Intermountain Foot&Ankle
KERRY E. BERG, DPM.

9348 GRAND CORDERA PKWY, STE 210, COLORADO SPRINGS, CO 80924 719-594-9920

PATIENT INFORMATION

First Name:_____ MI:_____ Last Name:_____

Date of Birth:_____ SS#:_____ Sex: M / F

Marital Status: Married Divorced Widow Single Primary Physician_____ Phone☎:_____

Address:_____Apt#_____ Home ☎:_____

City:_____State:_____Zip:_____ Cell ☎: _____

Employer:_____ Work ☎:_____

Email: _____ *(we will not solicit or sell your information)*

Preferred Language: _____ Ethnicity: _____

.....

Emergency Contact Name:_____ Emergency Contact ☎:_____

Responsible Party ☐same as above

(Please note, if you are being treated and are over 18, YOU are the responsible party)

First Name: _____MI: _____Last Name: _____

Relationship to Patient: _____ SS#:_____ Date of Birth: _____

Address: _____ City: _____State: _____

Home Phone #: _____Cell Phone #: _____Work Phone #:_____

Driver's License Number: _____

Insurance Information

Primary Insurance Company:_____

Group Number:_____ Policy/ ID Number:_____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:_____

Policy Holder Name (If other than "self"):_____**Date of Birth**:_____

.....

Secondary Insurance Company:_____

Group Number: _____Policy/ ID Number:_____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:_____

Policy Holder Name (If other than "self"):_____Date of Birth:_____

Assignment of Benefit & Authorization to release Information

If I am entitled to benefits under the Medicare, the Medicaid, or any insurance policy or other health benefit plan (covering me or anyone legally responsible for me), in consideration for services provided to me by Intermountain Foot and Ankle, I assign and convey the benefits payable under such program, policy or plan for services rendered to me. I authorize payment of benefits directly to Intermountain Foot and Ankle, with such benefits to be applied to my bill. **I understand and acknowledge that this assignment does not relieve me of financial responsibility for charges incurred by me or anyone on my behalf, and I herby acknowledge responsibility for and agree to pay charges not paid under this assignment, including any coinsurance amounts, deductibles, Durable Medical Equipment and any charges for services deemed to be non-covered, not pre-certified, or not pre-authorized by my insurance plan.**

_____ (initial) I give my consent for examination and treatment by Intermountain Foot and Ankle.
_____ (initial) I acknowledge that I read the Notice of Privacy Practices and understand the Notice
_____ (initial) I acknowledge that I have read the Financial Policy of Intermountain Foot and Ankle

Responsible Party Name (Please Print): _____ Relationship: _____

Responsible Party Signature: _____ Date: _____

☆ Parent or Legal Guardian Must Sign if Patient is Under 18! ☆

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FINANCIAL POLICY

We are doing everything possible to reduce the cost of medical care. You can help reduce the number of bills we send to you. The following is a summary of our payment policy.

ALL PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services are rendered. This includes applicable coinsurance and copayments for participating insurance companies. **INTERMOUNTAIN FOOT & ANKLE** accepts cash, personal checks, and all major credit cards. There is a service charge for **returned checks of $20**.

Patients with an outstanding balance 60 days or more overdue must make arrangements for payment in full prior to scheduling future appointments. If a payment plan has been arranged with our office and you would like additional statements, a **$20 fee** will be added to your account. If you have received 2 statements, as well as a letter from our billing company, you will be sent to collections. An additional **$30 collection fee** will be added to your account and you will be responsible for all court costs and attorney fees.

Patients that have FMLA or Disability paperwork to be submitted, a **fee of $25** (per set of documents) will be charged to the patient at the time of request.

INSURANCE

We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and copayments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid by you or your insurance carrier. If your plan requires a referral and you do not have one, it will be your responsibility to pay for your visit or your visit may be rescheduled.

It is the sole responsibility of the patient to know your insurance plans, benefits and to supply this office with correct information and current insurance card.

X-RAYS

If x-rays are done in this office, we cannot guarantee that insurance will cover the x-rays at 100%. There may be a co-pay or co-insurance for these.

MISSED APPOINTMENTS/LATE CANCELLATIONS

Broken appointments represent a cost to us, to you, and to other patients who could have been seen during the time reserved for you. Cancellations are required 24 hours prior to the appointment. We serve the right to charge $35 for missed or late-canceled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

I have read and understand the **INTERMOUNTAIN FOOT & ANKLE** Financial Policy. I also agree to assign insurance benefits to this practice whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I will also be responsible for the fee charged by the collection agency for costs of collections.

Signature:_____ Date:_____

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PATIENT CARE AGREEMENT

Due to recent insurance exchanges, your policy and covered services may have changed. If your insurance does not fully cover certain charges, you may be responsible for unpaid costs. Before we render these services, you have the right to decline treatment. The billing codes are listed so you may contact your insurance if you are concerned about coverage.

- Strapping of the feet to simulate orthotic devices (29540)
- Custom foot orthotics (L3000)
- Sclero therapy injections (64632) or cortisone injection (20550)
- Night splint. Durable Medical Equipment (L4396)
- Fracture boot. Durable Medical Equipment (L4360)
- X-rays of the feet. Even post-op X-rays may not be fully covered (73620) (73650) (73610)
- Office visits may only be partially covered (subject to deductible)
- Soft cast (29580)
- Post op shoes are not covered by insurance. They are $15.

Please sign and date that you have been notified and understand that you may be responsible for payment of any of the above services if your insurance denies payment.

Signature _____ Date _____

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Patient Name_____ Date of Birth_____

Height_____ Weight_____ Shoe Size_____

Do you have a DNR (Do Not Resuscitate Order)? ( ) yes ( ) no
Do you reside in a Skilled Nursing Facility?_____ How long _____
Do you smoke? ( ) yes ( ) no How much? _____
Do you consume alcohol? ( ) yes ( ) no, If yes, What kind?_____ How often? _____
Do you have Diabetes? ( ) yes ( ) no, ( ) Type 1 or ( ) Type II How Long? _____
Date of last Hemoglobin A1C test? _____ # _____ Insulin? _____ Oral Meds? _____
Family history: ( ) Diabetes ( ) Arthritis ( ) Cancer ( ) Gout ( ) Other _____

Primary Physician: _____ Date of Last Visit: _____

Pharmacy Name: _____ Location: _____

PLEASE CIRCLE IF YOU HAVE HAD ANY OF THE FOLLOWING:

Constitutional- Chills, Fatigue, Fever, Night Sweats, Weight Gain/Loss
Eyes- Blurry Vision, Cataracts, Double Vision, Dry Eyes, Glaucoma, Headaches, Ocular Pain, Visual Acuity, Visual Changes
Ear, Nose, Mouth & Throat- Altered Sense of Smell, Dry Mouth, Ear Pain/Pressure, Hearing Loss, Low Blood Pressure, Nasal Congestion, Neck Pain/Stiffness, Oral Pain, Post Nasal Drainage, Sinus Pain/Pressure, Sore Throat, Tinnitus, Trouble Swallowing
Cardiovascular- Anemia, Blood Clots, Chest Pain/Pressure with Rest, Chest Pain/Pressure with Exertion, Claudication, Cold Hands/Feet, Cramping in Legs/Feet, Defibrillator, DVT, Exercise Intolerance # blocks you can walk _____, Heart Murmur, Heart Stent, High Blood Pressure, High Cholesterol, Low Blood Pressure, Palpitations, Pacemaker, Phlebitis, Reynaud's Disease, Swelling Feet/Ankles, Syncope/Fainting, Valve Replacement, Varicose Veins, Venus Insufficiency
Respiratory- Asthma, COPD, Dyspnea at Rest, Dyspnea on Exertion, Hemoptysis, Pain with Inspiration, Productive Cough, Sleep Apnea, Wheezing
Gastrointestinal- Abdominal Pain, Chrons Disease, Constipation, Diarrhea, Dysphasia, Fecal Incontinence, GERD, Heartburn, Hematochezia, Hemoptysis, Melena, Odynophagia, Rectal Pain
Genitourinary- Arthritis, Blood in Urine, Discharge, Lesions, Osteoarthritis, Prostate Cancer, Tenderness
Musculoskeletal- Ankle Sprain, Back Pain, Bunions, Fibromyalgia, Flat Feet, Foot Drop, Fractures, Hammer Toes, Heel Pain, Joint Instability, Joint Pain(Any Joint), Joint Stiffness, Joint Swelling (Any Joint), Knee Pain, Muscle Weakness, Myalgias, Osteoarthritis, Psoriatic Arthritis, Rheumatoid Arthritis
Skin- Athletes Foot, Callus, Color Changes, Dry Skin, Fissures, Fungal Nails, Hyperhydrosis, Ingrown Toenails, Knots/Skin-nodules, Plantar Warts, Pruritis, Rashes,

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Skin Lesions, Skin Ulcers

PLEASE CIRCLE IF YOU HAVE HAD ANY OF THE FOLLOWING:

Neurological- Ataxia, Cerebral Palsy, Coordination Problem, Dizziness, Double Vision, Epilepsy, Extremity Weakness, Fainting, Gait Disturbance, Headache/Migraine, Multiple Sclerosis, Neuropathy, Numbness, Paresthesias, Parkinson's Disease, Peroneal Nerve Damage, Peripheral Neuropathy, Seizures, Speech Disturbance, Stroke, Tingling

Psychiatric- Anxious/Nervous, Alzheimer's, Bi-Polar, Chemical Dependency, Dementia, Depression Psychiatric Care

Lymphatic- Bleeding Tendency, Lymph Node Pain/Enlargement, Lymph Edema, Transfusions

Immuno- AIDS, Eye Discharge, Hepatitis A, Hepatitis B, Hepatitis C, Hives, HIV, MRSA, Sinus Congestion, Sinus Pressure, Tuberculosis, VRE, Wheezing

Endocrine- Non-Insulin Dependent (Diabetes Type II), Insulin Dependent (Diabetes Type I), Hypothyroid, Hyperthyroid, Kidney Disease/Dialysis, Liver Disease

ALLERGIES AND REACTIONS

Please list all drug allergies and other allergies and the reaction:

_____
_____
_____
_____

☐ No known drug allergies

Please list all prescriptions, over the counter medications, vitamins & dosage:

_____
_____
_____
_____
_____
_____

We participate in the Colorado Prescription Drug Monitoring Program, also known as (PDMP).

What is the reason for which you came to be treated?

_____
_____
_____

Please circle and describe your pain:

Right	Left	Both Feet/Ankles
No Pain	Dull/Aching	Painful All the Time
Sharp	Swelling	
Numbness/Tingling	A.M. Pain	

Have you seen a podiatrist before? ( ) Yes ( ) No. If yes, please list:

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Name: _____ Date of Last Visit: _____
Reason for last visit: _____

Have you been treated for this complaint previously? ( ) Yes ( ) No
How long ago? _____ What type of treatment did you receive? ___
_____
How long have you had this problem? _____
Do you ever recall injuring this area? If yes, when? _____
What have you tried to help with this problem? _____
_____
Do you wear orthotics or shoe inserts? ( ) Yes ( ) No
If so, How long and why? _____

Employment/ Occupation: _____
Please Circle: Full Time Part Time Student Unemployed Retired

Activities/ Exercise/ Type and Amount:
_____
_____
_____

List all surgeries and hospitalizations you had within the last 5 years (relating to back, feet, knee, & heart): _____
_____
_____

Consent

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet/ankles.

Signature_____ Date _____

(If patient is a minor)
Name of Parent/Guardian (Please Print) _____

Signature of Parent/Guardian _____ Date_____

☆ Parent or Legal Guardian Must Sign if Patient is Under 18! ☆