ASCEND
FOOT & ANKLE CENTER

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Patient Registration

Patient Information

Patient Full Name: ☐Mr. ☐Mrs. ☐Ms. ☐Dr.	**Last**	**First**	**M.I.**			☐M ☐F
By what name do you preferred to be addressed?			Single ☐	Married ☐	Divorced ☐	Separated ☐ Widowed ☐ Partner ☐
Patient's Address						
City	**State**	**Zip**				
Preferred Phone ☐ Home ☐ Cell ☐ Work		**Alternative Phone** ☐ Home ☐ Cell ☐ Work				
E-mail Address (required for access to your online patient portal)						
Social Security #	**Birth Date**	**I would like automated reminders by:** ☐ Email ☐ Phone ☐ Text (Choose up to 3)				
Employer		**Occupation**				
Emergency Contact	**Relationship**	**Phone**				

Do you give permission to Dr. Hofer Ogilvie to use your photos/videos? ☐ Yes ☐ No

Lower Extremity Medical History, Referral Information, Doctors and Pharmacies

Name: _____ **Date:** _____

What is the chief complaint(s) that brings you to our office for medical treatment? (Include foot, ankle, leg, knee, hip and back complaints: _____

_____

_____

_____

Symptoms of Current Problem (circle or fill in your answer)

Which Side : ☐ Right ☐ Left ☐ Both **Type of Pain** :☐Dull ☐ Achy ☐Throbbing ☐Burning ☐Sharp ☐ Shooting

Area of Pain :☐ Bottom of Heel ☐ Back of heel ☐ Arch ☐ Ball of foot ☐ Big toe ☐ Top of foot ☐ Ankle ☐ No Pain

☐ Other/Details: _____

On set :☐Slow ☐ Sudden ☐Traumatic **Has pain gotten :** ☐ Better ☐ Worse ☐ Stayed the Same

How long has this been a problem for you?: ☐ Days ☐ Weeks ☐Months ☐Years

What aggravates condition? ☐ Walking ☐ Running ☐ Standing ☐ Shoes ☐ Activities ☐ First steps after rest

☐ Other: _____ **Severity** : ☐ Mild ☐ Moderate ☐ Severe

What have you tried for the pain? ☐ Changing shoes ☐ Anti-inflammatory meds ☐ Decreasing activities ☐ Ice

☐ Heat ☐ Prefabricated Arch Supports ☐ Custom Orthotics ☐ Stretching ☐ Injections ☐ Physical Therapy ☐ Surgery

☐ Antibiotics ☐ Other OTC Meds ☐ Padding ☐ Massage ☐ Acupuncture ☐ Soaking

☐ Other: _____

After it starts, how long does pain last? _____

Have you ever had a similar pain ? (describe, including treatments received) _____

_____

How did you hear about our office?

☐ Relative ☐ Friend ☐ Google ☐ Bing ☐ Other Web Search ☐ Facebook ☐ Yelp

☐ Insurance Company ☐ Mail ☐ Phone Book ☐ TV ☐ Other: _____

☐ From My Doctor (name/specialty/city): _____

Who is your primary care physician and what other doctors treat you regularly?

Primary Care Physician: _____ ☐ MD ☐ DO ☐ IFMPC

Name of Clinic/Hospital: _____

Date last seen: _____ ☐ I don't have a primary care physician

Other doctors and their specialties: _____

_____

List your primary pharmacy (name and location) - This is where we will send any prescriptions

Primary pharmacy (include city and street): _____

NAME: DATE: _____

Past Medical History, Social and Family History Form

General

What is your weight: _____

What is your height: _____

What is your shoe size: _____

Allergies and Drug Intolerance

☐ **No Known Allergies**

☐ Adhesive/Tape ☐ Aspirin

☐ Codeine ☐ Iodine

☐ Local Anesthetics ☐ Penicillin

☐ Seafoods ☐ Sulfa

☐ Other: _____

Allergy sensitivity? ☐ Mild ☐ Moderate ☐ Severe

Medications

List all medications(and doses) you are taking:

_____ dosage: _____

_____ dosage: _____

_____ dosage: _____

_____ dosage: _____

_____ dosage: _____

_____ dosage: _____

_____ dosage: _____

_____ dosage: _____

_____ dosage: _____

_____ dosage: _____

_____ dosage: _____

Surgeries, Injuries, Illnesses

List surgeries, serious injuries, and illnesses not previously listed:

_____

_____

_____

_____

_____

_____

_____

_____

General Medical History

Mark "yes" or "no" to indicate if you or a family member have any of the following:

Personal			Family
☐ yes	☐ no	Anemia	☐ yes
☐ yes	☐ no	Arthritis: Type:	☐ yes
☐ yes	☐ no	Artificial Heart Valve or Joints	☐ yes
☐ yes	☐ no	Asthma	☐ yes
☐ yes	☐ no	Back Problems	☐ yes
☐ yes	☐ no	Bleed easily	☐ yes
☐ yes	☐ no	Cancer	☐ yes
☐ yes	☐ no	Chemical Dependency	☐ yes
☐ yes	☐ no	Chest Pain	☐ yes
☐ yes	☐ no	Circulatory Problems	☐ yes
☐ yes	☐ no	Diabetes	☐ yes
☐ yes	☐ no	Epilepsy	☐ yes
☐ yes	☐ no	Fibromyalgia	☐ yes
☐ yes	☐ no	Gout	☐ yes
☐ yes	☐ no	Heart Disease	☐ yes
☐ yes	☐ no	Hemophilia	☐ yes
☐ yes	☐ no	Hepatitis	☐ yes
☐ yes	☐ no	High Blood Pressure	☐ yes
☐ yes	☐ no	HIV Positive	☐ yes
☐ yes	☐ no	Kidney Problems	☐ yes
☐ yes	☐ no	Leg Cramps	☐ yes
☐ yes	☐ no	Liver Disease	☐ yes
☐ yes	☐ no	Lung/Respiratory	☐ yes
☐ yes	☐ no	Menopause	☐ yes
☐ yes	☐ no	Mental Illness	☐ yes
☐ yes	☐ no	Phlebitis / Clots	☐ yes
☐ yes	☐ no	Psoraisis	☐ yes
☐ yes	☐ no	Rheumatic Fever	☐ yes
☐ yes	☐ no	STD	☐ yes
☐ yes	☐ no	Stroke	☐ yes
☐ yes	☐ no	Thyroid Problems	☐ yes
☐ yes	☐ no	Tuberculosis	☐ yes
☐ yes	☐ no	Ulcers—Stomach	☐ yes
☐ yes	☐ no	Weight Change	☐ yes

Ethnicity: ☐ Hispanic/Latino
☐ Not Hispanic/Latino
☐ Other: _____
☐ **Decline**

Mental / Emotional

☐ yes ☐ no Eating Disorder

☐ yes ☐ no Anxiety

☐ yes ☐ no Depression

☐ yes ☐ no Psychiatric

☐ yes ☐ no Alcoholism

Exercise and Orthotics

In what athletic activities do you participate?

_____

How many days of moderate to strenuous exercise, like a brisk walk, did you do in last 7 days?

_____

On those days that you engage in moderate to strenuous exercise, how many minutes on average do you exercise? _____

Do you wear store-bought arch supports? ☐yes ☐no

Do you wear custom orthotics? ☐ yes ☐ no

If yes, who made them: _____

How old are the orthotics: _____

Social History

Your occupation?

_____

Do you smoke? ☐ yes ☐ no

Are you a past smoker? ☐ yes ☐ no

How Much? packs/day_____

Years Smoked:_____

Drink Alcohol?: ☐ yes ☐ no

How Much:_____

How often do you have a drink containing alcohol?

☐ Never ☐ Monthly or less ☐ 2-4 times a month
☐ 2-3 times a week ☐ 4 or more times a week

How many standard drinks containing alcohol do you have on a typical day?

☐ 0 ☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9
☐ 10 or more

How often do you have 6 or more drinks on 1 occasion?

☐ Never ☐ Less than monthly ☐ Monthly or less
☐ Weekly ☐ Daily or almost daily

Recreational Drugs? ☐ yes ☐ no
What: _____

Pregnant or possibly pregnant? ☐ yes ☐ no

The US HITECH Act requires us to ask the following questions:

Preferred Language: ☐ English
☐ Other: _____

Race: ☐ American Indian or Alaska native
☐ Asian ☐ Asian Indian
☐ Black/African American
☐ European
☐ Native Hawaiian/Pacific Islander
☐ White
☐ Other: _____
☐ **Decline**

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NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1998 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on the Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

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Financial Policy

Your insurance policy is a contract that exists between you and your insurance company. Our relationship is with you, the patient, and not the insurance company. The patient or responsibly party is responsible for their bill being paid in full.

Please initial each line indicating your understanding of our policies:

____ **PAYMENT**: Full payment is due at time of service. Payment for evaluation and management services at minimum will be required before seeing the doctor. Additional procedures/services may be recommended by the doctor. You will be informed of these charges before proceeding with treatment.

____ **NO SHOW (failure to present for your appointment): 24 hours–notice** is required for cancellation of your appointment and failure to do so will incur a **$50** fee. Failure to provide **24 hours–notice** for a scheduled office procedure will incur a **$100** fee.

At Ascend Foot and Ankle we understand life happens and do our best to extend grace to all families we serve, but this policy helps ensure we run an efficient and effective practice that meets the needs of our community. Please do not ask to override this policy.

____ **BALANCES/COLLECTION FEES:** If payment of an outstanding balance is not received within 30 days from the postmark date of a mailed statement or e–statement time stamp, a **$10** re–billing fee may be added to each additional statement. Patients with balances more than 90 days overdue will be turned over to collections and a **$35** administrative fee will be applied.

____ **FMLA/DISABILITY/MEDICAL RECORDS:** There is a **$40** charge for having the doctor complete these forms. Requested forms will be completed within 72 hours of diagnosis and care plan. There is a **$30** fee to obtain a copy of your medical records.

____ **REFUND:** All payments made for services rendered are final and non–refundable. Under no circumstances will refunds or discounts be issued for completed services, regardless of dissatisfaction with the treatment plan, inability to achieve desired outcomes, or perceived inadequacy of time spent with the provider. By receiving services, the patient acknowledges and accepts this policy in full.

____ **MEDICARE:** I understand that if I have Medicare, I cannot ask to be reimbursed by my insurance carrier. I will voluntarily sign an Advanced Beneficiary Notice (ABN) prior to receiving any care. **Please notify front office team member if you have Medicare.**

____ **MEDICAID:** Physicians at Ascend Foot & Ankle Center are prohibited from accepting cash payments from Medicaid patients for services covered under the Medicaid program. This restriction is grounded in both federal and state regulations aimed at protecting Medicaid beneficiaries from undue financial burden. This is in accordance with Federal law, under 42 U.S.C. § 1396a (a) (14) and Colorado Revised Statutes (C.R.S.) § 25.5–4–301.

I have read and understand these financial policies.

Patient Name (print): _____

Patient/Responsible Party Signature: _____

Date: ____/____/____

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Frequently Asked Questions Regarding the Credit Card on File Agreement

Do I have to leave my credit card information to be a patient at this practice?
Yes. This is our policy, and it is a growing trend in the healthcare industry. We have decided to focus on becoming more efficient in our billing and collections processes.

How do you safeguard the credit information you keep on file?
We use the same methods to guard your credit card information as we do for your medical information. The card information is securely protected by the credit card processing component of our HIPAA compliant practice management system. This system stores the card information for future transactions using similar technologies as an online retailer. Our billing and office staff are not able to see the card number – only the last four numbers, giving us no way to use the card outside of the billing system. The only way to use it is to process a payment in our practice management system.

What are the benefits?
It saves you time and eliminates the need to write checks, buy stamps or worry about delays in the mail. It also drives our administrative costs down because our staff sends out fewer statements and spends less time taking credit card information over the phone or entering it from the billing slips sent in the mail, which are less secure methods than storing the information in our practice management system. The extra time the staff has can now be spent on directly helping the patients, either over the phone, or in person.

I always pay my bills on time. Why do I have to do this?
The entire billing process is time consuming and wasteful, and the few patients that we do have to send to a collection agency end up costing a lot of money. Reducing unnecessary costs are essential to allowing us to provide quality care.

What if there is a payment discrepancy or I have other payment questions?
Please contact our office directly to settle payment discrepancies or for other payment questions. This policy in no way compromises your ability to dispute a charge of benefits.

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Credit Card on File Agreement

By signing below, I authorize Ascend Foot & Ankle Center to keep my signature and credit card information securely on-file in my account. I authorize Ascend Foot & Ankle Center to charge my credit card for any outstanding balances when due.

If the credit card that I provide today changes, expires, or is declined for any reason, I agree to promptly provide Ascend Foot & Ankle Center with a new, valid credit card of which I will allow them to use for payment processing. Even though Ascend Foot & Ankle Center is not processing in person, I agree that my updated card may be used with the same authorization as the original card presented.

Your ability to dispute a charge or remain unchanged. If you have any questions about our policy, please do not hesitate to ask.

Visa □ **MasterCard** □ **Discover** □ **American Express**

□ Patient's Name (Print):_____ DOB: _____/

_/ Name on Card (Print):_____

Last Four Digits of Credit Card Number:_____ Exp. Date:_/_____

Please fill out information below for any other person(s) you authorize this credit card for:

Patient Full Name (Print):_____ DOB:__/___/___

Patient Full Name (Print):_____ DOB:__/___/___

Patient Full Name (Print): DOB:__/___/

Credit Card Holder's Signature:*_____Date: _____