Anthony Valenti, DPM
Gregory Still, DPM
Meghan Hurley, DPM

Table Mountain Foot and Ankle Clinic

Today's Date: _____

Name: _____ Birth Date: _____ Age: _____
Last M.I. First

Address: _____ Marital Status: M S D W
Street Unit City State Zip

Home #: _____ Cell #: _____ Work #: _____

Primary Physician: _____ Social Security #_____-____-_____ Employer: _____

Emergency Contact Name: _____ Phone #: _____ Relationship: _____

Pharmacy Name: _____ Pharmacy Location: _____ Pharmacy #: _____

E-mail Address: _____

Race: WHITE AFRICAN AMERICAN ASIAN PACIFIC ISLANDER OTHER REFUSE TO REPORT
Ethnicity: NON-HISPANIC HISPANIC/LATINO REFUSE TO REPORT
Primary Language: ENGLISH SPANISH RUSSIAN FRENCH OTHER REFUSE TO REPORT

Current list of Medications & Strengths:

_____

_____

Have you had, or do you have any if the following? (CHECK ALL THAT APPLY)

___HIV/AIDS
___ANEMIA
___ARTHRITIS
___ASTHMA
___BLEEDING TENDENCY
___CANCER YR. DIAG. _____
___CIRCULATORY PROBLEMS
___CONVULSIONS/SEIZURES
___DIABETES YR. DIAG. _____
___ OTHER _____
___IMPAIRED EYESIGHT
___GOUT
___HEPATITIS ____
___HIGH BLOOD PRESSURE
___HEART PROBLEMS
___KIDNEY PROBLEMS
___KNEE PAIN
___LEG CRAMPS
___LOW BACK PAIN
___LOW BLOOD PRESSURE
___MULTIPLE SCLEROSIS
___NEUROPATHY
___PHLEBITIS
___CURRENT PREGNANCY
___RHEUMATIC FEVER
___RESPIRATORY PROBLEMS
___SHORTNESS OF BREATH
___STENTS
___STOMACH PROBLEMS

Please Describe Reason For Visit_____

_____

(PLEASE FLIP OVER TO BACK)

Allergies to medications/materials/food? _____

_____

Previous Surgeries/Hospitalizations & Dates: _____

_____

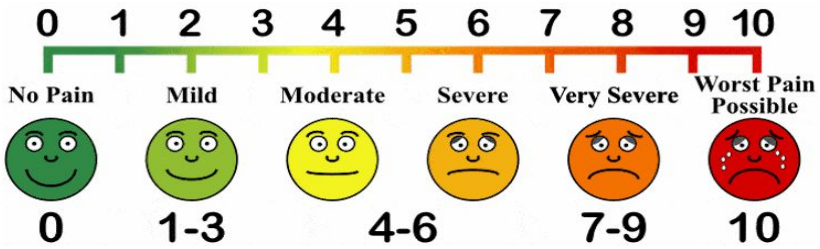
_____

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

Any falls within the last year? Y N # of Falls? _____

Height: ___ft ___in Weight: _____lbs Shoe Size: _____

Pain Scale (circle level of pain): 0 1 2 3 4 5 6 7 8 9 10



Please circle the type of pain you are feeling.

Sharp Stabbing Burning Numbness Aching Tingling Dull

Do you smoke? Y N # of Cigarettes /day: ____ Do you wish to quit? Y N Maybe

Do you Vape? Y N

Marijuana Use? Y N

Other Tobacco Use: Y N

Do you drink Alcohol? Y N # of Drinks /wk.? _____

TABLE MOUNTAIN FOOT AND ANKLE, P.C.

Primary Insurance: _____

Policy Holder's Name Policy Holder's S.S.#

Policy Holder's D.O.B. Relationship to Patient_____

Secondary Insurance: _____

Policy Holder's Name Policy Holder's S.S.#

Policy Holder's D.O.B. Relationship to Patient_____

By signing, I hereby authorize my insurance benefits be paid directly to the physician and acknowledge that I am financially responsible for any unpaid balance. I authorize the physician to release any information required to my insurance company for payment of benefits.

RESPONSIBLE PARTY SIGNATURE: DATE:

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)

(PLEASE FLIP OVER TO THE BACK)

TABLE MOUNTAIN FOOT AND ANKLE, P.C.

Name:_____

Family History: (CHECK IF APPLICABLE)

_____ ADPOTED AS A CHILD, FAMILY HISTORY UNKNOWN.

Parents: (CHECK IF APPLICABLE)

Father: LIVING or DECEASED CURRENT AGE or AGE PASSED_____

- Tuberculosis
- Cancer
- Diabetes
- Asthma
- Stroke
- Kidney Disease
- Arthritis
- Liver Disease
- Mental Illness
- Heart Disease
- Lung Disease
- Other _____

Mother: LIVING or DECEASED CURRENT AGE or AGE PASSED_____

- Tuberculosis
- Cancer
- Diabetes
- Asthma
- Stroke
- Kidney Disease
- Arthritis
- Liver Disease
- Mental Illness
- Heart Disease
- Lung Disease
- Other _____

Siblings: NUMBER OF BROTHERS_____ SISTERS_____

FINANCIAL POLICY

TABLE MOUNTAIN FOOT & ANKLE, P.C.

YOUR UNDERSTANDING OF OUT 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.** Because this is an insurance requirement, we cannot bill you for your co-payment. All New Patients (with exception to any state insurance plans i.e. Medicare/Medicaid) will have a $100.00 deposit taken at first visit plus any co-payment that is due. This deposit will be applied to any remaining balance after insurance, any remaining monies after will be refunded to patient. 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 are happy to make payment arrangements with you. We require patients with deductible plans to pay their portion of the bill at the time of service. Most major insurance companies are providing real time status of your remaining deductible and co-insurance so we can provide you an immediate statement of your charges for the day. We will submit all claims to your insurance company so you will receive full credit for your deductibles. It is possible that there might be a discrepancy after the claim is submitted to your insurance company. In this case, you may receive a bill or refund after we receive the explanation of benefits from your insurance company.

RETURNED CHECKS: There will be a fee of $30.00 for any returned checks as well as any fees assessed by the bank.

MISSED APOINTMENT FEE: We make every effort to remind patients of their appointment. After two missed, a $25.00 fee will be charged. This fee must be paid before any new appointments are made.

CONTRACT INSURANCE: 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 lower payment from the insurance company, and you may be responsible for the remainder.

NON-CONTRACTED INSURANCE: If you have insurance coverage with a plan that we are not contracted with, you will be responsible for any charges at the time of service.

1. You may choose to pay by cash, check or credit on the date of service.
2. 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.

PAYMENT OPTONS FOR INSURED

1. ANY CO-PAYMENTS REQUIRED BY YOUR INSURANCE COMPANY MUST BE PAID AT THE TIME OF SERVICE.
2. New Patients will have a deposit in their first visit which will be applied to any remaining balance after insurance.
3. Orthotics will be billed to your insurance **IF** they are a covered benefit. If you have a deductible that must be met, you will be responsible for a deposit, and any remaining balance at the time of dispense. Any credit you have after outstanding claims have been paid will be refunded to you. Orthotics that are **NOT** covered will requires a deposit and the remaining balance to be paid at the time of dispense.
4. Surgeries will require a deposit prior to the surgery 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.
5. Patients with high deductibles or out-of-pocket costs may decide for the monthly payment plans through our billing office.

DIVORCE: The parent authorizing treatment for a child will be the parent responsible for the charges, unless we are notified by the other parent and they agree to pay for all outstanding balances.

_____ _____

Patient Name Responsible Party (IF NOT PATIENT)

_____ _____

Signature of Responsible Party Date

_____ Patient Initials to Indicate Copy Received

NOTICE OF PRIVACY PRACTICES HIPPA

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 part of the Balanced Budget Act of 2007, new legislation regarding the privacy of your protected health information will become effective April 14, 2003.

The law known as HIPPA (Health Insurance Portability and 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. This 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 treatment, for administrative purposes, and to evaluate the quality of care you receive. Continuity of care is 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 health information about you without your authorization for several reasons. Subject to certain requirements, we may give out health 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 such as for 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 same information. We will accommodate all reasonable requests to the best of our ability. You have the right to receive confidential information by alternate means or at alternate 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
3555 Lutheran Parkway #210
Wheat Ridge, CO. 80033

AND/OR

Secretary of the Department of Health and Human Services
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 NAME RESPONSIBLE PARTY (IF NOT PATIENT)

_____ _____

SIGNATURE OF RESPONSIBLE PARTY DATE

_____PATIENT INTIALS TO INDICATE COPY RECEIVED