Mountain West Foot & Ankle Institute

Patient Information

Date: _____

Patient: _____

Address: _____

_____
City State Zip

Sex: ☐ M ☐ F Age: _____ Birthdate: _____

Race: _____ Marital Status: _____

Preferred Message Type (pick one)**:**

☐ Voicemail ☐ Text ☐ Email ☐ May not leave messages

Patient SS#: _____

Home Phone: _____ Work Phone: _____Ext._____

Cell Phone: _____ Email: _____

Primary Insured's Name: _____

Birthdate: _____ SS#: _____

Employer: _____

Referral Information

Whom may we thank for referring you?

☐ Physician: _____

☐ Family/Friend: _____

☐ Insurance Plan: _____

☐ Advertisements:

☐ Yellow Pages ☐ Internet: _____

☐ Newsletter ☐ Other: _____

Employer Information

(Only needed if accident occurred at work)

Patient's Occupation: _____

Employer: _____

Primary Care Physician

To facilitate the sharing of information with your family physician, please provide the following information:

Primary Physician: _____

Office Phone: _____

Last Visit Date: _____

In Case of Emergency, Contact:

Name: _____ Relationship: _____ Best Phone: _____ Alternate Phone: _____

Chief Complaints

Have you ever been to a Podiatrist before?

☐ Yes ☐ No

If yes, please list:

Name: _____

Last Visit: _____

What is the chief complaint for which you came to be treated? (Include foot, ankle, and lower leg complaints.)

_____

_____

_____

Is there any personal or family history of diabetes?

☐ Yes ☐ No

Do you have peripheral neuropathy or unexplained foot or ankle pain?

☐ Yes ☐ No

PODIATRIC HISTORY

Please indicate which foot problems you now have or have had in the past.

- ☐ Ankle Pain/Popping
- ☐ Athlete's Foot/ Foot Fungus
- ☐ Thick, Discolored Toenails
- ☐ Bunions
- ☐ Curly Toes/Hammer Toes
- ☐ Corns and Calluses
- ☐ Cramps or Numbness in Feet/Legs
- ☐ Flat Feet
- ☐ Heel Pain
- ☐ High Arch
- ☐ Ingrown Toenails
- ☐ Plantar Warts
- ☐ Swelling in Ankles or Feet
- ☐ Tired Feet
- ☐ Recurrent Foot or Leg Wounds
- ☐ Frequent Ankle Sprains/Twisting Ankle
- ☐ Shooting or Aching Pain to Feet
- ☐ Weakness of Legs or Feet
- ☐ Pseudo gout
- ☐ Gout
- ☐ Varicose Veins
- ☐ Plantar Fasciitis
- ☐ Neuropathy

Activity Level:

☐ Sedentary ☐ Mild ☐ Moderate ☐ High/Professional

Athletic activities in which you participate (please list frequency):

_____

_____

Pertinent Habits:

Cigarette/Tobacco Use: ☐ Yes ☐ No

If yes, years used: _____

Alcohol Use: ☐ Yes ☐ No

Recreational Drug Use: ☐ Yes ☐ No

Coffee/Caffeine Use: ☐ Yes ☐ No

High Risk Sexual Activity: ☐ Yes ☐ No

Frequent Travel: ☐ Yes ☐ No

MEDICAL HISTORY

Please indicate if you have had any of the following: ☐ None

- ☐ AIDS/HIV
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial Heart Valves
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Anxiety Disorders
- ☐ Back Problems
- ☐ Bipolar
- ☐ Bleeding Disorders
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chest Pain
- ☐ Chronic Diarrhea
- ☐ Circulatory Problems
- ☐ Complex Regional Pain Syndrome (RSD)
- ☐ Congestive Heart Failure
- ☐ Dementia
- ☐ Depression

Diabetes

☐ Type I ☐ Type II ☐ Insipidus ☐ Gestational

- ☐ Eczema
- ☐ Enlarged Prostate
- ☐ Epilepsy
- ☐ Fainting/Dizziness
- ☐ Fibromyalgia
- ☐ GERD (Reflux)
- ☐ Headaches
- ☐ Hearing Loss
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Joint Damage
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Keloid Scars
- ☐ Kidney Disease
- ☐ Low Blood Pressure
- ☐ Melanoma
- ☐ Menopause
- ☐ Muscle Pain
- ☐ Neuroma
- ☐ Osteoarthritis
- ☐ Osteomyelitis
- ☐ Osteoporosis
- ☐ Peripheral Neuropathy
- ☐ Peripheral Vascular Disease
- ☐ Phlebitis
- ☐ Psychiatric Care
- ☐ Psoriasis
- ☐ Respiratory Disease
- ☐ Restless Leg Syndrome
- ☐ Rheumatic Fever
- ☐ Sexually Transmitted Disease
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Sleep Disorder
- ☐ Sinus Problems
- ☐ Special Diet
- ☐ Stroke
- ☐ Tendonitis
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Vision Abnormalities
- ☐ Weak Bones
- ☐ Weight Loss, unexplained
- ☐ Other_____

SURGERIES & HOSPITALIZATIONS

Surgeries you have had: _____

_____

Hospitalizations (other than for surgeries): _____

_____

MEDICATIONS

List all medications: _____

_____

_____

Are you currently taking any of the following?

- ☐ Echinacea
- ☐ Garlic
- ☐ Ginger
- ☐ Gingko Biloba
- ☐ St. John's Wart
- ☐ Ginseng
- ☐ Kava kava
- ☐ Feverfew
- ☐ Ephedra
- ☐ Other: _____

Pharmacy Name(s) and City:

_____

Do you take oral contraceptives? ☐ Yes ☐ No

Are you currently ☐ Pregnant or ☐ Breastfeeding?

ALLERGIES

Indicate any allergies (include reaction on lines below):

- ☐ Adhesive Tape
- ☐ Anticoagulant Therapy
- ☐ Aspirin
- ☐ Codeine
- ☐ Demerol
- ☐ Iodine/Seafood's
- ☐ Local Anesthetics (Novocain, etc.)
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other: _____

Reactions: _____

_____

CONSENT/RELEASE

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I release the assignment of benefits from my insurance to Mountain West Foot and Ankle Institute. I authorize the use of this signature on all insurance submissions.

Patient's Signature: _____ Date: _____

PAYMENT POLICY FOR MOUNTAIN WEST FOOT & ANKLE INSTITUTE

Thank you for choosing Mountain West Foot & Ankle Institute as your foot care provider. We are committed to providing you with the highest quality of health care and strive to keep healthcare affordable in our office. As such, we provide this document to ensure your understanding of the payment policies. Please read the following office payment policy carefully and feel free to ask us any questions that you may have. Once you accept this policy, kindly sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare and Medicaid. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. A billing fee of $15.00 will be billed for any co-payment not received at the time of service. If additional bills are required, additional fees will be applied.

3. Non-covered services. Please be aware that some - and perhaps all - of the services you receive may be uncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of your visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. On your first visit, we must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. On subsequent visits, a current valid insurance card must be provided as proof of continued insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Referral. Referrals are often not required for podiatric care, but some insurances still require a referral. If required, obtaining the proper referral from your Primary Care Physician is your responsibility. Patients presenting to our office without a valid referral will be asked to pay in full. This payment will be held for 48 hours and will become non refundable if the proper referral is not obtained by then.

6. Claims submission. As a service to you, we will prepare and 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. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

7. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

8. Nonpayment. Invoices are sent out at least every 30 days. Your prompt payment will assist us in keeping the cost of healthcare down. If accounts are not paid in the first 30 days, a 20% APR billing fee will be charged. If your account is over 60 days past due, you will be submitted to collections and a collection fee of $25.00 will be applied. If at this time, additional collection procedures are required, an additional collection fee will be applied up to 50%. You are financially responsible for all charges, whether or not paid by insurance, including any applicable attorneys fees, court costs, filing fees and all collection costs which may be assessed by any collection agency retained to pursue this matter.

Partial payments will not be accepted unless otherwise approved by our Billing Department. Please be aware that if a balance remains unpaid, we may refer your account to small claims court and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative podiatric care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

9. Bounced checks. All checks that are returned for insufficient funds will by assessed a $25.00 reprocessing fee to cover bank and administrative costs. Payments on the check value and the reprocessing fee will be expected immediately to avoid further reprocessing fees.

10. Missed appointments. Our policy is to charge $30.00 for missed appointments not canceled within a reasonable amount of time or for an understandable reason. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

11. Forms and Documents. Due to administrative costs, it is our policy to charge $10.00 for completion of all forms, such as disability applications, etc. This fee will be collected prior to completion of the forms.

12. Medical Records. You have a legal right to access your medical records. To facilitate this, we are able to provide for you copies of your medical records and radiographs (x-rays) within 1 week for an administrative fee. This fee is $8.00 for a radiograph CD and copies of your medical records at $0.25/page. The fee is required prior to receipt.

13. Fees. Our fees are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date