Patient Registration and Health History

We are pleased that you have chosen this office for your care.
To assist us with your service, please complete the following form.

I. Patient Information Date _____

Patient _____
Address _____
City _____ State _____ Zip _____
Phone _____ Cell _____ Work _____
Patient SS# _____
Birthday _____ Age _____ Sex M or F
Email address _____
Whom may we thank for referring you? _____

II. Emergency Contact

Name _____ Relationship _____
Home Phone _____ Cell Phone _____

III. Insurance

Who is responsible for this account? _____ Relationship to Patient _____
Primary Insurance _____
ID # _____ Group# _____
Subscriber Name _____
Birthdate _____ SS# _____

Secondary Insurance _____
ID # _____ Group# _____
Subscriber Name _____
Birthdate _____ SS# _____

IV. Basic Health Information

Primary Care Provider _____ Date Last Seen _____
Preferred Pharmacy Name and Location _____
*Preferred Language _____
*Please Select Your Race: American Indian / Alaskan Native / Asian / African American / Caucasian / Pacific Islander/ Other/ Declined
*Please Select Your Ethnicity: Hispanic / Non-Hispanic / Declined

***Requirement of our Government's Health Information Technology for Economic and Clinical Health Act (HITECH)**

V. Podiatric History (Are you currently or have you been treated in the past for any of the following conditions? Please Circle.)

Ankle Pain	Athlete's Foot	Bunions	Corns & Calluses	Cramps or Numbness
Flat Feet	Foot or Leg Cramps	Heel Pain	Ingrown Toenails	Plantar Warts

What is the reason for your visit today?_____

_____

_____

Have you been to a Podiatrist before? If yes, please list_____Last Visit_____

VI. Medical History (Are you currently or have you been treated in the past for any of the following conditions? Please Circle.)

Alcohol chemical dependency	COPD	Heart disease	Liver disease
Anemia	Depression	Heart murmur	Menopause
Arthritis (type): _____	Diabetes- Type I or Type II	Hepatitis (type): _____	Migraines
Asthma	Emphysema/Bronchitis	High cholesterol	Osteoporosis
Bipolar disorder	Epilepsy/ Seizure Disorder	HIV Status: + - unknown	Prostate problems
Bleeding disorders	Fibromyalgia	HTN/ High blood pressure	Rheumatic fever
Blood clots/ DVT/PE	GERD/ Reflux	Hyperthyroidism	Sleep apnea/ difficulties
Cancer (type):	Glaucoma	Hypothyroidism	Stroke/TIA
Cardiac arrhythmia	Gout	Hypotension	Stomach ulcers
Crohn's/ Ulcerative Colitis	Heart attack- MI	Kidney disease	Tuberculosis

Others: _____

VII. Surgeries & Hospitalizations (List all procedures, locations and any complications.)

_____

_____

_____

VIII. Medications (List all prescription or over-the-counter that you are currently on. Please include dosage and frequency.)

_____

_____

_____

_____

IX. Allergies (List the medication and the reaction that it has caused.)

_____

_____

X. Social History

Marital Status: ___Single ___ Married ___Widowed ___Divorced

Employed? ___yes ___no Type of work? _____

Smoking Status: ___never ____current smoker ___former smoker ___social smoker

Smoking Amount: ½ pack/day 1 pack/ day 2 pack/ day 3 pack/ day 4 or more pack/ day How Long?_____

Tobacco Exposure at your home? ___yes ___no Smoker in home smokes: ___ inside ___outside

Do you drink alcohol? ___yes ___ no ___Rare ___Occasional ___Social ___Daily ___Former ___Recovering Alcoholic

Drinking amount: 1-2/ day 3-4/ day 5-6/ day >7/day 1-2/ week 3-4/ week 5-6/ week >7/ week

Do you use recreational drugs? ___ yes ___ no How often? _____

Do you exercise routinely? ___ yes ___ no What activities? _____

XI. Family History (Do you have any family members being treated for the following medical condition? If so, who and for what?

Anemia	___yes	___no	Who?
Arthritis	___yes	___no	Who?
Asthma	___yes	___no	Who?
Cancer	___yes	___no	Who?
Diabetes	___yes	___no	Who?
Heart Disease	___yes	___no	Who?
High Cholesterol	___yes	___no	Who?
Hypertension	___yes	___no	Who?
Kidney Disease	___yes	___no	Who?
Neurologic	___yes	___no	Who?
Stroke/ TIA	___yes	___no	Who?
Thyroid Disease	___yes	___no	Who?
Vascular Disease	___yes	___no	Who?

XII. Review of Systems (Please circle any of the following symptoms that you are currently experiencing.)

Nausea	Vomiting	Fevers	Chills	Night Sweats
Dizziness	Light Headiness	Headaches	Hearing loss	Ringing in ears
Blurred Vision	Dry eyes	Itchy eyes	Sinus congestion	Sneezing
Cough	Dry Mouth	Sore throat	Difficulty swallowing	Shortness of breath
Wheezing	Chest Pain	Heart Palpitations	Heartburn	Constipation
Diarrhea	Bloody stool	Abdominal Pain	Incontinence	Frequent Urination
Leg swelling	Calf or leg cramps	Foot Cramps	Muscle Pain	Back Pain
Joint pain/ swelling/ stiffness (list locations) _____			Chronic Pain Affecting Work or Home Life	
Weakness	Abnormal Sensation	Numbness	Tingling	Burning
Tremors	Memory loss	Speech difficulties	Confusion	Disorientation
Skin Ulcers	Rashes	Skin Sores	Warts	Calluses
Dry skin	Changes in toenails	Varicose veins	Hair loss	Excessive sweating
Increased thirst	Increased hunger	Weight gain	Weight loss	Heat Intolerance
Cold Intolerance	Depression	Irritability	Mood swings	Sleep problems
Bruises easily	Bleeding issues	Swollen lymph nodes	Recurring infections	Chronic Fatigue

XIII. Consent to Treat

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations.

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

_____

_____

_____

____Accepted _____ Denied

Colorado Prescription Drug Monitoring Program

IF YOU RECEIVE A PRESCRIPTION FOR"CONTROLLED" (SCHEDULE II THROUGH V) DRUG, YOUR IDENTIFYING PRESCRIPTION INFORMATION WILL BE ENTERED INTO COLORADO'S ELECTRONIC PRESCRIPTION DRUG MONITORING DATABASE (PDMP) WHEN THIS DRUG IS DISPENSED TO YOU. YOUR PRESCRIPTION INFORMATION IN THE DATABASE IS A PROTECTED HEALTH RECORD AND CANNOT BE ACCESSED BY NON-CAREGIVERS EXCEPT AS PART OF AN AUTHORIZED INVESTIGATION.

YOU HAVE A RIGHT TO ACCESS YOUR INFORMATION IN THE PDMP THROUGH THE COLORADO BOARD OF PHARMACY. YOU MAY SEEK CORRECTIONS TO THE INFORMATION AS YOU WOULD YOUR OTHER MEDICAL RECORDS.

_____ _____

Patient/Parent or Guardian Signature Date

Jeremy A. McVay, DPM, FACFAS
Candice Cooper, DPM, AACFAS
8580 Scarborough Dr., Suite #120
Colorado Springs, CO 80920
Phone: (719) 266-5000 Fax: (719) 266-6596

Patient Payment Policy

Payments: We accept cash, check, Visa, MasterCard, or Discover. All insurance co-payments, co-insurances and deductibles will be collected at the time of service prior to treatment. If you do not have your payment(s), your appointment may be rescheduled and a cancellation fee charged.

Outstanding Balances: We may refuse to see patients with balances over $250, who have not made prior arrangements with our billing department. Any and all balances, regardless of insurance coverage, are **due within 60 days** of the date of service, unless prior arrangements are made. Any unpaid balances older than 60 days may be subject to account maintenance and finance charges of $35 per month. Returned checks will result in a $30 service charge and payment of all fees incurred resulting from the returned check. Disputes resulting from unpaid balances are agreed to be settled by mediation at your expense and request. If the account is referred to a collection agency, you the patient (or guarantor of the patient) shall pay an additional collection fee of at least 50% of the principal balance plus reasonable attorneys' fees and all Court costs of the other party incident to any action brought to enforce this Agreement.

Refunds: Refunds due to overpayment will be issued within 4-6 weeks from the date requested. Refunds will be held until all outstanding insurance claims or balances are paid in full. All products and orthotics purchased from our office are medical grade and Non-Refundable.

Cancellations: Please notify us at least 24 hours in advance if you need to cancel or change your regular appointment (5 business days for surgery). There will be a $50 charge for regular appointments and a $250 charge for surgical appointments in the event that you do not show up at your scheduled appointment time, cancel or change your appointment without 24 hours' notice (5 business days for surgery). Notification allows the doctor to care for another patient during that time.

Forms/Letters/Medial Records: There is a $30 charge for the completion of paperwork (ex: disability, FMLA, work releases etc.). We charge a $25 copy fee for medical records requested for personal use and $25 copy fee for x-rays. Letters completed on your behalf will be charged at a rate consistent with the doctor's time spent creating the letter.

Workers Compensation: If your claim is denied you will be responsible for payment in full. Outstanding balances follow the same rules and timeframes as above. Out of State claims will be handled only if first approved by the physician rendering treatment.

Auto Accidents/Personal Injury: Payment is due in full at time of service.

If you have health insurance coverage: As a courtesy to our patients, we will submit your insurance claim(s), however, **we must emphasize that as medical providers, our relationship is with you and not your insurance company.** Although we attempt to verify benefits with your insurance policy, please be advised any quote of benefits provided by your insurance company is considered a general overview, and only a guideline until final coverage determinations are made and payment is received.

This office makes **NO** guarantee of benefits.

- It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified prior to your appointment.
- Not all services provided in our office are a covered benefit under all insurance plans.
- If your insurance policy requires a referral of any type, it is your responsibility to have that referral sent to our office prior to your appointment. Without an appropriate referral you are solely responsible for payment.
- It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under your insurance policy. You are responsible for any non-covered or denied service by your insurance policy.
- Most insurance companies require preauthorization before you have a surgical procedure. Failure to obtain preauthorization may result in refusal of payment by insurance and becomes your responsibility.
- We do not enter into disputes over insurance benefits. We bill insurance in accordance with all federal, state and other contractual requirements in cases where we have an agreement or we are a participating provider.
- Our office does participate with some insurance plans out of network and benefits may be different from in network benefits

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, please do not hesitate to ask us. **We are here to help you.**

I have read and understand the above Patient Payment Policy and agree to meet all financial obligations as outlined regardless of my insurance status. I acknowledge that these policies do not obligate McVay Foot & Ankle, P.C. to extend credit.

_____

Patient Name (Please print)

_____ _____

Patient/ Parent or Guardian Signature Date

McVay Foot & Ankle

Jeremy A. McVay, DPM, FACFAS
Candice Cooper, DPM, AACFAS
8580 Scarborough Dr., Suite #120
Colorado Springs, CO 80920
Phone: (719) 266-5000 Fax: (719) 266-6596

Designation for Release of Medical Information to a Family Member, Friend or Legal Representative

It is the physicians' responsibility to ensure that the physician-patient relationship is confidential. The Health Portability and Accountability Act (HIPAA) allow physicians to use their professional judgment on disclosing certain personal health information to family, friends, etc. without an authorization. This form is an aid to the physicians in making a determination on disclosing such information. Dr. McVay, Dr. Cooper and staff realize that there are times when you, the patient, may want another person to be knowledgeable about your medical condition or medical needs. Your doctor wants you to be able, if you so desire, to name a person to whom you want the office staff to speak with about your medical condition. To enable that, we would ask that you complete the form listed below.

Please note the following points:

- Only one person can be designated for this role.
- The designation is valid until you cancel it in writing.
- If you designate no one this practice will not release information to any family member or friend or legal representative.

Designation Statement

I, _____, designate the following person to be able to speak to a Dr. McVay, Dr. Cooper or other staff member, should it be necessary, on my behalf. I hereby give permission to Dr. McVay, Dr Cooper and staff to release to my designee any information about my medical condition or medical needs or the status of my account and McVay Foot & Ankle, P.C., the physicians and staff, from any claim of confidentiality in connections with the release of this information.

Name of Designated Person: _____

Relationship: _____ Phone Number _____ (home/work)

Patient's Name:_____

Patient's Signature:

_____

Date: _____

I decline to designate another person to speak with my physician or clinical staff.

Patient's Signature: _____Date: _____