answered questions on this form accurately. I authorize Dr. Fleming, Dr. Thomas, Dr. Peck, Dr. Gearhart, or their extenders to examine and treat me medically, surgically, or biomechanically. I assign my insurance benefits to be paid directly to Colorado Springs Foot and Ankle Clinic. I authorize release of medical information necessary to process all claims.

Patient Signature: _____ **Date:** _____/_____/_____

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Patient Name: _____ Today's Date: _____/_____/_____

Height: ___' ____" Weight: _____LBS Shoe Size: _____

Please describe the reason for your visit today: _____

_____

Is this a result of an accident or work injury? ☐ Yes ☐ No Date of Injury: ____/____/_____

Medical Information

Name of Preferred Pharmacy: _____ Phone Number: _____

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

Primary Care Physician: _____

Phone: _____ Date Last Seen: ___/___/_____ Did they refer you to our care? ☐ Yes ☐ No

Date of Last Flu Shot: ____/____/_____ Did You Get A Pneumococcal Vaccination? ☐ Yes ☐ No

Current Medications:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Medication Allergies:

1. _____
2. _____
3. _____
4. _____

Medical Conditions: *(Please circle any condition past or present)*

Anemia	Frequent Urination	Hernia	Pulmonary Embolism
Anxiety Disorder	Fibromyalgia	Hypertension	Rheumatoid Arthritis
Arthritis	Gerd/Reflux	Kidney Disorders	Seizures/Epilepsy
Asthma	Gout	Leg or Foot Ulcers	Sleep Apnea
Bleeding Disorders	Heart Attack	Liver Disease	Slow Healing
Blood Clots	Heart Disease	Lung Disorders	Stroke
Cancer	Heart Problems	Migraines	Stomach Ulcers
Coronary Artery Disease	High Blood Pressure	Osteoporosis	Thyroid Problems
Diabetes	HIV/AIDS	Pacemaker	Tuberculosis
Depression	Hepatitis	Peripheral Vascular Disease	Urinary Tract Infection

Additional Medical Disorders: _____

_____

_____

DO YOU SMOKE? ☐ Yes ☐ No DO YOU DRINK ALCOHOL DAILY OR EXCESSIVELY? ☐ Yes ☐ No

Previous Surgeries or Hospitalizations with year: _____

_____

_____

Family Health History: *(Immediate Family Has or Had)* _____

_____

_____

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Financial Policy

Thank you for coming to Colorado Spring Foot and Ankle Clinic. We believe that good care for you and your family starts with good communication, and we have created this policy to help our patients have a clear understanding of the responsibilities that they and their families have for payment of our fees.

As a courtesy, on your behalf, we will bill to your insurance company. Please provide us with insurance card(s) and any additional information we may need during your first visit. This is not a guarantee of payment. We recommend that you call you insurance company to verify your coverage. **It is YOUR responsibility to know your policy benefits and limitations.**

In the event that insurance denies payment of services rendered, you are responsible for all medical charges left unpaid. If you do not agree with the patient responsibility amounts or reimbursement amounts by your insurance, or other program, this is a matter between you and that program. We are happy to provide you with factual information about your care and billing to help you discuss this with them, but still require you to promptly pay the entire charge we present you, even if the issue with the program is not resolved.

***PLEASE INITIAL EACH POLICY, SIGN AND DATE:**

_____ **Payment and Fees**. We require that our patients promptly pay all charges that we present to them. Payment is due at the time services are rendered, including co-pays, deductibles, co-insurances, over the counter supplies and any previous balances. We may present to you by written statement for the remainder of any charges that are your responsibility to pay after coverage by your insurance or other programs**. The co-pays, deductibles, co-insurances amount left as patient responsibility by law is non-negotiable. The rates will be billed according to the contracts you have signed with your insurance company. Because of these laws we are not able to discount, waive or change the amount due**. We accept personal checks, cash, and most major credit cards. A $25 fee will be charge for all returned checks. This will be reflected on your statement and a new payment will need to be paid promptly.

_____ **No Health Insurance Coverage**. Patients who do not have insurance will pay in advance for all services rendered at the time of service.

_____**Past Due Accounts**. Unpaid charges over 60 days will be considered delinquent and are subject to a processing fee. All patients who fail to make payments on delinquent accounts will be turned over to a collection agency. You will receive statements in the mail alerting you of your account balance. You may receive a call about the same. Patients with accounts in collections will be required to satisfy their financial obligation to us prior to being seen by our doctors.

_____**If my visit involves Workman's Compensation, injury or accident**: A letter from your employer or attorney along with specific information regarding the injury and insurance information must be provided, if this is neglected CSFAC will bill my health insurance. All third-party fees not paid promptly I will be responsible to pay.

_____**Medical Records**. We gladly send your medical records to other physicians at no charge. They will also be available to you on your patient portal. A copy of your medical records will cost you a $20.00 fee.

BY ACCEPTING OUR SERVICE, YOU ARE CONSENTING TO RECEIVE THESE COMMUNICATIONS. I HAVE READ THE ABOVE AGREEMENT AND I AGREE TO THE TERMS AND CONDITIONS SET FORTH BY COLORADO SPRING FOOT AND ANKLE CLINIC AND WILL BE FINICIALLY RESPONSIBLE FOR THE FOLLOWING PATIENT:

Patient Name: _____ **Name of responsible party**: _____
Signature of responsible party: _____ **Date:** ____/____/____

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Advanced Beneficiary Notice

As part of our efforts to communicate all charges that could be your responsibility please read over this notice. Our doctors may recommend supplies as part of your treatment. We offer these in our office for your convenience to take home and use as instructed.

BENEFICARY NOTICE FOR ALL PATIENTS REGARDLESS OF INSURANCE COVERAGE

Most insurances will pay for services that determines to be "reasonable and necessary" under Section 1862(a)(1) of the Social Security Act.

We believe that, in your case, your insurance is likely to deny payment for "**Take home supplies" or "Over the Counter Supplies".**

BENEFICARY AGREEMENT:

I have been notified by my physician that it is believed that, in my case, insurance is likely to deny payments for the supplies given.

If my insurance provider denies payment, I agree to be personally and fully responsible for payment.

Beneficiary Signature: _____ **Today's Date**: _____/_____/_____

Privacy Notice

At Colorado Springs Foot and Ankle Clinic we are committed to ensuring your privacy and confidentiality of your medical records. Please read the Notice of privacy practice. If you have any questions, please let us know.

May we leave a message on your voicemail at home? Yes ☐ No ☐
May we leave a message on your cell phone? Yes ☐ No ☐
May we leave a voicemail message at your work? Yes ☐ No ☐

Whom may we speak, if any, with other than yourself regarding your medical care?
Please list their full names and telephone numbers:

Name: _____ Phone: _____

Relationship to Patient: _____

Name: _____ Phone: _____

Relationship to Patient: _____

Name: _____ Phone: _____

Relationship to Patient: _____

Privacy Notice: I hereby acknowledge that I have received the Notice of Privacy Practices from Colorado Springs Foot and Ankle Clinic.

Patient Signature: _____ **Today's Date**: _____/_____/_____