Welcome To Our Office

Patient's Name ______________________________ M F Today's Date: ______________
(Please enter complete legal name)

By what name would you like our office staff to address you? ______________________________

Home Address ______________________________

City ______________ State ________ Zip__ ________ E-mail ______________

Home Phone: ______________ Mobile Phone: ______________ Birthdate: ______________ Age:________

Social Security Number ______________ Patient Status: Single Married (Name of Spouse ______________) Other

Employer ______________________________ Occupation ______________

Employer's Address ______________________________

City ______________ State ________ Zip ______________ Work Phone: ______________

Primary Care Physician ______________________________ Date Last Seen ______________

Spouse, Friend or Neighbor to Contact in an Emergency ______________ Phone # ______________

Your Pharmacy: ______________________________
(Name & Address)

Would you prefer future appointment reminder calls by Phone or E-mail?

We would like to know how you heard about us? ***(Please indicate below)***

Patient at our office ______________ *(Name)*

Doctor/Primary Care Physician ______________

Yellow Pages______________ *(Which One)*

Insurance Company ______________

Newspaper Ad ______________ *(Which One)*

Our Sign ______________

Foot Info Line ______________

Our Web Site ______________

Other *(Please Explain)* ______________________________

Please supply us with your insurance card so we may photocopy it for our files
(Services must be paid at time of service if we don't participate with your insurance)

I authorize A Step Ahead Foot & Ankle Center to perform examination or treatment needed to diagnose and/or treat my foot/ankle problem. I also authorize the taking of and the use of clinical photographs. I understand that these X-rays are the property of A Step Ahead Foot & Ankle Center. I understand that I or the person responsible for paying my bills is financially responsible for charges not covered by my insurance. All insurance plans are not the same and do not cover the same procedures. In the event my health care plan determines a service to be "not covered", I will be responsible for the complete charge.

I request that payment of authorized benefits be made to A Step Ahead Foot & Ankle Center for any services furnished me by A Step Ahead Foot & Ankle Center. I authorize any holder of medical information about me to release to my insurance co and its agents any information needed to determine these benefits or these benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 13 of the HCFA 1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown.

Signed: ______________________________ Date: ______________
(insured or authorized person)

A Step Ahead Foot & Ankle Center

To insure a complete medical history, please complete ALL sections of this form

Name ____ Date ____________________

What is your present foot or ankle problem? ____

If female, could you possibly be pregnant? ❑ Yes ❑ No

Have you had or do you now have any of the following: (Please check all applicable)

❑ Measles ❑ Chicken Pox ❑ Mumps ❑ Alcoholism ❑ Drug Addiction ❑ Tuberculosis ❑ Polio ❑ Epilepsy

History of Cancer: (type) ____

Constitutional: ❑ Dizziness ❑ Chills

CV: ❑ Heart Attack ❑ High Blood Pressure ❑ Congestive Heart Failure ❑ Blood clot ❑ Raynauds ❑ High Cholesterol

Endocrine: ❑ Diabetes ❑ Fatigue ❑ Unexplained weight loss ❑ Hypothyroid

ENMT: ❑ Ringing in ears ❑ Hearing Loss ❑ Difficulty swallowing ❑ Bad breath ❑ Deviated Septum

Eyes: ❑ Dry eyes ❑ Loss of vision ❑ Wears glasses ❑ Wears contacts ❑ Cataract ❑ Glaucoma

GI: ❑ Nausea ❑ Vomiting ❑ Diarrhea ❑ Blood in stool ❑ Constipation ❑ Hemorrhoids ❑ Hepatitis A / B / C

GU: ❑ Painful urination ❑ Blood in urine ❑ frequent urination ❑ Impotence ❑ STDs ❑ HIV infection

Immunologic: ❑ Gout ❑ Rheumatic disease ❑ Allergies

Integumentary: ❑ Dermatitis ❑ Eczema ❑ Psoriasis ❑ Athletes foot ❑ Rash ❑ Skin condition ❑ Warts

Lymphatic: ❑ Bloating ❑ Swelling ❑ Pitting edema ❑ Inability to stop bleeding

MSK: ❑ Back pain ❑ Joint pain ❑ Muscle pain ❑ Bone pain ❑ Osteoarthritis ❑ Rheumatoid Arthritis ❑ Fibromyalgia

Neurological: ❑ Seizures ❑ Tremors ❑ Tingling/Numbness ❑ Peripheral neuropathy

Psychiatric: ❑ Anxiety ❑ Depression ❑ Binging ❑ Paranoia

Respiratory: ❑ Asthma ❑ Sleep Apnea ❑ Snoring ❑ Shortness of breath ❑ Pneumonia

❑ OTHER: ____

Clinical Use Only

Ht:__________

Wt:__________

BP:__________

Pulse:________

Temp:________

Please list any surgeries and/or hospitalization that you have had: (Indicate procedure, date, where performed and attending physician, if known. *Example: Tonsillectomy, 1984, Dr. Smith, Loveland)*

____

____

____

Have you suffered any injuries to:

❑ Feet ❑ Hip ❑ Head ❑ Legs ❑ Back ❑ Neck ❑Knees ❑ Other

____

Please list names and dosages of any medication that you are currently taking (or provide list that may be photocopied): (Example: Feldene, 20 mg, 1 x daily):

____

____

Have you had or do you now have allergies:

❑ Local Anesthesia ❑ Sulfa Drugs ❑ Erythromycin ❑ Iodine ❑ Penicillin ❑ Latex ❑ Foods __________________
❑ Tapes or bandaids ❑ Clindamycin ❑ Iodine ❑ Codeine ❑ Aspirin ❑ Silver ❑ Other __________________

Do you have a family history of any of the following: (check all that apply)

❑Asthma/Respiratory Diseases ❑ Heart Disease ❑ Diabetes ❑ Gout ❑ Cancer (type)__________________
❑ High Blood Pressure ❑Severe Arthritis ❑ Strokes ❑ Arthritis ❑ Unknown – Patient was adopted.

How much alcohol do you consume? ❑ None ❑ Daily ❑ Weekly ❑ Occasionally

Are you a smoker? ❑ No ❑ Yes: How much per day? ______________________________

By signing below, I am certifying that this is my/the patient's complete medical history to the best of my knowledge.

Patient or Responsible Party ____________________ ____________________ Date ______________

(Signature) (Print)

A Step Ahead Foot & Ankle Center

Financial Policy and Payment Agreement

Please read this form carefully. We hope you understand our financial policies are established to assure the financial resources needed to maintain our offices for all our patients. We will work with you so that your medical care does not become a financial burden.

If you have health insurance with which we participate: *(Our receptionist can clarify if we participate with your insurance plan)*

- It is your responsibility for obtaining any necessary referrals. If you do not obtain this referral, you are responsible for any charges incurred.
- Additional charges may be applied for Strapping/Taping of your feet, x-rays and laboratory services. Depending on your insurance plan, these services *(and not limited to)* may be applied to a co-insurance or deductible.
- We will file your insurance claims for you, provided we have all current billing information. We need a copy of your insurance card(s) in order to provide this service.
- Any co-pays are required at the time of service.
- You are responsible for charges not covered by your insurance.

If we do not participate with your insurance:

- We will file your claims as a courtesy to you, however, payment for services is required at the time services are provided.

Charges for services *(co-payments, deductibles and non-covered services)* are due and payable at the time services are provided. We accept personal checks (no third party checks), cash & VISA, MasterCard, Discover and American Express.

Your major medical health insurance is an agreement between you and your insurance company. Our relationship is with you, not your insurance company. Therefore, all charges are *ultimately* your responsibility, regardless of your insurance & if we participate or do not participate with your insurance.

Responsibility for payment for services rendered to any dependent children whose parents are divorced or separated rests with the parent who seeks treatment for the child.

X-rays taken in this office are part of the patient's permanent record and are the property of A Step Ahead Foot & Ankle Center. Copies of original X-rays may be obtained with at least 24 hours prior notice. These copies are available for pick-up or mailing but a release form will need to be signed by the patient or responsible party beforehand.

There is a $20.00 charge for returned checks.

A billing charge of $5.00 per month will be added to your account each month on any unpaid balance after 90 days. Accounts 90 days past due are subject to collection proceedings.

For those who do not pay their co-pay at time of service, there will be a $10.00 rebilling fee assessed.

Three missed appointments will result in a missed appointment fee of $25.00.

If you do not have any questions regarding our financial policies, please sign the bottom of this form indicating you understand and accept this policy agreement.

Signature_____________________________ Print Name ____________________________ Date_________________

(insured or authorized person)

HIPAA Notice of Privacy Practices

A Step Ahead Foot & Ankle Center

THIS NOTICE WAS PUBLISHED & BECAME EFFECTIVE ON APRIL 14, 2003 & DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Healthcare Operations: We may use or disclose, as-needed, your protected health information and/or x-rays in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.** You may also revoke this authorization or request a copy at any time.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number at (970)493-4660.

Your signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Signature ________________________________ ***Print Name*** ____________________________ ***Date***_____________

If you would like to give us permission to speak with and give medical information to any other individuals regarding your care, please indicate who this is in the areas provided below.

Name __________________________________ *Relationship to you* ______________________ *Your initials* _______

Name __________________________________ *Relationship to you* ______________________ *Your initials* _______

Robert C. Schulte, DPM
Chad M. Knutsen, DPM
Michael J. Burns, DPM#

Board Certified:
American Board of Podiatric Surgery
#Am. Board of Podiatric Orthopedics

Members:
American Podiatric Medical Assn.
Colorado Podiatric Medical Assn.

Fellows:
Am. College of Foot & Ankle Surgeons
#Am. Academy of Podiatric Sports Med.

Soothing, effective treatments for:

Flat feet, high arches, heel pain, bunions & hammertoes
Ankle sprains, fractures & chronic pain
Nail problems
Infant deformities
Sports injuries & prevention
Corns & calluses
Diabetic foot care
Nerve problems
Skin problems
Warts

Care that fits your schedule:

Morning, lunchtime & evening hours
Same-day appointments
Major insurances & credit cards accepted

2001 South Shields, Bldg. F
Spring Creek Medical Park
Fort Collins, CO 80526
970-493-4660
Fax 970-493-6710

3850 N. Grant Ave., Suite 130
Loveland Medical Plaza
Loveland, CO 80538
970-667-0769
Fax 970-493-6710

Web Site: www.asafoot.com

Please help us in updating our records!

As part of the government initiative to encourage doctors to use Electronic Health Records, we are obligated to demonstrate 'meaningful use' of our medical software.

Part of that involves tracking basic demographics to better ensure equal access and care throughout the patient population.

Your choices below are needed to help us to fulfill our 'meaningful use' medical reporting obligations.

If you wish **not** to participate, please simply select 'not specified.'

Thank you! – the Staff at *A Step Ahead Foot & Ankle Center*

Preferred Language:

______ Not Specified
______ Arabic
______ Chinese
______ English
______ French
______ German
______ Spanish
______ Russian
______ Vietnamese
______ Other ________________
(please specify)

Race:

______ Not Specified
______ American Indian or Alaska Native
______ Asian
______ Black or African American
______ Native Hawaiian or Other Pacific Islander
______ White

Ethnicity:

______ Not Specified
______ Hispanic or Latino
______ Not Hispanic or Latino

*Name:*________________________________ *Date of Birth:*______________

*Signature:*________________________________

A Step Ahead
Foot & Ankle Center
Personalized solutions for your foot and ankle care

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Complete this section only if someone other than the patient is financially responsible.

Guarantor Agreement

(* items are required)

____
(today's date)

*Patient ______________________________ ______________
(First) (Middle Initial) (Last) (date of birth)

*Relationship to Patient ____________________________

*Guarantor's Name ____________________________

*Guarantor's Social Security No. ____________________

*Guarantor's Date of Birth ______________

*Address ____________________________

*City ____________________ *State _____ *Zip ________

*Home Telephone ______________ Mobile phone ______________

Employer ____________________________

Business Telephone ____________________

E-mail ____________________________

Guarantor Agreement:

I ____________________________ agree to be responsible for the
(Signature of Guarantor)

payment of services rendered by A Step Ahead Foot & Ankle Center on behalf of the above-named patient until ____________________.
(expiration date)

I give permission to see and treat above minor without any adult being present.

Signed & Dated: ____________________

________________________ ________________________
Name *Signature*