COLORADO SPRINGS FOOT & ANKLE CLINIC

Dr. Lee T. Fleming, DPM Dr. Matthew R. Thomas, DPM Dr. Michael S. Peck, DPM

Dr. Teague Gearhart, DPM

Name:_____

Primary Care Physician:_____

Pharmacy and Street:_____

Email Address:_____

Height:_____'_____" Weight:_____LBS

Current Medications:

1)_____ 5)_____

2)_____ 6)_____

3)_____ 7)_____

4)_____ 8)_____

Known Medication Allergies

1)_____

2)_____

3)_____

4)_____

Please Circle Medical Conditions (Past or Present)

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

Other:_____

Family History:_____

_____

Medical Alert:_____

List Any surgeries with Year:_____

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PATIENT INFORMATION SHEET

Patient Name:_____ Date Of Birth:_____

Current
Address:_____S:S:N:_____

City:_____State:_____Zip Code_____

Gender:_____ Marital Status:_____

Cell Phone #:_____ Email:_____

Employer and Address:_____

Occupation:_____

Spouse's Name:_____Telephone #:( )_____

Emergency Contact Name and Relation:_____

Emergency Contact #:( )_____

Family Physician Name, Telephone # &
Address:_____

How did you hear about our
office?_____
_____

Patient or Guardian Signature:_____

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At Colorado Springs Foot and Ankle Clinic we are committed to ensuring your privacy and confidentiality of your medical records.

In order to assist us in protecting your privacy, please complete the following;

Patient Name:_____Date of Birth:_____

Whom may we speak with other than yourself regarding your medical care:

Please circle one or more of the following:

Spouse Child Sibling Caregiver Friend Parent(s) Guardian

Please list their full names and telephone numbers:

_____ Phone _____

_____ Phone_____

_____ Phone_____

May we leave a message on you voicemail at home? Yes or No

May we leave a message on your cell phone? Yes or No

May we leave a voicemail message at your work? Yes or No

Patient Signature:_____ Date:_____

1155 Kelly Johnson Blvd. Suite 310 Colorado Springs, CO 80920 (719) 574-9800

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY POLICIES & PROCEDURES

As required by the Health Information Portability and Accountability Act of 1996 (**HIPPA**), The Colorado Springs Foot and Ankle Clinic, P.C. (Practice) may not use or disclose your personal health information without your authorization.

The Practice has policies and procedures to comply with HIPPA. Every attempt has been made to keep the process for patients and staff as efficient as possible. However, the requirements are extensive and take time, effort and cooperation to process required tasks.

All patients are presented with certain notices and must sign additional forms. The following is a summary of the most common notices and some patients may be required to sign additional forms. The following is a summary of the most common notices and forms:

NOTICE OF PRIVACY PRACTICES: This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

CONSENT FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION: The Practice may not use or disclose your health without your written authorization. Your signature on this form indicates that you are giving permission for the use and disclosure of your health information for the purpose of treatment, payment and health care operations. You may revoke this authorization at any time by signing, dating and revocation section of your copy of this form and returning it to our office.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATIION: The Practice may not use or disclose your health information without your authorization. Your signature on this form indicates that you are giving permission to the people listed on the form, for the use and disclosure of the health information listed on the form for the purpose listed on the form, to the people/organization listed on the form, you may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning to the office.

COMPLAINT: You have the right to complain about the Practice's Privacy Policies; Procedures or Actions. The Practice will not engage in any discriminatory or other retaliatory behavior against you because of a complaint.

REQUEST FOR INSPECTION OF PROTECTED HEALTH INFORMATION: You have the right to request the opportunity to inspect and copy health information that pertains to you. The Practice will evaluate your request and will either grant it or explain the reason why the request is not granted, you may request that the decision be reviewed by someone other than the person who originally denied the request.

REQUEST FOR ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION: You have the right to request an accounting of health information that pertains to you.

CONFIDENTIAL CHANNELING COMMUNICATIONS REQUEST: You have the right to request that communications concerning your personal health information be made through confidential channels. The Practice will do its best to accommodate all reasonable requests.

DESIGNATION OF PERSONAL REPRESENTATIVE: You have the right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By making this request, you are informing the Practice that you wish to designate the named person as your personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form and returning it to this office.

DO NOT SIGN UNLESS YOU HAVE READ AND THROUGHLY UNDERSTAND THIS FORM.

Patient or person with authority to sign for the patient Date and time

Witness Date and time]

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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, you insurance is likely to deny payment for **Take home 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 Date & Time

1155 Kelly Johnson Blvd. Suite 310 Colorado Springs, CO 80920 (719) 574-9800

1155 Kelly Johnson Blvd. Ste 310
Colorado Springs, Co. 80920

Policy on Patient Responsibility for Fees

Thank you for coming to Colorado Springs 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 understand the responsibilities that they and their families have for payment of our fees.

As a courtesy to you, we will bill your insurance company. Please provide us with your insurance card(s) and any additional information we may need during your first visit. We recommend that you call your insurance company to verify your coverage. It is your responsibility to know your policy benefits and limitations.

We require that our patients promptly pay all charges that we present to them.

If you do not agree with 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 we still require you to promptly pay the entire charge we present to you, even if your issue with the program is not resolved. We accept personal checks, cash, and most major credit cards. A $25 fee will be charged for all checks returned. A $25.00 fee will be charged for any claims that go into collections.

Payment for services is due at the time that those services are provided to you, and we expect that all charges we present to you at a visit will be paid at the time of the visit. This includes, among other things; take home supplies, copay amounts, coinsurance amounts, program deductibles, earlier charges that remain unpaid, and charges for services that we believe are not covered by, or are left over as your responsibility to pay after coverage by, insurance or other programs. We may also present charges to you by written statement via the mail following a visit. If we do this, we expect that each charge will be paid in full by return mail the first time it is presented to you. We or our agents may send you statements and reminders of charges made and amounts that we believe must be paid, or may call you about the same. By accepting our services, you are consenting to receive these communications.

I understand the above information, and I will be financially responsible for the following patient:

Name: _____
(print name of patient)

Signature: _____
(also print name, if different from patient)

Date: _____