

Dr. James C. Anderson, DPM

DATE OF APPOINTMENT OR UPDATE _____

PATIENT INFORMATION (please print, fill out all sections completely – you will be asked to fill in any blank sections)

LEGAL NAME (first) _____ (last) _____ (M.I.) Female Male
 Married Single Divorced Widowed Child (under 18) NICK NAME _____

BIRTHDATE _____ SS# _____ (required for unique identification) PHONE () _____
CELL PHONE #() _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMPLOYER (School, if student) _____

WORK PHONE # () _____ Full-time Part-time Retired (if retired, Name of Company) _____

EMAIL ADDRESS _____

NAME, ADDRESS & PHONE # OF FAMILY DR. _____

_____ FOR MEDICARE PATIENTS: EXACT DATE OF LAST VISIT: _____

How did you hear about us? Provide name, address and phone so we may send a thank-you!

Relative _____

Friend _____

Doctor _____

Internet (check one): Search Dex Online Website Other: _____

Yellow Pages (which one) _____ Newspaper (which one) _____

Coupon (Type) _____ Mailer (Type) _____ Other (please specify) _____

Family Information Spouse Parent/Guardian Other (specify) _____

Name _____

Street _____ City _____ State _____ Zip _____

Phone # () _____ Employer _____ Work Phone # () _____

Name & Phone # of closest person not living with you to contact in case of emergency _____

Payment Information *Please fill in info below and hand your card to receptionist. A copy will go in your medical record.

Primary Insurance Name _____ **Group #** _____

Name of policyholder _____ **ID #** _____

Employer _____ **Policyholder's SS #** _____ **Policyholder's Birthdate** _____

Patient's relationship to policyholder: Self Spouse Child Other (please specify) _____

Secondary Insurance Name _____ **Group #** _____

Name of policyholder: _____ **ID #** _____

Employer _____ **Policyholder's SS #** _____ **Policyholder's Birthdate** _____

Patient's relationship to policyholder: Self Spouse Child Other (please specify) _____

Is this a work related injury? Y N If yes, date of injury _____

Is your injury related to an auto accident? Y N If yes, date of accident _____

Please explain how your injury happened, if not work or accident related: _____

Patient Name _____

Date _____

PAST MEDICAL HISTORY

Major Illnesses:

- Diabetes Heart Disease High Blood Pressure Chest Pain Cancer
 Heart Attack Mitral Valve Prolapse Murmur Arrhythmia Stroke HIV

Please Explain: _____

Respiratory:

- Asthma (Last Attack/Regular Inhaler Use) Bronchitis Emphysema Frequent Colds
 Sinus Problems or Infections Shortness of Breath Lung Disease Pneumonia Tuberculosis

Please Explain: _____

Head/Ears/Eyes/Nose/Throat:

- Tonsillitis or Throat Infections Glaucoma Eye or Vision Problems Regular Headaches
 Migraine Headaches Ear Infections Hearing Deficit

Please Explain: _____

Gastro-Intestinal:

- Ulcers Acid Reflux (GERD) Hiatal Hernia Stomach Disorder Bowel Disorder
 Irritable Bowel Syndrome GI or Rectal Bleeding

Please Explain: _____

Genito-Urinary:

- Kidney or Bladder Infections Kidney Stones Prostate Disease Venereal Disease

Please Explain: _____

Vascular Disease/Blood Disorders:

- Anemia Sickle Cell Bleeding Disorders Poor Circulation PVD
 Leg Pain when Walking Night Cramps Excessive Bleeding following surgery
Vein Problems Swelling Spider Veins Varicose Veins Leg Ulcers
Clotting Disorders Blood Clots Arms Legs Lungs Phlebitis

Color Changes of Skin When Cold / Reynaud's Syndrome

Please Explain: _____

Arthritis:

- Joint Implants Rheumatoid Arthritis Osteoarthritis Gout Other

Please Explain: _____

Skin Disorders:

- Keloids or Thick Scar Formation Psoriasis Skin Cancer

Please Explain: _____

Psychological:

- Anxiety Depression History of Drug or Alcohol Dependency

Please Explain: _____

Pain Syndromes:

- Reflex Sympathetic Dystrophy Fibromyalgia Chronic Pains

Please Explain: _____

Misc Illnesses:

- Epilepsy or Seizures Thyroid Disease Muscle Disease Hepatitis HIV / AIDS

Please Explain: _____

Patient Name _____

Date _____

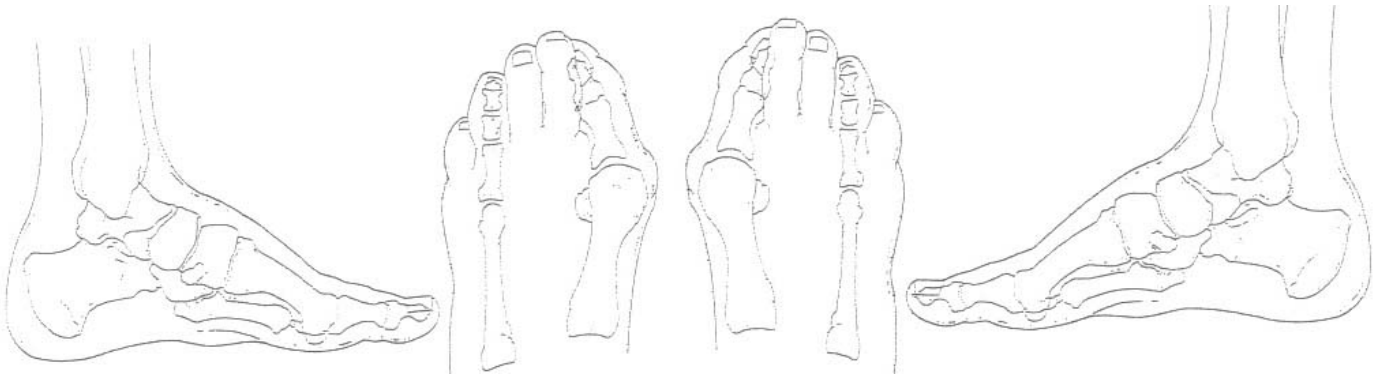
Medical History

Chief Complaint(s)/Reason for Coming to the Clinic:

How long has this been a problem? _____

Prior home/professional treatment (orthotics, injections, surgery, etc.) _____

Circles areas of concern:



Vitals: **B/P:** _____ **Pulse:** _____ **Temp:** _____

Allergies: No Known Drug Allergies

Please state Reactions:

- | | |
|--|---|
| <input type="checkbox"/> Penicillin: _____
<input type="checkbox"/> Codeine: _____
<input type="checkbox"/> Latex: _____
<input type="checkbox"/> Local Anesthetics: _____
<input type="checkbox"/> Metals / Earrings / Jewelry: _____
<input type="checkbox"/> Other Medications: _____
<input type="checkbox"/> Food Allergies : _____
<input type="checkbox"/> Environmental Allergies : _____
<input type="checkbox"/> Other: _____ | <input type="checkbox"/> Sulfa Drugs _____
<input type="checkbox"/> Iodine / Shellfish _____
<input type="checkbox"/> Aspirin: _____
<input type="checkbox"/> General Anesthetics: _____ |
|--|---|

Medications:

- Echinacea Garlic Ginger Ginko Biloba St. John's Wort Ginseng Ephedra
 Kava Kava Valerian Other Diet Pills: _____

Patient Name _____

Date _____

Previous Surgery: (Type / Date)

Hospitalizations / injuries:

Social History:

Do you use Tobacco? Y/N Did you Smoke? Y/N Yrs. Quit _____ How Much? _____ How many years? _____

Do you drink Alcohol? Y/N Did you Drink? Y/N Estimate # of drinks per day/week/month? _____

Occupation: _____ Physical / Athletic Activities _____

Family History:

Any family members with anesthesia difficulties? _____

Diabetes: _____

Other: _____

Vital Statistics:

Height: _____ Weight: _____ Age: _____ Shoe Size: _____

Are you pregnant? Y/N Could you be pregnant? Y/N Are you nursing? Y/N

PERMISSION / RELEASE OF INFORMATION:

1. I HEREBY GIVE MY PERMISSION TO Dr. James Anderson, Dr. Michael Thomas, and Dr. Jared Overman to administer, with my permission, treatment and to perform such procedures as may be deemed necessary in the diagnosis and treatment of the extremity condition.
2. I also hereby assign to the above named physician all benefits provided to my insurance company policy or policies for medical or surgical care.
3. I authorize my consent to Poudre Valley Foot & Ankle Clinic, PC to call and remind me of upcoming appointments or to make follow-up calls after treatment.

Signature of Patient: _____

Signature of Parent / Guardian: _____

**POUDRE VALLEY FOOT AND ANKLE CLINIC, PC (PVFAC)
NOTICE OF PRIVACY PRACTICES**

This notice describes how your health information may be used, disclosed and how you can access this information. Please review it carefully.

At the Poudre Valley Foot and Ankle Clinic, PC we have always kept your health information secure and confidential. We take precautions to secure electronic information. Firewalls and passwords are in place. A new law requires that we continue to maintain your privacy, give you this notice and follow the terms of this notice.

The law permits our clinic to use or disclose your health information to those involved with your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company in order to be reimbursed for services.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. The PVFAC has a written contract with each business associate that requires them to protect your privacy.

We may use information to contact you. For example, we may send newsletters or other information to the address you have provided us with. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

With the exceptions as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you to the requested office.

You have the right to see and receive a copy of your health information, with a few exceptions you will be required to give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. You will be required to make the requested changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add the new information.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.

However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy and Security Officer at (970) 484-4620.

This notice goes into effect as of April 14, 2003.

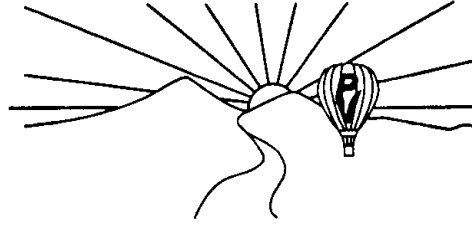
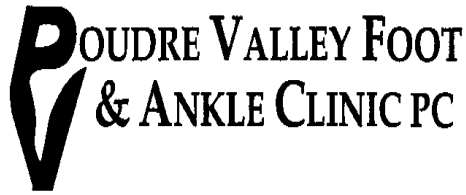
Acknowledgement

I have read the above and I am aware that a copy of the Poudre Valley Foot and Ankle Clinic, PC Notice of Privacy Practices is available per my request.

Signed: _____ Print Name: _____

If signing as a parent or guardian, please note the name of the patient: _____

Date: _____



Dr. James C. Anderson, DPM
Certified: American Board of Podiatric Surgery
Member, American College of Foot and Ankle Surgeons
Fellow: American College of Podiatric Sports Medicine

Dr. Michael I. Thomas, DPM
Certified: American Board of Podiatric Surgery
Member, American College of Foot and Ankle Surgeons

Dr. Jared L. Overman, DPM
Member, American College of Foot and Ankle Surgeons
Qualified: American Board of Podiatric Surgery

Financial Policy

Thank you for choosing our practice! We are committed to providing you with quality podiatric care. We have developed this payment policy to assist you in understanding our financial practices. Please read it carefully and sign in the space provided.

Insurance

We participate with many insurance plans, including Medicare. If you are not insured by a plan we do business with or you do not have insurance, payment in full is expected at each visit. Your insurance benefit is a contract between you and your insurance company. Knowing your insurance benefits is your responsibility. Please contact your insurance carrier with questions regarding your coverage.

If you have insurance coverage, you must present a valid insurance card at each visit. We will keep a copy of the most recent insurance card in your medical record. If your insurance coverage changes, you must notify us as soon as possible to avoid delay in your claims processing. If you fail to inform us of updated insurance, balance on unpaid claims will become your responsibility. Co-payments and deductibles must be paid for at the time of service. This is part of your contract with your insurance company.

Non-Covered Services

Please be aware that some of the services you receive may be non-covered by your insurance carrier. These services must be paid for at time of visit.

Claims Submission

We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.

Payment

For your convenience, we accept cash, checks, VISA, MasterCard, American Express, Discover, and Care Credit. We reserve the right to refer your account to a collection agency if your account is over 90 days past due.

Thank you for understanding our payment policy. Please let us know if you have any questions. ***I have read and understand the payment policy and agree to abide by its guidelines:***

Signature

Date