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

PATIENT INFORMATION

Full Name: _____

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

SS#: _____-_____-_____ DOB: ____/____/____ Age: _____ Gender: _____

Email Address: _____

Cell Phone: _____ Work Phone: _____ Other: _____

Circle preferred phone number: Cell / Work / Other

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer: _____ Employer Phone: _____

RESPONSIBLE PARTY (if other than patient)

Name: SS#: _____-_____-_____ DOB: ____/____/____

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

Relationship to patient: ☐ Spouse ☐ Parent ☐ Other: _____

ADDITIONAL INFORMATION

Emergency Contact: _____ Relationship: _____ Phone: _____

Do you have a medical power of attorney: ☐ YES ☐ NO

How were you referred to us? ☐ Primary Physician ☐ Insurance ☐ Friend/Family ☐ Web Search

INSURANCE INFORMATION

*We *MUST* have a copy of your current insurance card(s) in order to bill 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. 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 & Ankle Clinic. I authorize the 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: _____ Men's ☐ Women's ☐

Please describe the reason for your visit today: _____

_____

Is this the result of an accident or work injury? YES ☐ NO ☐ Date of Injury: _____/_____/_____

Medical Information

Name of Preferred Pharmacy: _____ Phone: _____

Address: _____ City: _____ State: _____

Primary Care Physician: _____ Phone: _____

Date of Last Visit: _____/_____/_____ Did they refer you to our care? YES ☐ NO ☐

List Current Medications and Dosage: _____

_____

Allergies: _____

_____

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? YES ☐ NO ☐ Use marijuana? YES ☐ NO ☐

Previous surgeries or hospitalizations over the last year: _____

_____

Family Health History: (Immediate Family) _____

_____

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Financial Policy

Thank you for visiting 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 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 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 your 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 the reimbursement amounts determined by your insurance, or other program, it will be a matter to be resolved between you and your insurance or other program. We are happy to provide you with factual information about your care and billing to help you in your discussions, but still require you to promptly pay the entire charge that we present to you, even if the issue with insurance or other program has not been 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 that services are rendered, including co-pays, deductibles, co-insurances, over the counter supplies, and any previous balances. We will send a billing 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, and co-insurance amounts left as patient responsibility are non-negotiable by law. 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 charged for all returned checks. This fee 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 coverage will need to 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 a statement 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 your 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 you fail to provide this information, CSFAC will bill your health insurance on file. All third-party fees not paid promptly must be paid by the patient.

____ **Medical Records.** We will gladly send your medical records to other physicians at no charge. They will also be available to you on your patient portal. A physical copy of your medical records will cost you a $20 fee.

BY ACCEPTING OUR SERVICES, 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 SPRINGS FOOT AND ANKLE CLINIC AND WILL BE FINANCIALLY RESPONSIBLE FOR THE FOLLOWING PATIENT:

PATIENT NAME: _____ RESPONSIBLE PARTY: _____

SIGNATURE OF RESPONSIBLE PARTY: _____ DATE: _____/_____/_____

If not signed, we cannot provide services.

1155 Kelly Johnson Blvd., Suite 310, Colorado Springs, CO 80920
1512 N. Union Blvd., Colorado Springs, CO 80909
(719) 574-9800

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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. For your convenience, we offer many of these in our office for you to take home and use as instructed.

BENEFICIARY NOTICE FOR ALL PATIENTS REGARDLESS OF INSURANCE COVERAGE

Most insurances will pay for services determined 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".

BENEFICIARY AGREEMENT

I have been notified by my physician that 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:** _____/_____/_____

Privacy Notice

At Colorado Springs Foot and Ankle Clinic we are committed to ensuring your privacy and the 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 cell phone voicemail? YES ☐ NO ☐

May we leave a message on your home voicemail? YES ☐ NO ☐

May we leave a message on your work voicemail? YES ☐ NO ☐

To whom my we speak, if anyone 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.

SIGNATURE OF PATIENT: _____ **DATE:** _____/_____/_____