New Patient Information

1818 10th Avenue Suite 250
Caldwell, ID 83605

1828 Millennium Way Suite 200
Meridian, ID 83642

PHONE: 208-855-5955 FAX: 208-459-8628

Rocky Mountain Foot & Ankle

Name		
First	Middle	Last
Date of Birth	SSN	Gender: F M
Email		
Address		
	city state	zip
Phone Home	Work	Cell
Please mark the preferred telephone number we may contact you at		
Referring Provider		
Primary Provider		
	Phone	
Primary Language	Race	Ethnicity
Emergency Contact		
	Relationship	Phone
Marital Status Married Single Widowed Divorced	Spouse/ Partner's Name	
Employer	Occupation	
Address	Phone:	

If Patient is a minor, please complete this section

Parent/Guardian		
Last	First	Middle
Address		
	city state	zip
Date of Birth	SSN	Phone
Contact Preference: *Please tell us how you would like to be contacted for reminders*		
Please circle:	Phone (list number)	Mail
Email (list email address)		Text: (list number)

Primary Insurance Company:			
ID#		Group#	
Policy Holder			Date of Birth
Relationship to Patient:	Self	Spouse	Parent/Guardian
Secondary Insurance Company:			
ID#		Group #	
Policy Holder			Date of Birth
Relationship to Patient:	Self	Spouse	Parent/Guardian

PAYMENT POLICY

Our practice is committed to providing the best treatment possible for our patients. The filing of insurance claims is a courtesy we extend to our patient's. However, your insurance policy is a contract between you (the patient) and your insurance company. It is the patient's responsibility to know what services are OR are not covered under their policy. **Full payment is due at time of service for co-pays, coinsurance and deductibles. We accept Cash, Checks, Visa, MasterCard, Discover and Care Credit.**

Rocky Mountain Foot and Ankle uses a third party agency to collect on accounts that are past due. It is YOUR responsibility to provide current and accurate insurance information at the time of your visit. Returned checks and balances older than 30 days are subject to collection fees. We require 24 hours notice for appointment cancellations. Otherwise, a **$25.00 "No Show" fee will be billed to you.**

DURABLE MEDICAL EQUIPMENT (DME)

These are supplies that are ordered by our physician(s) in the course of treatment of many conditions. Typical supplies are codes: (but not limited to)

L3260 Post Op Shoe	$25.00 ea*	L3060 Generic Foot Orthotics	$60.00/pair*
L3010 Custom Orthotics	$400.00/pair*	L2999 Toe correctors	$15.00 each*

These supplies are not always covered by many insurance companies. We strongly encourage you to review your insurance policy or contact your insurance company with the codes listed above to verify coverage to determine what your cost would be. We do our best to assist our patient's in verifying their coverage prior to dispensing these supplies; however it is ultimately the patient's responsibility to know their insurance coverage.

We encourage you to contact us for assistance in the management of your account. If you have any questions or need to make financial arrangements, please ask. We are here to help.

MEDICAL RECORDS

We will provide a copy of your medical records once at no cost, per course of treatment, upon receipt of a signed Medical Records Release. There will be a charge of $15.00 for additional requests and must be paid at the time the records are released.

NOTICE OF PRIVACY PRACTICE

I understand that, under the Health Insurance and Portability & Accountability Act of 1996 (HIPPA), I have certain rights regarding the protected health information. I understand that this information can and will be used to:

- Conduct, Plan and Direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.
I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Persons Authorized to access my information:

1. _____Relationship: _____

2. _____Relationship: _____

3. _____Relationship: _____

I authorize the release of any information necessary to determine liability for payment to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign benefits to which I am entitled including private insurance and other health plans to Rocky Mountain Foot and Ankle. This assignment shall remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges that are not paid by insurance.

TREATMENT CONSENT

I hereby consent and give my permission to the doctor(s) (and the doctor's assistants or designated replacement) to administer and perform such procedures or treatment upon me as the doctor has suggested and that I have agreed to.

_____Date:_____
Signature of Patient

_____Date:_____
If Minor; Signature of Responsible party

_____
Printed Name

*Fees are subject to change without notice. Updated Feb. 2014

Brief Medical History

Please describe what brought you in to see the doctor today:

_____
_____
_____
_____

Was this an injury/accident? Y/N Work related Y/N

Have you notified your employer about this injury? Y/N Date of injury:_____

Allergies	**What happens if you have this?**

Medication or Supplement	**Dose**	**Reason**	**Medication or Supplement**	**Dose**	**Reason**

Medical Conditions - Do you have a history of any of the medical problems listed? CIRCLE all that apply:

AIDS/HIV
Alcoholism
Anemia
Angina
Asthma
Bleeding disorders
Blood clots/thrombosis
Cancer
Cerebral palsy
Chemical dependency
Cellulitis
Crone's disease
Coronary artery Dz
Cirrhosis of the liver
COPD
Depression
Diabetes/Pre-diabetes
Emphysema
Fibromyalgia
GERD/Peptic ulcers
Gluten intolerance
Gout
Heart disease
Heart attack
Hemophilia
Hepatitis ____
High blood pressure
Immune disorder
Irritable bowel Dz
Kidney disease
Leg/foot ulcer
Low blood pressure
Liver disease
MRSA- infection
Neuropathy
Osteoarthritis
Psoriasis
Psychiatric illness
Respiratory disease
Rheumatoid arthritis
Spine injury/deformity
Stroke
Thyroid disease
Urinary track Infections
Venereal disease

Surgical History & Hospitalization History – please list all surgeries and any recent hospitalizations with dates

_____
_____

Perinatal History- For Pediatric Patients Only- please complete this if the patient is a child under the age of 18

Gestation: was the child born prematurely? How old was the child when they began to:

Cruise _____ Crawl _____Walk _____Talk _____

Have there been any developmental delays? Yes/No Are all immunizations up to date?- Yes/No

Additional History

List any other issues the doctor should be aware of:

_____

Family History

	Diabetes
	Cancer
	Heart Disease
	Stroke
	Rheumatoid arthritis
	Gout
	Lupus
	Other:

Social History

Activity		Quantity/Frequency
Exercise		
Reading/Education		
Working		
Alcohol		
Cigarettes		
Chewing tobacco		
Marijuana		
Narcotics		

Please mark any symptoms you have experienced within the last 30 day and are NEW to you.

General	**Genitourinary**	**Musculoskeletal**
fatigue	leaking urine	stiffness out of bed in morning
unexplained weight gain loss	urinary track infection	ankle pain
fever, chills	blood in urine	foot pain
dehydration	excessive urination	toe pain
		knee pain
Endocrine	**Gastrointestinal**	back pain
heat or cold intolerance	heartburn	
exhaustion	bloating	**Neurological**
dry skin	diarrhea	headache
	nausea/vomiting	dizziness
Ears, Nose , Throat	constipation	unsteady gait
ringing in ears		frequent falls
ear infection	**Dermatologic / Integumentary**	tingling in legs or numbness
sinus infection	rash	
bloody nose	darkened mole	**Respiratory/Heart**
strep throat	itchy feet	racing heart beat
difficulty swallowing	ulcers	chest pains
swollen tonsils	painful callus	irregular heart beats
		history of blood clots
Eyes	**Lymphatic**	shortness of breath
blurred vision	swollen lymph nodes	asthma
blindness	easy bruising	pneumonia
glasses		sleep apnea
seeing spots		