Peter D. Schultz, D.P.M., F.A.C.F.A.S
Board Certified, American Board of Foot & Ankle Surgery
Fellow, American College of Foot & Ankle Surgeons
1440 N, Boise Avenue • Loveland, Colorado 80538
970-278-1440 • 970-203-0329 (fax)
www.footandanklecare.net

FAX COVER SHEET

Date _____

To: _____ Fax# _____

Number of pages (NOT including cover sheet) _____

From: **ADVANCED FOOT & ANKLE CARE** Fax # **970-203-0329**

Peter D. Schultz, DPM, FACFAS

If problems occur during this transmission, **please call 970-278-1440**

Confidentiality Notice

Comments:

_____

_____

_____

_____

Welcome To Our Office

(PLEASE PRINT AND FILL OUT ALL ITEMS COMPLETELY

This document will be shredded once the information is entered into the computer system.

Today's Date _____

Patient's Name _____ Date of Birth _____

How would you like our staff to address you/Nickname? _____ Male Female

Home Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone # (____) _____ Email _____

Social Security # _____ Preferred method of contact: Phone___ E-mail___ Letter___

Race: I refuse to give this info___ Caucasian___ Black/African American___ Hispanic or Latino___ Japanese___
Asian/Native Hawaiian or Pacific Islander___ Chinese___ Filipino___ American Indian/Alaska Native___
Other/undetermined___

Ethnicity: Non-Latino___ Latino___

Preferred language: English___ Spanish___ Other___

Primary Care Physician _____ Date Last Seen _____

Preferred Pharmacy _____ Location _____

Emergency Contact _____ Relationship _____

Home Phone # (____) _____

Complete this section if the patient is a minor, or if someone else is the Primary Policy Holder.

Responsible Party _____ Relationship to patient _____ Legal Guardian _____

Social Security # _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Home Phone # (____) _____ Work Phone # (____) _____

How did you hear about our office? **(Please check appropriate source)**

My Doctor referred me (name) _____ Insurance Company _____ Family Member (name) _____

Friend (name) _____ I have seen Dr. Schultz before ___

Our Sign___ Our Website___ Dex Yellow Pages___ Yellowbook Yellow Pages___ Front Door Direct Yellow Pages___

Google Search___ Yahoo Search___ Dex Online Search___ Radio___ Other _____

Insurance Information

Patient's Primary Insurance

Name of Company _____ Policy Holder's Name _____

Group # _____ Policy ID # _____

Patient s Secondary Insurance (If Applicable)

Name of Company _____ Policy Holder's Name _____

Group # _____ Policy ID # _____

Complete this section if someone else is the Primary Policy Holder

Responsible Party _____ Relationship to patient _____ Legal Guardian _____

Social Security # _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Home Phone # (___) _____ Work Phone # (___) _____

Employer _____ Occupation _____ Length of Employment _____

Phone # (___) _____ City _____ State_____ Zip _____

Workers Compensation Claims

Referred By Doctor _____ Date of Accident _____

Employer (at time of accident) _____ Employer's Phone # (___) _____

Claim # _____ Name of Insurance carrier: _____

Adjuster's Name _____ Phone # (___) _____

Our office will file the insurance claims for medical and surgical charges. Self-Pay patients require payment on the date of service. Please remember, you are responsible for all fees, regardless of insurance coverage & all charges if a referral for HMD plans is not obtained prior to date of service.

I authorize the release of any medical information to process insurance claims.

I authorize payment directly to Loveland Foot and Ankle Clinic, P.C. dba Advanced Foot and Ankle Care (AFAC) for medical and/or surgical benefits, if any, otherwise payable to me for the services as described, realizing that I am responsible to pay for non-covered services.

I have reviewed, understand and consent to the Financial Policies of Loveland Foot and Ankle Clinic, P.C. dba AFAC.

Signature of Patient or Legal Guardian _____ Date _____

PATIENT MEDICAL HISTORY

Patient's Name: _____

Height: _____ Weight: _____

MEDICAL HISTORY: Have you had, or do you currently have any of the following? Please check **all** that apply.

___ No Previous Medical History

___ Diabetes
___ Hepatitis/Liver problems
___ Kidney Disease/Renal Failure
___ Hyperthyroid
___ Hypothyroid
___ Previous Injuries
___ Gout
___ HIV/AIDS
___ Bone/joint disease
___ Rheumatoid Arthritis
___ Osteoarthritis/DJD
___ Asthma
___ Circulatory problems
___ High Blood Pressure
___ Low Blood Pressure
___ Heart Disease/ Heart attack
___ Bleeding Tendency
___ Blood Transfusion
___ Stroke (CVA)
___ Slow to heal
___ Frequent anxiety
___ COPD
___ Leg cramps
___ Shortness of Breath
___ Cancer _____
___ Previous Injuries _____
___ Neuritis/neuralgia
___ Neurologic Disorder
___ Numbness
___ Depression
___ Bipolar Disorder
___ Skin rashes/conditions
___ Stomach Ulcers
___ Weakness/fatigue
___ Low Back pain

Any other problems or conditions **not** listed above:

HOSPITALIZATION AND SURGICAL HISTORY ___ No Previous Hospitalization/ surgeries

List all previous surgeries or hospitalizations: _____ Date: _____

_____

_____

_____

_____

_____

ALLERGIES

___ Aspirin
___ Novacaine (Local Anesthetic)
___ Tape/ Band-Aids
___ Latex
___ Cipro
___ Penicillin
___ Iodine
___ Metals
___ Cortisonc/Prednisonc
___ Food/Shellfish
___ Sulfa
___ Codeine
___ Morphine
___ Other antibiotics _____
___ Environmental _____
___ Keflex
___ Contrast dyes

MEDICATIONS: Please list **ALL** medications you are currently taking

Medication	Strength (Dosage)	How Often taken	Reason for Taking

Are you taking any blood thinners? ___ YES ___ NO

Are you taking any steroid medication (prednisone)? ___ YES ___ NO

Do you have any metal implants? ___ YES ___ NO

SOCIAL HISTORY

Occupation: _____

% of work day Spent standing or walking? _____

Use of Alcohol: Never ___ Occasionally ___ Weekly ___ Daily ___

Smoking: No ___ Previously but quit ___ Yes, Packs per day? _____

Recreational/ Street Drug Use: _____ Never ___ Rarely ___ Daily ___

Exercise, Sports, or Recreational Activities _____

_____

FAMILY HISTORY

Please list all diseases/conditions common to your family including heart disease, diabetes, rheumatoid diseases, arthritis, and genetic problems, (May refer to conditions listed under medical history on previous page)

Has anyone in your family had a similar foot problem? ___YES ___NO

if deceased, cause of death

Father: _____

Mother: _____

I state that the above medical Information is true and accurate to the best of my knowledge. I understand that providing incorrect Information can be dangerous to my health, I understand it is my responsibility to inform the doctor's office of any changes in my medical status.

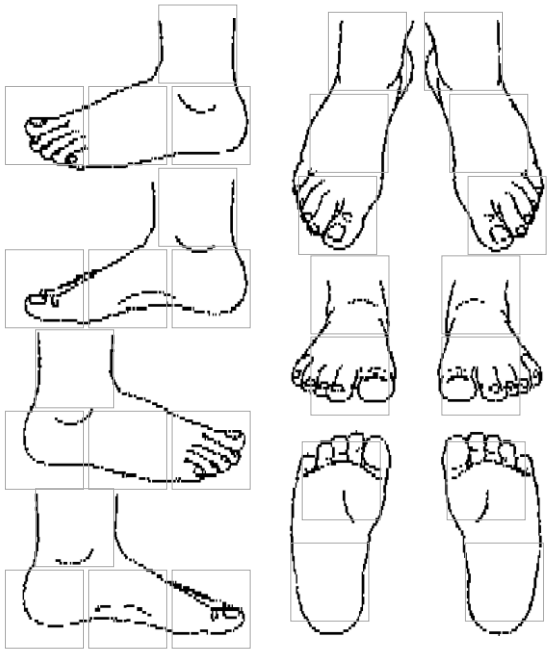
_____ _____

Signature of Patient/Parent or Guardian Date

What is the main problem that brings you to our office today? _____

_____

Where is the problem located? Please mark on the diagram below.



How long ago did this problem start? _____

Did your pain or problem begin: ___ Suddenly ___ Gradually

Was this problem caused by an injury? ___ Yes ___ No

If yes, was It a work-related injury? ___ Yes ___ No

If yes, please describe: _____

How would you describe your pain? ___ sharp ___ dull ___ throbbing ___ aching ___ shooting ___ burning ___ numb ___ tingling ___ other

How would you rate your pain on a scale from 0 to 10?

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst possible)

Since your pain or problem began, has it: ___ worsened ___ improved ___ remained unchanged

What makes your problem feel worse? ___ standing ___ walking ___ daily activities ___ running ___ dress shoes

___ other: _____

What makes your pain or problems feel better? ___ resting ___ ice ___ elevation ___ wrapping ___ massage

___ other: _____

What treatments have you had for this problem? _____

How has this problem affected your lifestyles or ability to work? _____

_____

FINANCIAL POLICY

LOVELAND FOOT & ANKLE CLINIC, P.C. dba

ADVANCED FOOT & ANKLE CARE

Authorization and Assignment of Benefits

Treatment Authorization: I give consent to Dr. Peter Schultz and the Doctors of Advanced Foot and Ankle Care to perform office based medical procedures to treat my condition, symptoms, illness, or injuries

Medication History Authorization: I give consent to Advanced Foot and Ankle Care to access and download my prescription medication history.

Release of Medical Information and Assignment of Benefits: I authorize the release of all information necessary to submit, document, and process insurance claims on my behalf, I assign to Dr. Peter Schultz and Advanced Foot and Ankle Care the payment and benefits of any and all health insurance and personal injury insurance policies to which I may be entitled.

Acknowledgement of Notice of Privacy Practices (HIPAA): I understand that I am entitled to receive a copy of the notice of privacy practices, available upon request and on our website.

Financial and Office Policies

As a courtesy to our patients, we submit charges to contracted insurance plans. We arc obligated by our contract with your carrier to collect patient responsibility amounts such as co-payment, co-insurance, deductible, and any non-covered services at the time of service. Sometimes, exact coverage cannot be determined until the insurance company receives the claim. For the patients without insurance, or with insurance plans with which the practice is not contracted, payment is due in full at the time of service.

If services provided are determined by your health plan to be fully or partially non-covered for any reason, you agree to waive your contractual coverage and agree to be responsible for the complete charge.

PATIENTS UNDER 18 YEARS QF AGE OR LIVING AT HOME

The adult accompanying the patient to the office is responsible for full payment of all charges. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan or payment by cash or check at time of service,

MISSED APPOINTMENTS

Please give us a courtesy call if you cannot make your scheduled appointment. There will be a **$35.00 charge** for appointments that are either missed* or not canccled/rescheduled at least 24 hours in advance of the appointment scheduled. For the 2nd or more missed appointments, the charge is SS0.00 for each missed appointment.

LATE FEES. RETURNED CHECK FEES. ETC.

Payment is due in full upon receipt of the billing statement. **A late fee of $10.00 will be assessed each billing cycle that payment in full is not received.** There is a **$25.00 returned check fee** for checks that do not clear your bank.

There is a **$20.00** charge to fill out any paperwork requested pertaining to your treatment, for whatever purpose i.e, time-off work, work restrictions, parking permits, etc.

There will be a **$50.00** collection charge applied to patient balances for any account turned over to collection for non-payment. I agree that if my account is turned over to a collection agency, I will responsible for all collection costs, court costs, attorney fees and any other fees incurred in the collection of my balance,

I have read, understand, and accept the terms of the Financial Policy as stated above.

Print Name _____

Signature of Patient/Parent or Guardian _____ Date: _____

LOVELAND FOOT AND ANKLE CLINIC P.C.

dba ADVANCED FOOT AND ANKLE CARE

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Loveland Foot and Ankle Clinic, P.C. dba Advanced Foot and Ankle Care (AFAC) to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO), (Loveland Foot and Ankle Clinic, P.C. Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent, Loveland Foot and Ankle Clinic, P.C. reserves the right to revise the Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Loveland Foot and Ankle Clinic, P.C. at 1440 N. Boise Ave. Loveland, CO 80538.

With this consent, Loveland Foot and Ankle Clinic, P.C. may call my home or alternative locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, calls pertaining to my clinical care, including laboratory results, and billing issues among others.

With this consent, Loveland Foot and Ankle Clinic, P.C. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Loveland Foot and Ankle Clinic, P.C. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Loveland Foot and Ankle Clinic, P.C. restrict how it uses my PHI to carry out TPO. However, the practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Loveland Foot and Ankle Clinic, P.C. may decline to provide treatment to me.

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HELATH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize LOVELAND FOOT AND ANKLE CLINIC, P.C. (AFAC) to use and/or disclose all medical protected health information (PHI) and billing information about me to or for the party or parties listed below, other than for information requested/required by your insurance company.

Name _____ Relationship _____

When my information is used or disclosed following this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HI PA A Privacy Rule. I have the right to revoke this authorization in writing except to the extent that LOVELAND FOOT AND ANKLE CLINIC, P.C. (AFAC) has acted in reliance upon this authorization. My written revocation, dated and signed, must be submitted to LOVELAND FOOT AND ANKLE CLINIC, P.C. (AFAC) at 1440 N. Boise Ave. Loveland, CO 80538,

Print Name of Patient or Legal Guardian	Signature of Patient or Legal Guardian	Date