Rocky Mountain Foot & Ankle is excited to welcome you to our specialty practice. Here at RMFA, our goal is to provide you with exceptional patient care. In order to succeed, our goal is to provide an outstanding visit at our office. We do ask that you come prepared for your new patient appointment.

Please provide the following while checking in for your appointment:

- Entire New Patient Paperwork packet completed
- Updated Medication List
- ID, Insurance Card(s), Prescription Card
- Copay

Please arrive 30 mins early to your appointment, to insure that we can complete all necessary steps to make sure you get properly checked in.

Thank you for understanding; we look forward to you coming to Rocky Mountain Foot & Ankle.

New Patient Information

1818 10th Avenue Suite
250 Caldwell, ID 83605
PHONE: 208-855-5955

2667 E. Gala Court Suite 130
Meridian, ID 83642
FAX: 208-459-8628

Name:
First Middle Last
Date of Birth: SSN and DL #: 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:
First Middle Last
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

Brief Medical History

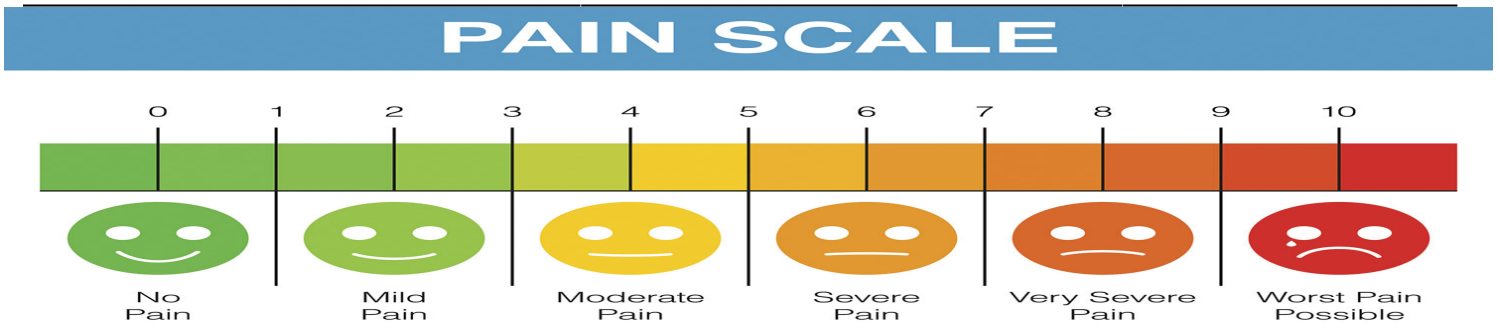
Please describe what brought you in to see the doctor today:

_____

_____

_____

_____



Was this an injury/accident? Y/N Work related? Y/N Shoe Size? _____

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**

If patient has Diabetes:

Blood sugar this morning: _____ Last HbA1c: _____

When was the last time your HbA1c was tested? _____/_____ (Month/Year)

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? Yes/No 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 tract 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		

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

AIDS/HIV
Alcoholism
Anemia
Angina
Asthma
Bipolar Disorder
Bleeding Disorders
Blood Clots/DVT
Cancer _____
Cerebral Palsy
Chemical Dependency
Cellulitis
Crone's Disease
Coronary Artery Disease
Cirrhosis of the Liver
COPD/Pulmonary Disease
Depression/Anxiety
Diabetes/Pre-diabetes
Emphysema
Fibromyalgia
GERD/Peptic Ulcers
Gluten Intolerance
Gout
Heart Disease
Heart Attack
Hemophilia
Hepatitis
A/B/C
High Blood Pressure
High Cholesterol
Immune Disorder
Irritable Bowel Disease
Kidney Disease
Leg/Foot Ulcer
Low Blood Pressure
Liver Disease
Lupus
MRSA- Infection
Neuropathy
Multiple Sclerosis
Osteoarthritis
Psoriasis
Psychiatric Illness
Reynolds Disease
Respiratory Disease
Rheumatoid Arthritis
Spine injury/Deformity
STD
Stroke
Thyroid Disease
Urinary Tract Infections
Venereal Disease

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

_____

_____

Have you received a pneumonia vaccination with the last 12 months? Y/N
Have you received an influenza vaccine within the last 12 months? Y/N

Do you have an Advanced Care Plan/Living Will? Y/N

FINANCIAL 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, 60% of 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. If there is a payment plan set up you will be required to pay that balance in 3 consecutive payments. If your balance is not paid within 90 days there will be an 18% interest charge added. Returned checks and balances older than 90 days are subject to collection fees. We require 24 hours' notice for appointment cancellations.

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.*	L3040 Generic Foot Orthotics	$70.00/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. Once DME products are dispensed they **cannot** be returned.
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.

TOE NAIL/FOOT CARE

Simple toe nail care (Trimming and cutting of the Nail) is $35.00
Extensive toe nail care- Grinding/Trimming and cutting of the nail is $50.00
Removal of corns and callus- $20.00+

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 $45.00 for additional requests and must be paid at the time the records are released.

FORMS

There will be a $50.00 charge for all forms that need to be filled out by the physician. The patient need to make an appointment for FMLA forms to be completed and the form will be an additional charge of $50.00.

Orthotic Repair/Modification

There will be a $150.00 charge for any and all repairs/modifications after the 30 day warranty has expired, beginning the day of dispensement.

_____ _____

Patients Signature Date

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