Table Mountain
Foot and Ankle Clinic

Anthony Valenti, DPM

Raquel Litherland, DPM

Date: _____

Name: _____ Preferred Name: _____

Last M.I. First

Birthdate: _____ Age: _____ Sex: M / F Preferred Sex: _____ Marital Status: M S W D

Address: _____ City: _____ Zip code: _____

Home Phone Number: _____ Cell Phone Number: _____

Social Security #: _____-_____-_____ Email: _____

Primary Physician Name: _____ Phone Number:_____

Emergency Contact: _____ Phone Number:_____

Relationship: _____ Can we discuss your care? Y / N

Local Pharmacy: _____ Location: _____ Phone Number: _____

Race: ☐ White ☐ African American ☐ Asian ☐ Declined to Specify

Ethnicity: ☐ Non-Hispanic ☐ Hispanic/Latino ☐ Declined to Specify

Primary Language: ☐ English ☐ Spanish ☐ Declined to Specify ☐ Other: _____

Advanced Directive (Age 65 or older) Please circle one

No Decision Maker/ Surrogate Decision maker/No Decision maker discussed/Power of Attorney

Primary Insurance:_____ Guarantor:_____ DOB:_____

Secondary Insurance:_____ Guarantor:_____ DOB:_____

Describe the reason for your visit today:

_____

_____

Please rate your pain level 1-10 (0=no pain, 10=worst pain): _____

Please circle the type of pain you are feeling: Sharp Stabbing Burning Numbness Aching Tingling

Was this an injury: Y / N Date of Injury: _____ Auto/other: _____

Current List of all medications and their strengths:

_____

_____

Have you had or do you have any of the following? (Check all that apply)

__HIV/AIDS __Impaired eyesight __Low Blood Pressure __Anemia

__Gout __Multiple Sclerosis __Arthritis __Hepatitis _____

__Neuropathy __Phlebitis __High Blood Pressure __Asthma

__Bleeding Tendency __Heart Problems __Current Pregnancy __Kidney Problems

__Cancer Yr. Diag_____ __Rheumatic Fever __Circulatory Problems __Knee Pain

__Respiratory Problems __Convulsions/Seizures __Leg Cramps __Shortness of Breath

__Diabetes Yr. Diag_____ __ Low back pain __Stents __Stomach Problems

Other _____

Do you Smoke? Y / N # of cigarettes/day Do you wish to quit? Y N Maybe

Other Tobacco Use? Y / N Please list recreational drugs if applicable _____

Do you drink alcohol? Y / N # of drinks per week ____

Have you had any falls in the past year? Y / N How Many? _____

Allergies to Medication / material / food? _____
_____

Previous surgeries/hospitalizations & dates:
_____
_____
_____

Height: _____ft _____ in Weight: _____lbs Shoe Size: _____

Family History: (Check if applicable)

____Adopted as a child/ family history unknown

Parents: Father: Living / deceased Current age or age passed _____

__Diabetes __Tuberculosis ___Liver Disease __Asthma __Cancer __Mental Illness __Lung Disease

__Heart Disease __Kidney Disease __Stroke __Arthritis __Other: _____

Mother: Living / deceased Current age or age passed _____

__Diabetes __Tuberculosis __Liver Disease __Asthma __Cancer __Mental Illness __Lung Disease

__Heart Disease __Kidney Disease __Stroke __Arthritis __Other: _____

Siblings: # of Brothers _____ # of Sisters _____

Notice of Privacy Practices HIPAA

Table Mountain Foot & Ankle, P.C.

This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review this carefully.

As a part of the balanced Budget Act of 2007, new legislation regarding the privacy of your protected health information became effective April 14, 2003.

The law known as HIPAA (Health Insurance Portability Accountability Act) requires that all healthcare providers maintain the privacy of protected health information and provide individuals with notices of its legal duties and privacy practices with respect to protected health information. The office is required to follow the terms of the notice currently in effect.

We use health information about you for treatment, to obtain payment for your treatment, for administrative purposes, and to evaluate the quality of care you receive. Continuity of care is a part of treatment, and your records may be shared by paper mail, electronic mail, fax, or other methods.

In addition, we may disclose identifiable personal information about you without your authorization for several reasons. Subject to certain requirements, we may give out heath information without your authorization for public health purposes such as reporting of communicable diseases, birth, death, injury and child abuse or neglect for auditing purposes, for research studies and for emergencies. We may provide information when otherwise required by law enforcement or by court order in specific circumstances. Contact with you may also take place in the form of appointment reminders, prescription refills, referrals, test results, etc. In any other situation, we will ask for your written authorization before using or disclosing any identifiable information about you. If you choose to sign an authorization to disclose information, you may later revoke either part of the authorization to limit or stop any future uses or disclosures. You have the right to request a restriction on the use of disclosure of the same information. We will accommodate all reasonable requests to the best of our ability.

You have the right to receive confidential information by alternative means or at alternative locations. You have the right to see and make a copy of all information that is contained in your medical record or chart at this office. This includes information that other providers may have sent to this office. If you believe that information contained in your medical records is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add missing information. You have the right to an accounting of disclosures of all protected health information that was released by this office for purposes other than treatment, payment, and health care operations. You have the right to a paper copy of this notice regardless of whether you received a prior copy either in printed or electronic format. Finally, you have the right to express concern about any perceived privacy violations, or if you disagree with a decision we made about access to your records.

You may contact the practice manager at this office AND/OR Secretary of the Department of Health and Human Services

3555 Lutheran Parkway # 210
Wheat Ridge, CO 80033

200 Independence SW
Washington, DC 20201

We may change our policies at any time. Before we make any significant changes to our policies, we will modify this notice to reflect the changes, and post the new notice in the waiting area. You can also request a copy of our notice and obtain your written acknowledgment that you have read this notice, given the opportunity to ask any questions regarding the notice and have been given a copy of the notice if you requested one.

Patient/Responsible Party Signature_____Date_____

FINANCIAL POLICY TABLE MOUNTAIN FOOT & ANKLE, P.C.

YOUR UNDERSTANDING OF OUR FINANCIAL POLICY IS AN ESSENTIAL ELEMENT OF YOUR CARE AND TREATMENT. IF YOU HAVE ANY QUESTIONS, PLEASE DISCUSS THEM WITH OUR STAFF OR SUPERVISOR.

-REQUIRED PAYMENTS: **Any co-payments required by your insurance must be paid at the time of service**. This is an insurance requirement; we cannot bill you for your co-payment. All new patients (with the exception to any state insurance plans i.e. Medicare/Medicaid) will be required to keep a credit card on file for any patient balance including copays, coinsurance, deductible, or non-covered charges. We will submit claims to your insurance company (if applicable). Once your claim is processed and insurance payment is posted to your account, you will have 5 days upon receipt of your billing statement or balance notification to pay the amount due with any form of payment. If you do not pay the amount due within 5 days, the card on file will be charged. The card will be stored in a secure and encrypted manner along with your health records. Table Mountain Foot and Ankle Clinic is authorized to charge up to $500.00. If the amount due exceeds $500.00, you will receive an invoice for the remaining balance. The card on file will need to be renewed annually.

If you refuse to keep a card on file, you will be required to pay a $150.00 deposit prior to your first appointment. This can be paid with a credit card (will not be saved to your account), check or cash. The deposit will be applied to any remaining balance after your insurance has processed the claim. You will receive a statement if there is a balance after the deposit has been applied. Any remaining money will be refunded to you.

Any balance on the account must be paid in full before we are able to see you, if you are unable to pay the balance in full, we can set up a monthly payment plan. Table Mountain Foot and Ankle Clinic reserves the right to refuse service to patients that have a balance on their account.

-RETURNED CHECKS: There will be a fee of $50.00 for any returned checks as well as any fees assessed by the bank.

-CONTRACT INSURANCE: All eligible claims and charges will be submitted to your insurance provider(s). As our patient, YOU ARE RESPONSIBLE FOR ALL AUTHORIZATION / REFERRALS NEEDED to be treated in our office. Failure to obtain the referral or prior authorization may result in a denial or lower payment from the insurance company, and you may be responsible for the balance.

-MINOR PATIENTS: The parent authorizing treatment for the child will be responsible for the charges unless we are notified otherwise.

-NON-CONTRACTED INSURANCE: If you have insurance coverage with a plan that we are not contracted with, you will be considered self-pay and will be responsible for all charges at the time of service. It is your responsibility to verify network status for your specific insurance plan.

ACCEPTED FORMS OF PAYMENT: Cash, Check or Credit Card.

TREATMENT INVOLVING ORTHOTICS: You will be required to pay 50% on the date of casting, and the remaining balance at the time orthotics are dispensed, unless other arrangements are made prior with our office. Deposits resulting in a credit will be refunded to you. Please review the complete orthotic policy and payment options.

SURGICAL PROCEDURES: Surgery will require a deposit prior to the scheduled date. If you have a deductible or co-insurance that has not been met, a monthly payment plan can be set up for the remaining balance. The surgery scheduler will provide you specific details regarding coverage and deposit amount required.

COLLECTION POLICY: I understand that responsibility for payment of medical services in this office for myself and my dependents is mine; due and payable at the time of services are rendered unless financial arrangements have been made. I understand that I am responsible for all costs of collection including attorney fees, collection fees of 30% and court costs. Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. I fully understand I am responsible for payment of fees not covered by insurance. I hereby authorize Table Mountain Foot & Ankle and its employees, agents, and assignees to contact me via e-mail, text messaging and to my cellular devices using automated telephone dialing systems.

I have read and I understand Table Mountain Foot and Ankle Clinic's financial policies and I accept responsibility for the payment of any fees associated with my care.

_____	_____
Patient Name	Responsible Party (if not patient)
_____	_____
Signature by responsible party	Date

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Medicare patients ONLY:

I request that payment of authorized Medicare benefits be made to my doctor for any care or services provided by that physician. I authorize any holder of medical information, regarding my care to be released to the health care financing administration and its agents, including any information needed to determine these benefits or the benefits payable for related services.

_____ _____ _____

Print Name of Beneficiary (Patient) Signature of Beneficiary (Patient) Date

OUT OF NETWORK INSURANCE NOTICE

Out-of-network refers to a health care provider who does not have a contract with your health plan. If you use an out-of-network provider, health care services could cost more since the provider doesn't have a pre-negotiated rate with your health plan. If you incur costs at an out-of-network rate, we will discount those charges to our self-pay rate as a courtesy. These plans may include pathway plans, exchange plans, Friday health plans, Kaiser, etc. This is not a complete list of out of network plans. To verify network status, please contact your insurance provider directly. By signing, you understand that you could incur self-pay costs if our providers are out of network with your plan.

Signature: _____ Date:_____

CANCELLATION AND NO-SHOW POLICY

It is paramount that we keep providers and staff as close to on time as possible, so that we may provide quality care to our patients in a timely manner. This policy allows us to better utilize appointments for our patients in need of medical care and respect your time as well.

Cancellation/ No-Show Appointments:

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, if you do not call to cancel your scheduled appointment, you may be preventing another patient from receiving much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a full appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a $50.00 fee, which is NOT covered by your insurance company.

Timeliness of Scheduled Appointments:

We understand that delays can happen, however, we must try to keep the other patients, staff, and doctors on time. If you are running late, please notify the office as soon as possible. If you are 15 minutes past your scheduled appointment time, we may have to reschedule the appointment.

_____ _____
Patient Name Responsible Party (if not patient)

_____ _____
Signature by responsible party Date