CONFIDENTIAL
PATIENT HEALTH RECORD

PINNACLE
Foot and Ankle Clinic
1333 West 120th Ave • #113 • Westminster, CO • 80234
Phone: 720-917-9022 · Fax: 720-379-6759

Todays' Date: _____

Patient Name: _____ Date of Birth: _____

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

Sex: □ Male □ Female Social Security No.: _____

Phone Number: _____ E-mail Address: _____

☐ **Check this box to subscribe to our email list to receive special offers, coupons, and newsletters.**

Employer: _____ Occupation: _____

Marital Status (circle one): Single Married Divorced Separated Widowed

Name and Phone Number of Emergency Contact: _____

Name of Primary Care Physician (PCP): _____ PCP Phone:_____

Date of last PCP visit: _____

HOW DID YOU HEAR ABOUT US? _____

RESPONSIBLE PARTY (Primary Insurance Holder): ☐ Self ☐ Spouse ☐ Other_____

Name: _____ Date of Birth: _____

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

Sex: □ Male □ Female Social Security No.: _____

Phone Number: _____ E-mail Address: _____

CONSENT *for* MEDICAL TREATMENT: I, the undersigned patient, having come to Pinnacle Foot and Ankle Clinic voluntarily to obtain medical advice and treatment, give my informed consent to be evaluated and treated by the medical doctors and staff of Pinnacle Foot and Ankle Clinic. This includes all verbal discussions, physical examinations, and medical procedures that may be deemed necessary by my care providers. I can, at any time, withdraw my consent for specific procedures after discussion with my care providers.

CONSENT *for* TEST RESULTS: I, the undersigned patient, give Pinnacle Foot and Ankle Clinic permission to leave x-ray, lab results, prescriptions, and other medical information or advice on the voicemail to the following phone number(s): _____

I, the undersigned patient, give Pinnacle Foot and Ankle Clinic permission to discuss x-ray findings, lab results, prescriptions, treatment plans, and other medical information or advice with the following family member or friend: Name _____ Phone Number: _____

ACKNOWLEDGEMENT *of* RECEIVING NOTICE *of* PRIVACY PRACTICES (Pinnacle Foot and Ankle Clinic reserves the right to modify the privacy outlines in the notice.)

I, the undersigned patient, have received a copy of the Notice of Privacy Practices for Pinnacle Foot and Ankle Clinic.

_____ _____

Patient Signature Date

_____ _____

Signature of Patient Representative (required if the patient is a minor or adult who is unable to sign this form.) Relationship to Patient

MEDICAL HISTORY

PINNACLE
Foot and Ankle Clinic

Patient Name: _____

CURRENT HEALTH CONDITION

What is the reason you are here?

_____

_____

When did this condition begin? _____

Have you seen other physicians for this condition? (Circle one) yes no

Name of Physician(s) _____ _____

Previous Treatments: _____

Height: _____ Weight: _____ Shoe Size: _____ Primary Shoe Type: _____

Do you exercise? Y / N. If so, how much: _____ times per week. If so, what type? _____

Do you have or have you ever had...

(please check all that apply)

- ☐ AIDS/HIV
- ☐ Allergies
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Anxiety
- ☐ Alcohol Dependency
- ☐ Back Pain
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Bronchitis
- ☐ Cancer (Type: _____)
- ☐ Chemical Dependency
- ☐ Chest Pain
- ☐ Circulatory Problems
- ☐ COPD
- ☐ Diabetes
- ☐ Depression
- ☐ Elevated Cholesterol
- ☐ Foot Ulcer
- ☐ Gout
- ☐ Headaches
- ☐ Heart Attack (Date: _____)
- ☐ Heart Disease
- ☐ Hypothyroidism
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ Kidney Failure
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Osteoporosis
- ☐ Pace Maker
- ☐ Pneumonia
- ☐ Psychiatric Care
- ☐ STD
- ☐ Stroke

Other: _____

Other: _____

Other: _____

Family History

Check any of the following your parents have had:

	Arthritis	Osteoporosis	Cancer	Diabetes	Heart Disease	Stroke	Bleeding Disorder	Foot Deformity
Father	☐	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐	☐

MEDICAL HISTORY (cont'd)

PINNACLE Foot and Ankle Clinic

Patient Name: _____

Have you received a flu vaccination for the current season? (circle one) YES NO
If no, what was the reason? (circle one) ALLERGY DECLINED VACCINE UNAVAILABLE

Date of last tetanus vaccination: _____

For those patients 65 years of age or older:

1. Do you have a living will or a legal document granting someone the ability to make medical decisions on your behalf? (circle one) YES NO
2. Have you had a pneumonia vaccination: (circle one) YES NO
   If no, what was the reason? (circle one) ALLERGY DECLINED VACCINE UNAVAILABLE

Please list any prescription or over-the-counter medications you are currently taking:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Are you allergic to any of the following (please check all that apply):

☐Adhesive Tape ☐Aspirin ☐Pain Medications ☐Iodine ☐Anesthesia ☐Sulfa ☐Penicillin
Other Drug Allergies: _____
Food/Animal Allergies: _____

Please list all surgical procedures you have had and year of surgery:

Procedure	Date of Procedure
_____	_____
_____	_____
_____	_____
_____	_____

Have you been hospitalized in the past 5 years? YES NO
If yes, what for?: _____
_____

Tobacco Use: # of years smoked _____ Packs per day _____ Quit Date: _____
☐ I have never been a tobacco user

Alcohol Use: # glasses per week _____ ☐ I do not drink alcohol
Other Substance Use: Name of Substance: _____ Last Date of Use: _____

OFFICE POLICY

PINNACLE
Foot and Ankle Clinic

To Our Patients

Each time you check in at the front desk, please notify us of any changes in your insurance coverage, home address, phone number, e-mail address, & Primary Care Physician. This allows the physician to always have the most current information to contact you regarding test results or updates on your medical status. This will also allow us to bill your insurance correctly.

Insurance Billing

There are over 1,000 insurance companies in the U.S. and different plans of coverage to choose from, therefore, it is impossible for our office to know the covered benefits of your insurance plan. Your insurance will be billed as a courtesy. It remains your responsibility to know what your insurance covers. You will need to know the following:

a) what information is required by your insurance
b) if referrals must be obtained
c) what co-payments are due
d) if your insurance covers at risk foot care (trimming nails & calluses).
e) if your insurance covers orthotics, diabetic shoes, or medical supplies.

Though we are happy to assist you, we must emphasize that as your podiatric medical provider, our relationship is with you, not your insurance company and knowing the above information will expedite the process of your treatment and avoid unexpected account balances.

Referrals

Required referrals must be obtained and presented at the time of your initial visit or prior to services rendered. If you do not have the required referral, we may ask you to reschedule your appointment.

Insurance Cards

You must present your insurance card at the time of your initial visit prior to services rendered. If you do not have your card, we may ask you to reschedule your appointment.

Orthotics

Orthotics are custom made inserts made especially for you. Orthotics are not always covered by insurance. The cost for a pair of custom orthotics is $395 for the first pair and $295 for each additional pair. A $100 deposit is required prior to the devices being sent for fabrication with the remaining balance due the day the devices are dispensed to you. Children's orthotics are $275 up to a children's size 10. We are happy to bill your insurance for the devices if they are deemed a covered benefit by your insurance provider. If your insurance denies payment, you must understand that you are financially responsible for the payment of these devices.

Missed or Cancelled Appointments

As a courtesy to our physicians and other patients, please provide a 24 hour notice of an appointment cancellation and a one week notice of a surgery cancellation. Repeat missed or last minute cancelled appointments may result in dismissal from our practice. ***Attention Medicaid patients***, if you do not provide a 48 hour notice of an appointment cancellation or do not provide a one week notice of surgery cancellation, you will be dismissed from our practice.

Financial Policy

Full payment of services received and any outstanding account balance is always expected at the time of service. We accept Visa, MasterCard, personal checks and cash. If your check is returned, your account will be charged the amount of the check plus a $50 processing fee. Should your account become delinquent and forwarded to collections, you shall be assessed maximum legal collection fees. All copays (agreement with your insurance company) are required before each visit. If you have a deductible that has not been met, 50% of service charges are to be paid at the time of your visit. Our office staff cannot predict the total cost of your visit and will not be held liable for accuracy of quotes given over the phone.

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Pinnacle Foot and Ankle Clinic, Inc 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 hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

I have read and received a copy of these policies.

_____ _____ _____

Printed Name of Responsible Party Signature Date

Thank you for taking the time to read these policies. Should you have any questions, please do not hesitate to ask.