LITTLETON FOOT & ANKLE CLINIC, PLLC

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PLEASE FILL OUT COMPLETELY Today's Date: _____

First name: _____ **Middle Initial:** ____ Last **Name:** _____
Date of Birth: _____/_____/_____ M / F / Non-binary/Self-describe: _____

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

Social Security Number: _____-_____-_____

My Race is: ◯ Native American ◯ Alaska Native ◯ Asian ◯ African American
◯ White ◯ Other ◯ **Decline**

My Ethnicity is: ◯ Hispanic/Latino ◯ NOT Hispanic or Latino ◯ **Decline**

Marital Status: ◯ Married ◯ Single ◯ Partner ◯ Widowed ◯ Divorced ◯ Separated

Phone Number: (Home) _____-_____ -_____ (Cell) _____-_____-_____

My Email address is: _____

Employment status: ◯ Employed ◯ Unemployed ◯ Retired ◯ Disabled ◯ Student

Employer: _____ Occupation: _____

Emergency contact name: _____ **Phone #** _____-_____-_____

Their Relationship to me is: _____

Primary Insurance Name: _____
Member ID# _____ **Group #** _____
Primary/Policy Holder: _____ **DOB** _____/_____/_____

Secondary Insurance Name: _____
Member ID# _____ **Group #** _____
Primary/Policy Holder: _____ **DOB** _____/_____/_____

My preferred Pharmacy is: _____ Phone # _____-_____-_____
Pharmacy cross-streets: _____

I was referred to this clinic by: ◯ PCP ◯ Other specialist ◯ Family Member ◯ Friend
◯ Previous patient ◯ Internet/Mailer/Other_____
Patient Name: _____ **DOB**: _____

My Primary Care Physician is: _____
Date of last visit: _____ **City of Physician's office**:_____
Phone: _____-_____-_____

HISTORY

Have you ever been to a Podiatrist before? ◯ Yes ◯ No

What is your main foot or ankle complaint for which you are seeking treatment?_____
_____

◯ **Right** ◯ **Left** ◯ **Both**

When did the problem begin? _____

Have you received treatment for this condition? ◯ Yes ◯ No

If so, what was done? _____
_____
_____

Does this problem interfere with your activities? ◯ Yes ◯ No

Circle the degree of pain you are experiencing: Minimal 1 2 3 4 5 6 7 8 9 10 Maximum

My shoe size is _____ ◯ Narrow ◯ Medium ◯ Wide

Current Height ____'_____" **Current weight** _____lbs

Surgery description and Date

- _____
- _____
- _____
- _____

Medications Are you currently taking blood thinners? ◯ Yes ◯ No

- _____ **Dosage**_____ **Frequency**_____
- _____ **Dosage**_____ **Frequency**_____
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- _____ **Dosage**_____ **Frequency**_____
- _____ **Dosage**_____ **Frequency**_____
- _____ **Dosage**_____ **Frequency**_____

- **Smoking history** ◯ Current ◯ Former ◯ Never **# years smoked** _____

How many packs/day? _____ If quit, what year? _____

Alcohol history ◯ Yes ◯ No

◯ Beer _____ How many? ◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly
◯ Wine _____ How many? ◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly
◯ Other _____ How many? ◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly

Do you participate in any exercise or physical activity on a regular basis? ◯ Yes ◯ No

If so, what type? ◯ Aerobic ◯ Strength ◯ Balance ◯ Flexibility ◯ Endurance ◯ Work related

Intensity: ◯ Light ◯ Moderate ◯ Vigorous For how long each time? _____

Frequency: ◯ Daily ◯ 2-3 times a week ◯ 4-6 times a week ◯ Other_____

Have you ever experienced any of the following?

____Ankle Instability
____Hip pain
____Arthritis
____Ingrown toenails
____Back pain
____In/out toe walking
____Blisters
____Knee pain
____Bone spurs
____Limb length in equal
____Bunions
____Neuromas
____Burning feet
____Numbness/tingling
____Corns/calluses
____Plantar fasciitis
____Flat feet
____Shin splints
____Foot infection
____Sprains
____Fracture
____Sweating/odor
____Fungal infection
____Fungal toenails
____Tendonitis
____Gout
____Tired feet
____Hammertoes
____Ulcers/wounds
____Heel pain
____Warts

Are you pregnant? ◯ Yes ◯ No ◯ N/A

FAMILY HISTORY (Please check all that apply)

___Heart disease Relationship:_____ ◯ Maternal ◯ Paternal

___Diabetes Relationship:_____ ◯ Maternal ◯ Paternal

___Cancer Relationship:_____ ◯ Maternal ◯ Paternal

___Other: _____ Relationship:_____ ◯ Maternal ◯ Paternal

DRUG ALLERGIES ◯Yes ◯ No Check all that apply

_____Adhesive Tape
_____Aspirin
_____ Iodine
_____Metals
_____Penicillin
_____Tylenol
_____Anticoagulants
_____Codeine
_____Latex
_____Lidocaine/Novocaine
_____Seafood
_____Motrin/ibuprofen
_____Anti-inflammatories
_____Cortisone
_____Peanuts
_____Sulfa

Any Others not listed: _____

Have you been treated for any of the following conditions? Please check all that apply:

__Acid reflux
__Low blood pressure
__Alcoholism
__Hyperthyroidism
__Allergies
__Hypothyroidism
__Alzheimer's disease
__Kidney/bladder problems
__Anemia
__Liver Disease
__Arthritis (type_____)
__Medical Implants (type_____)
__Asthma
__Nerve System disorder
__Back problems
__Osteoporosis
__Osteopenia
__Bleeding disorders
__Peripheral vascular/arterial disease
__Blood clots/DVT/PE
__Parkinson's Disease
__Cancer (type_____)
__Psychiatric care
__Circulatory problems
__Respiratory disease
__Congestive heart failure/CHF
__Rheumatic fever
__Depression
__Seizure disorders/epilepsy
__Drug or chemical dependency
__Sinus problems
__Ear problems
__Sleep Apnea
__Eye problems
__Stomach Ulcers
__Fibromyalgia
__Stroke
__Headaches (type_____)
__Tuberculosis/TB
__Heart condition (type_____)
__Varicose veins
__Hepatitis
__Vertigo
__High Blood Pressure
__Other: _____
__HIV/AIDS
__High cholesterol/LDL____ Date of test:_____
__Diabetes/A1C_____ Date of test: _____

INFECTIONS ___ MRSA ___Hepatitis B ___Hepatitis C

I certify that the above information is true and correct to the best of my knowledge. I give my permission to Littleton Foot and Ankle Clinic, LLC and any qualified staff to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient/Guardian (under 18) Signature: _____

Date: _____

Release of Information I authorize the release of information including the diagnosis, records; examination rendered to me and claims information.

This information may be released to:

- ◯ Spouse _____
- ◯ Child(ren)/Other _____
- ◯ Phone Number(s) _____
- ◯ Information is not to be released to anyone
- ◯ Email appointment reminders
- ◯ I DO NOT authorize email appointment reminders
- ◯ I authorize detailed messages regarding my medical information on _____ (Phone #)

Patient/Guardian (under 18) Signature: _____

Date: _____

Notice of Privacy Practices

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number. (Copy Available at Front Desk) PLEASE NOTE THAT DUE TO HIPPA REGULATIONS IT IS OUR POLICY TO NOT ALLOW ANY TYPE OF VIDEO RECORDING OF PROCEDURES.

Patient/Guardian (under18) Signature: _____

Date: _____

Financial Policy

Thank you for choosing our practice! We are committed to providing you with quality podiatric care. We have developed this payment policy to assist you in understanding our financial practices**.**

Please read it carefully and sign in the space provided below.

Insurance

We participate with most insurance plans. If you do not have insurance or we do not participate in your insurance plan, payment in full is expected at each visit. Your insurance benefit is a contract between you and your insurance company. Knowing your insurance benefits is your responsibility but we will help explain your podiatric benefits so you can understand them.

We will keep a copy of your insurance card in your record, but you must notify us immediately if there has been any change. If you fail to inform us of updated insurance information, the balance on unpaid claims will become your responsibility. The Co-Pay is due at each visit. Co-Insurance, and deductibles are your responsibility and we may ask for pre-payment.

I certify that I have insurance with

_____

Name of insurance company

and assign directly to Littleton Foot and Ankle Clinic, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Littleton Foot and Ankle Clinic may use my health care information and disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I request that payment authorized Medicare/Medicaid/Private insurance benefits, and, if applicable, Medigap benefits be made either to me or on my behalf Littleton Foot and Ankle Clinic for any services rendered to me by that provider. To the extent of the law, I authorize any holder of medical or other information about me to release to the Center for Medicare and Medicaid services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services. I authorize Littleton foot and ankle clinic to contact the guarantor for billing questions only, no medical information will be disclosed. Non-covered Services Please be aware that some of the services you receive may be non-covered by your insurance carrier. These services must be paid for at the time of visit. There will be a $25-$50 charge for all paperwork needed to be filled out for work (FMLA), attorneys, etc. Claims Submission We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request promptly. The office will perform reasonable effort to notify you of services that may be denied or non-covered. The patient is responsible for any charges/services that the insurance company denies. Payment For your convenience, we accept cash, checks, VISA, MasterCard, and Discover. We reserve the right to refer your account to a collection agency if your account is over 60 days past due. Any collection fees, court costs, reasonable attorney fees, or returned check fees are the responsibility of the adult person(s) named on the delinquent account. A collection fee is 20% of the amount due. Monthly service fee of 1.5% per month or 18% per annum will be assessed on all past due accounts.

Thank you for understanding our financial policy. Please let us know if you have any questions.

I have read and understand the financial policy and agree to abide by its guidelines.

Patient/Guardian (under 18) Signature: _____

Date: _____