COLORADO FOOT+ANKLE SPORTS MEDICINE

19284 Cottonwood Dr. Suite 201B Parker Co 80138
T 720-822-0735 F 866-214-1528 www.footsportsmed.com

Welcome to Colorado Foot + Ankle Sports Medicine!

Thank you for selecting our office for your foot and ankle health care needs. We have prepared this packet of information and patient forms in order to help make your visit a convenient and pleasant experience.

Prior to your appointment, please contact your insurance company to clarify your coverage requirements.

When you come for your appointment, please bring the following:

- ≠ Written referral (If required by your insurance company, this needs to be sent to our office prior to your visit)
- ≠ Government issued photo ID
- ≠ Medical insurance Card
- ≠ Completed *New Patient Forms (3 pages)*
- ≠ Completed and signed *Financial Policy Form*
- ≠ Completed and signed *Privacy Policy Form*
- ≠ Previous X-rays and medical records (including a disc with recent imaging from an MRI/CT scan)
- ≠ Shoes (bring a sample of the more common shoes that you wear –including athletic and walking shoes)

Note: As you will be receiving advice on the proper shoes for your feet, we recommend that you not purchase any new shoes before your visit.

Please be prepared to pay for the following at the time of your visit:

≠ Co-Payment (If applicable)

≠ **If Deductible is not met, we will collect a partial payment/deposit of $150 at the time of visit** ≠

If you will not be using insurance, please be prepared to pay for your visit at the time you are seen

As a courtesy to other patients who are waiting to get in, please call at least 24 hours in advance if you must cancel your appointment. We reserve the right to charge $50 for missed appointments.

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Patient Registration (Please Print)

LAST NAME: _____ **FIRST:** _____ **MIDDLE INITIAL:** _____ ❑M❑F

BY WHAT NAME DO YOU PREFER TO BE ADDRESSED? _____ **D.O.B:** _____ **AGE:** _____

BILLING ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

PRIMARY PHONE # (_____) _____ - _____ **SECONDARY PHONE #** (_____) _____ - _____

EMAIL ADDRESS: _____ **SS #** _____

OCCUPATION: _____ **EMPLOYER:** _____ **HOW LONG?** _____

WORK PHONE # (_____) _____ - _____ **MARITAL STATUS:** ❑ SINGLE ❑ MARRIED ❑ N/A

EMERGENCY CONTACT: _____ **PHONE #** (_____) _____ - _____

NAME OF PARENT OR GUARDIAN (IF PATIENT IS A MINOR): _____ **RELATIONSHIP:** _____

PRIMARY PHONE # (_____) _____ - _____ **WORK PHONE NUMBER #** (_____) _____ - _____

PLEASE TELL US HOW YOU CHOSE US TO PROVIDE YOUR FOOT & ANKLE CARE:

☐REFERRED BY: _____ CLINIC NAME/LOCATION: _____

PRIMARY CARE PHYSICIAN: _____ DATE LAST SEEN: _____

PRIMARY INSURANCE COMPANY: _____

LAST NAME OF INSURED: _____ FIRST: _____ MIDDLE INITIAL: _____

RELATIONSHIP TO PATIENT: _____ INSURED D.O.B: _____ SS #: _____

DO YOU NEED A REFERRAL TO SEE A SPECIALIST? ☐YES ☐ NO **CO-PAY AMOUNT $** _____

SECONDARY INSURANCE COMPANY: _____

LAST NAME OF INSURED: _____ FIRST: _____ MIDDLE INITIAL: _____

RELATIONSHIP TO PATIENT: _____ INSURED D.O.B: _____ SS #: _____

MILITARY: ❑ YES ❑ NO **BRANCH:** _____

DO YOU NEED A REFERRAL TO SEE A SPECIALIST? ☐YES ☐ NO **CO-PAY AMOUNT $** _____

ACCIDENT/INJURY: DATE: _____ TYPE: ☐ LABOR & INDUSTRY ☐ SELF-INSURED ☐AUTO

☐OTHER: _____

HAS A CLAIM BEEN FILED? ☐ YES ☐ NO CLAIM # _____ COMPANY: _____

NAME OF ADJUSTER/AGENT: _____ PHONE # (_____) _____ - _____

ADDRESS: _____ CITY: _____ ZIP: _____

CAUSE OF INJURY: _____

RELEASE OF BENEFITS INFORMATION

I authorized my insurance benefits to be paid directly to the doctor. I understand that the doctor's office will bill my insurance as a courtesy and that I am responsible for all co-pays, deductibles, and non-covered services. I authorize the release of any information required to process my claims.

Signed: _____ Date: _____

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This history form provides us with information to help us meet your healthcare needs. Please complete this form answering each question. **This is a confidential part of your medical record and will be kept on file electronically.**

Patient Name: _____ **Date:** _____

What condition/body part(s) are you being seen for today? _____

Onset date: _____ **Previous treatment for this condition?** ❑ Yes ❑ No
Treatment by: _____ **Date treated:** _____
Clinic: _____ **Phone Number:** _____

Check all treatment(s) received for this condition:

Anti-inflammatories _____ X-rays _____ Hospitalization _____
Pain medication _____ MRI _____ Physical Therapy _____
Injection _____ Bone Scan _____ Surgery _____

Past Medical History

Have you ever had?	No	Yes	Year
Anemia			
Angina			
Arthritis			
Asthma			
Bad teeth			
Bladder infection			
Bladder problems			
Blood clots			
Cancer			
Depression			
Diabetes			
Emphysema			
Epilepsy			

Have you ever had?	No	Yes	Year
Glaucoma			
Gout			
Heart attack			
Heart arrhythmia			
High blood pressure			
Kidney stones			
Liver disease/hepatitis			
Psychiatric treatment			
Stomach ulcers			
Stroke			
Thyroid disorders			
Tuberculosis			
Other			

Surgeries - (List procedure and date performed):

_____
_____
_____

Family History:

Is there a family history of arthritis, heart disease, stroke, or cancer? ❑ No ❑ Unknown ❑ Yes (explain below)

Condition and relative:

_____
_____

Height: _____ _____ **Weight:** _____ **Shoe Size:** _____

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Patient Name: _____

Social History:

Please answer each of the following:

	No	Yes	Frequency
Caffeine:			
Drugs:			

	No	Yes	Frequency
Tobacco:			
Alcohol:			

Allergies: ❑ None

List all known allergies: _____

_____

_____

Current Medications: ❑ None ❑ See attached list

Review of Systems:
Check all condition and symptoms that you currently have -

General	Fever		Chills		Weight Loss		Weight Gain	
Opthalmologic	Blurred Vision		Double Vision		Poor Vision		Glasses	
Ears/Nose/Throat	Ringing in ears		Sinus Congestion		Hearing Loss		Sore Throat	
Heart	Chest Pain		Arrythmia		Palpitations		Heart Disease	
Respiratory	Cough		Shortness of Breath		Difficulty Breathing		Chest Pain	
Intestinal	Upset Stomach		Bloody Stools		Constipation		Diarrhea	
Urinary	Burning		Frequent Urination		Incontinence		Painful Urination	
Musculoskeletal	Joint Pain		Joint Stiffness		Muscle Weakness		Other	
Skin	Rashes		Sores		Masses		Scars	
Neurological	Tremors		Numbness		Poor Balance		Dizziness	
Psychiatric	Depressed Mood		Mood Swings		Anxiety		Psychiatric condition	
Blood/Lymphatic	Leg Swelling		Bleeding Tendency		Easy Bruising		Other	
OB/GYN	Pregnant		Menopausal		Hormone Therapy		Birth Control	

_____ _____
Patient Signature **Date**

_____ _____
Legal Guardian Signature (if patient a minor) **Relationship to patient**

COLORADO
FOOT+ANKLE
SPORTS MEDICINE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I consent to the use or discloser of my protected health information by Kevin J Blue, D.P.M. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Kevin J Blue, D.P.M.

I understand that diagnosis or treatment of me by Dr. Blue, and Associates may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Dr. Blue, and Associates are not required to agree to the restriction that I request. However, If Dr. Blue, D.P.M., agrees to a restriction that I request, the restriction is binding on Dr. Blue, D.P.M., and Associates.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Blue, and Associates or Kevin Blue, D.P.M. has taken action in reliance on this consent.

My protected health information means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Signature: _____ Date: _____

Financial Policy for Colorado Foot and Ankle Sports Medicine

This is an agreement between Colorado Foot and Ankle Sports Medicine, and the Patient/Guarantor named on this form. By executing this agreement, you are agreeing to pay for all services that are received.

Co-Payments, Deductibles and Balances are required as services are rendered: Any co-payments required by an insurance company must be paid at the time of service.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account and any payments or credits applied to your account during the month. Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the due date on your statement.

Missed Appointment Fee: Any patient who does not show up for an appointment, a $50 fee may be charged. This fee must be paid before a new appointment is scheduled.

Contracted Insurance: If we are contracted with your insurance, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in non-payment or zero reimbursement from the insurance company.

Non-contracted (Out-Of-Network) Insurance: In the instance where we are NOT contracted or in Network with your insurance carrier, we must ask for payment in full at the time of service. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in non-payment or zero reimbursement from the insurance company.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees which we incur plus all court costs. In case of suit, you agree the venue shall be Douglas County, Colorado.

Returned Checks: There is a fee (currently $25.00) for any checks returned by the bank.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee if you want to have copies of your records sent to another doctor or organization. The amount of the fee is dependent on the number of pages we need to copy. By signing a Release of Records document, you authorize us to include all relevant information to the recipient of your choice.

Worker Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier **prior** to your initial visit. ***If your claim is denied, you will be responsible for payment in full.***

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility.

Signature: _____ Date: _____

Surprise/Balance Billing Disclosure Form

Surprise Billing – Know Your Rights

Beginning January 1, 2020, Colorado state law protects you from "surprise billing", also known as "balance billing." The protections apply when:

- You receive covered emergency services, other that ambulance services, from an out-of-network provider in Colorado, and/or you unintentionally receive covered services from an out-of-network facility in Colorado

What is Surprise/balance billing, and when does it happen?

If you are seen by a health care provider or use services in a facility or agency that is not in your health insurance plan's provider network, sometimes referred to as "Out of Network", you may receive a bill for additional costs associated with that care. Out-of-network heath care providers often bill you for the difference between what your insurer decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called "surprise" or "balance" billing.

When you CANNOT be balance-billed

Emergency services

If you are receiving emergency services, the most you can be billed for in your plan's in-network cost-sharing amount, which are copayment, deductibles, and/or coinsurance. You cannot be balance-billed for any other amount. This includes both the emergency facility where you receive emergency services and any providers that you see for emergency care.

Nonemergency Services at an In-Network or Out-of-Network Health Care Provider

The health care provider must tell you if you are at an out of-network location or at an in-network location that is using out-of-network providers. They must also tell you what types of services that you will be using may be provided by any out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. In this case, the most you can be billed for covered services is your in-network cost-sharing amount, which are copayments, deductibles, and/or coinsurance. These providers cannot balance bill you for additional costs.

Additional Protections

- Your insurer will pay out-of-network providers and facilities directly
- Your insurer must count any amount you pay for emergency services or certain out-of-network services (described above) toward your in-network deductible and out-of-pocket limit
- Your provider, facility, hospital, or agency must refund any amount you overpay within sixty days of being notified
- No one, including a provider, hospital, or insurer can ask you to limit or give up these rights

If you received services from an out-of-network provider or facility or agency in any OTHER situation, you may still be balance billed, or you may be responsible for the entire bill. If you intentionally receive nonemergency services from an out-of-network provider or facility, you may also be balance billed.

If you want to file a complaint against your health care provider, you can submit an online complaint by visiting this website: https://www.colorado.gov/pacific/dora/DPRO_File_Complaint. If you think you have received a bill for amounts other than your copayments, deductibles, and/or coinsurance, please contact the billing department, or the Colorado Division of Insurance at 720-822-0735 or 800-930-3745.

This law does NOT apply to ALL Colorado health plans. It only applies if you have a "CO-DOI" on your health insurance ID card. Please contact your health insurance plan at the number on your health insurance ID card or the Colorado Division of Insurance with questions

_____

Signature of Patient or Responsible Party

_____

Responsible Party's Relationship to Patient

USE AND DISCLOSURE OF HEALTH INFORMATION

CONSENT TO LEAVE VOICE OR TEXT MESSAGES

I hereby authorize Colorado Foot + Ankle Sports Medicine, Dr. Kevin Blue DPM, Dr. Ryan Muchowski DPM, Associates and/or third-party billing agent to call or text me. I understand that text messages may be unsecured. I understand that the communication could be read by a third party. The number I want text communications sent to is following telephone number **Mobile**: _____

I AUTHORIZE detailed voice or text messages to be left with the following information:

- ☐ Details about my next appointment, including physician name, date/time, and callback number
- ☐ Tests and other exam results
- ☐ Account payment, balances, cost estimates, or information needed for claims processing

CONSENT TO BE AUDIO AND VIDEO RECORDED I hereby authorize Colorado Foot + Ankle Sports Medicine, Dr. Kevin Blue DPM, Dr. Ryan Muchowski DPM, and/or associates to utilize audio and visual recording for medical documentation purposes. I understand that the recordings will not be released to anyone outside of this clinic. Initials _____

CONSENT FOR MARKETING USE OF IMAGES I hereby give permission to Colorado Foot + Ankle Sports Medicine, Dr. Kevin Blue DPM, Dr. Ryan Muchowski DPM, and their associates to use before and after images of my treatment for marketing on their website and in other promotional materials. I understand these images may be used anonymously unless I explicitly consent to reveal my identity. Initials _____

I ACKNOWLEDGE these images are owned by the clinic and no compensation will be provided to me. This consent is voluntary and can be revoked at any time, with the understanding that revocation cannot affect any uses already made. Initials _____

I **DECLINE.** Please do NOT leave any voice or text messages. Initials _____

By signing, I confirm understanding and agreement to these terms.

Name of Patient or Responsible Party: _____ Date: _____

Signature of Patient or Responsible Party: _____ Date: _____