COLORADO CENTER FOR PODIATRIC SPORTS MEDICINE
JAMES D. YAKEL, D.P.M.

NAME ____ Sex: M F

DATE OF BIRTH _______________________ AGE ______ SSN __________________________

ADDRESS ____

CITY _________________________________ STATE _________ ZIP CODE________________

PHONE __________________________ EMAIL ____________________________________

MARITAL STATUS: M S D W OTHER

PRIMARY CARE PHYSICIAN ____

PERSON RESPONSIBLE FOR ACCOUNT ____

PATIENT OR PARENT EMPLOYER INFORMATION

OCCUPATION ____

EMPLOYERS NAME _______________________________ PHONE ______________________

EMPLOYERS ADDRESS ____

CITY _________________________________STATE __________ ZIP CODE ________________

INSURANCE INFORMATION

PRIMARY INSURANCE ____

SUBSCRIBER NAME _______________________ ID# _______________ GROUP# ___________

SECONDARY INSURANCE ____

SUBSCRIBER NAME ______________________ ID# _______________ GROUP# ____________

I, the undersigned, consent to any and all such medical care which may include routine diagnostic procedures, x-rays, injections, medical treatment, and medications deemed necessary to diagnose or treat my foot/ankle problem. I agree that I am responsible for the payment of all charges incurred by me for any treatment and the cost of collection of unpaid balance. I authorize release of any medical information to process this claim or future claims and authorize my insurance benefits to be paid to Colorado Center for Podiatric Sports Medicine.

SIGNATURE ____ DATE ___________________

PATIENT NAME ______________________________________ **DATE OF BIRTH** ______________

CURRENT FOOT/ANKLE PROBLEM (Please be as specific as possible)

____
____
____

PATIENT SHOE SIZE ______________________

PATIENT MEDICAL HISTORY (Please check all that apply)

___Heart Trouble	___Liver Disease	___Vascular Disease	___Rheumatic Fever
___Heart Murmur	___Kidney Disease	___Circulation Problems	___Tuberculosis
___High Blood Pressure	___Diabetes	___Emphysema	___Arthritis
___Stroke/Heart Attack	___Fainting Spells	___Asthma/Bronchitis	___Cancer
___Stomach Ulcers	___Depression/Anxiety	___Polio	___Gout
___Bleeding Problems	___Epilepsy/Seizures	___Pregnant, Months ______________________	

___Other, Specify ________________________ ___Other, Specify ________________________

ALLERGIES (Please indicate type of reaction)

___Penicillin ___________________________	___Tapes/Adhesives _____________________
___Novocain ___________________________	___ Food, Specify ________________________
___Aspirin _____________________________	___ Other, Specify _______________________
___Codeine ____________________________	___Other, Specify ________________________

PREVIOUS SURGERIES & HOSPITALIZATIONS

1. ____	4. _____________________________________
2. ____	5. _____________________________________
3. ____	6._____________________________________

MEDICATIONS

1. ____	5. _____________________________________
2. ____	6. _____________________________________
3. ____	7._____________________________________
4. ____	8. _____________________________________

PATIENT NAME ______________________________________ **DATE OF BIRTH** ______________

Has anyone in your family ever been treated for:

	You	Father	Mother	Brother	Sister	Children	Relatives
Arthritis							
Cancer							
Diabetes							
Foot Problems							
Gout							
Stroke							
Poor Circulation							
Tuberculosis							
Varicose veins							
Heart disease							
Bleeding disorder							

FAMILY MEDICAL HISTORY

Mother _____Living _____Deceased Cause of Death ________________________________

Father _____Living _____Deceased Cause of Death ________________________________

Brother _____Living _____Deceased Cause of Death ________________________________

Sister _____Living _____Deceased Cause of Death ________________________________

Do you use tobacco? ______Yes _____Never _____Former

If yes, how much? ____

If former, when did you stop? _____________________________

Did you receive a flu vaccine? ______Yes ______No When? ___________________________

If over 65, have you received a pneumococcal vaccine? _____Yes _____No When? _________

Do you have a living will or someone who is your decision maker? _____Yes _____No

If no, why? ____

OFFICE FINANCIAL POLICY

All charges for services rendered are due and payable at the time and on the same day of service unless Dr. James D. Yakel is a contracted provider with your insurance company.

It is the patient's responsibility to see that the bill is paid in full. We must emphasize that, as your podiatric medical care provider, our relationship is with you and not your insurance company. We will try to make sure that your insurance claim will be filed on the same day or the next day following your visit. The filing of a medical insurance claim is an expensive process that we extend to you at no charge as a courtesy. However, we do ask that you pay all **co-pays, deductibles, and non-covered charges the day of your service.** This office offers to you the very best medical care that can be obtained anywhere, but that type of service creates a very high office overhead and our bills must be paid, just like yours. All charges are your responsibility and not the insurance company's.

Medicare will cover surgery, x-rays, injections, and some other types of foot care. Medicare will not cover routine care such as the trimming of corns, calluses, or toenails. You will need to pay for that service unless you are diabetic as documented by your family doctor.

In the event I default, I agree to pay, whether or not legal proceedings are instituted, a reasonable collection fee, which shall be 35% of the principal balance for any debt incurred hereunder and to pay all reasonable legal costs and attorney fees as a result of my default.

I have read and understand this office policy:

____
Patient Name Printed

_____________________________________ _____________________________________
Patient Signature Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the *Health Insurance Portability & Accountability Act of 1996 (HIPPA)*, 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 have received, read, and understand 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 to obtain a current copy of the *Notice of Private 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 acknowledgement on this *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below:

Date: __________________ Initials: ______ Reason: ___________________________________