Rocky Mountain Foot & Ankle

New Patient Paperwork

Rocky Mountain Foot & Ankle welcomes you to our specialty practice. Here at RMFA, our goal is to provide you with exceptional patient care. In order to succeed, our goal is to provide an outstanding visit to our office. We ask that you come prepared for your new patient appointment.

Please provide the following while checking in for your appointment:

- Entire new patient paperwork packet completed
- Updated Medication List
- ID, Insurance card(s), Prescription Card
- Copay/Payment at the time of service

Please arrive 30 mins early to your appointment, to ensure that we can complete all necessary steps to make sure you get properly checked in.

Thank you for understanding. We look forward to you coming to Rocky Mountain Foot & Ankle.

Rocky Mountain Foot & Ankle

New Patient Information

Phone: 208-855-5955

Fax: 208-459-8628

Caldwell Clinic

1818 10th Ave, Suite #250

Caldwell, ID 83605

Meridian Clinic

2667 E. Gala Ct. Suite #130

Meridian, ID 83642

Patient Name:			
Date of Birth:	SSN#:	Gender: F M	
Email:			
Address:	City:	State:	ZIP:
Phone: Home #:	Cell #:		
Please circle which number is best to contact			
Referring Provider:	Primary Doctor:		
Primary Language:	Race:		
Emergency Contact:			
Relationship:	Phone #:		
Marital Status:	Spouse/Partner Name:		
Employer:	Occupation:		
Address:			

If the patient is a minor, please complete this section.

Parent/Guardian Name:		
Address:		
Date of Birth:	SSN:	Phone #:

Primary Insurance:			
ID #		GRP #	
RXBIN:	RXGRP:		RXPCN:
Policy Holder:		Date of Birth:	
Relationship to Patient:	Self	Spouse	Parent/Guardian

Secondary Insurance:			
ID #		GRP #	
RXBIN:	RXGRP:		RXPCN:
Policy Holder:		Date of Birth:	
Relationship to Patient:	Self	Spouse	Parent/Guardian

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Self Pay Options

This policy is established to provide transparency for self-pay patients in regards to service rates and fees, patients rights and collection purposes. Outlines are operational guidelines for RMFA to accurately provide “self-pay” rates for uninsured patients. This policy shall also outline self pay "rights" and identify if and when services may be constricted, if reasonable payment for services is not identified, and how a patient's financial responsibility will be managed.

Self-pay patients will be identified when they make the initial office visit appointment with our New Patient Coordinator. A self pay patient is classified as:

- Someone who has no health insurance coverage of any kind
- Does not claim third party liability for the patient's health care treatment.

When an established self pay patient calls to make a follow-up appointment, please verify the balance and make sure the patient is current. If the patient is not currently on their payment plan the patient will need to speak with billing before rescheduling. At that time the billing department will either offer care, credit or set the patient up on a payment plan.

CareCredit: Helps you pay for out-of-pocket healthcare expenses for you, your family. Once you are approved, you can use it again to help manage health. With shorter term financing options of 6, 12, 18 or 24 months no interest is charged on purchases of $200 or more. https://www.carecredit.com

- **New Self Pay:** The patient will pay everything at checkout at time of service. IF a patient pays the full amount **AT TIME OF SERVICE**, they will then get a 10% discount on the amount. If they aren't able to pay the full amount then they owe half at time of service, with a payment plan.
- **Established Self Pay:** patient will arrive, then at check out, the front desk will add all codes, the patient will then owe the full amount. If they aren't able to pay the fall amount then they owe half at time of service, with a payment plan. IF they are able to pay full price at time of service the patient then gets a 10% discount at the appointment.
- The payment plan will be set up with a credit card on file. It is to be paid in 3 consecutive payments.

Patient Signature: _____ Date: _____

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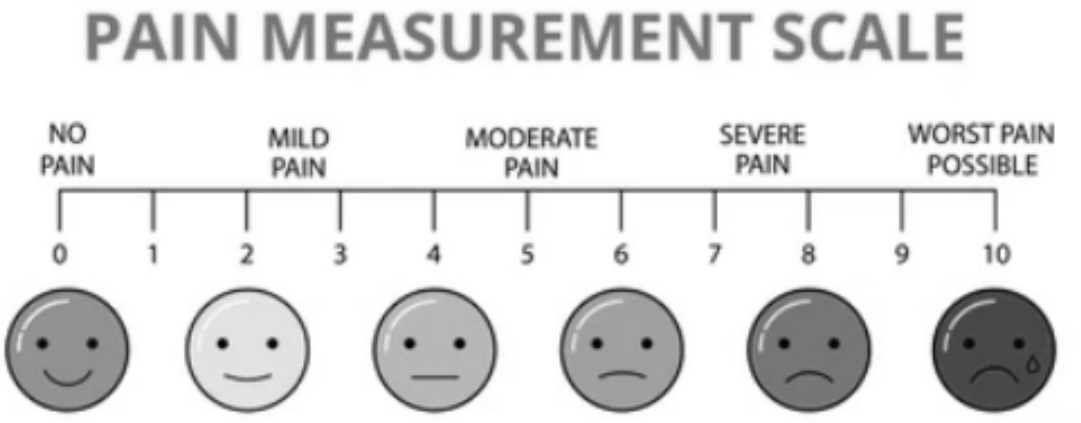
Brief Medical History



Please describe what brought you in to see the doctor today:

Was this an injury/accident? Y / N Work Related? Y / N Shoe Size _____

Have you notified your employer about this injury? Y / N Date of Injury _____

Allergies	Reaction

Medication	Dose	Reason	Medication	Dose	Reason

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If Patient Has Diabetes:

Blood sugar this morning _____ Last HbA1c _____
When was the last time your HbA1c was tested? (Month/Year) _____

Perinatal History - For Pediatric Patients Only

Please complete if patient is a child under the age of 18
Gestation: Was the child born prematurely? Y / N
How old was the child when they began to:
Cruise _____ Crawl _____ Walk _____ Talk _____
Has there been any developmental delays? Y / N
Are all immunizations up to date? Y / N

Additional History

Please list any other issues the doctor should be aware of:

Social History:	**Frequency/Quantity:**
Exercise	
Working	
Alcohol	
Tobacco	
Marijuana	
Narcotics	

Family History:	**Who:**
Diabetes	
Cancer	
Heart Disease	
Stroke	
Rheumatoid Arthritis	
Gout	
Other	

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Please mark any symptoms you have experienced in the last 30 days.

GENERAL	GENITOURINARY	MUSCULOSKELETAL
Fatigue	Leaking urine	Stiffness out of bed
Unexpected weight gain/loss	Urinary Tract Infection	Ankle pain / Foot pain
Fever / chills	Blood in urine	Toe pain / Knee pain
Dehydration	Excessive urination	Back pain

ENDOCRINE	GASTROINTESTINAL	NEUROLOGY
Heat / Cold intolerance	Heartburn	Headaches / Dizziness
Exhaustion	Bloating	Tingling or numbness
Dry Skin	Diarrhea	Steady gait
		Frequent falls

EARS, NOSE, THROAT	DERMATOLOGIC	RESPIRATORY / HEART
Difficulty Swallowing	Rash	Racing heartbeat
Ear infection / Sinus infection	Darkened mole	Chest pains
Bloody nose	Itchy feet	History of blood clots
EYES	Ulcers	Asthma
Blurred vision	**LYMPHATIC**	Pneumonia
Glasses / Contacts	Swollen lymph nodes	

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Medical Conditions

Do you have a history of any of the medical problems listed?
CIRCLE all that apply:

AIDS/HIV
Alcoholism
Anemia
Asthma
Bipolar Disorder
Bleeding Disorders
Blood Clots/DVT
Cancer _____
Cerebral Palsy
Chemical Dependency
Cellulitis
Crohn's Disease
Coronary Artery
Cirrhosis of the Liver
COPD/Pulmonary Disease
Depression/Anxiety
Diabetes/Pre-diabetes
Emphysema
Fibromyalgia GERD/Peptic Ulcers
Gluten Intolerance
Gout
Heart Disease
Heart Attack
Hemophilia Hepatitis A / B / C
High Blood Pressure
High Cholesterol
Immune Disorder
Irritable Bowel Disease
Kidney Disease
Leg/Foot Ulcer
Low Blood Pressure
Liver Disease
Lupus
MRSA- Infection
Neuropathy
Multiple Sclerosis
Osteoarthritis Psoriasis
Psychiatric Illness Reynolds Disease
Respiratory Disease
Rheumatoid Arthritis
Spine injury/Deformity
STD
Stroke
Thyroid Disease
Urinary Tract Infections
Venereal Disease

Surgical History & Hospitalization History
Please list all surgeries and any recent hospitalizations with dates.

Have you received a pneumonia vaccination within the last 12 months? Y / N

Have you received an influenza vaccination within the last 12 months? Y / N

Do you have an Advanced Care Plan / Living Will? Y / N

FINANCIAL POLICY

Our practice is committed to providing the best treatment possible for our patients. The filing of insurance claims is a courtesy we extend to our patient's. However, your insurance policy is a contract between you (the patient) and your insurance company. It is the patient's responsibility to know what services are OR are not covered under their policy. **Full payment is due at time of service for co-pays, 60% of coinsurance and deductibles. We accept Cash, Checks, Visa, MasterCard, Discover and Care Credit.** Rocky Mountain Foot and Ankle uses a third party agency to collect on accounts that are past due. It is YOUR responsibility to provide current and accurate insurance information at the time of your visit. If there is a payment plan set up you will be required to pay that balance in 3 consecutive payments. Returned checks and balances older than 90 days are subject to collection fees. We require 24 hours notice for appointment cancellations.

Mountain Pharmacy is owned by Dr. P. Roman Burk

CARD ON FILE

We ask that you provide us with a card to have on your patient chart for charges that may arise in the future of your visits. These charges may include: Overdue balances, failure to follow our no show/cancellation policy, or payments taken over the phone. If you have a patient balance with our clinic, you will be charged 60 days after those charges are added to your account. Failure to pay or payments that are declined will result in our team reaching out to you for updated information and payment.

DURABLE MEDICAL EQUIPMENT (DME)

These are supplies that are ordered by our physician(s) in the course of treatment of many conditions. Typical supply codes include: (but are not limited to)

L3260 Post Op Shoe $30.00 ea.*	L2999 Toe Correctors $15.00 each
L3040 Generic Foot Orthotics $85.00/pair	L3000 Custom Orthotics $750.00/pair*

These supplies are not always covered by many insurance companies. We strongly encourage you to review your insurance policy or contact your insurance company with the codes listed above to verify coverage to determine what your cost would be. We do our best to assist our patient's in verifying their coverage prior; however it is ultimately the patient's responsibility to know their insurance coverage. Once DME products are dispensed they **cannot** be returned.

TOE NAIL/FOOT CARE

Simple toe nail care (Trimming and cutting of the Nail) is $40.00
Extensive toe nail care- Grinding/Trimming and cutting of the nail is $50.00
Removal of corns and callus starts at $20.00+

MEDICAL RECORDS/ FORMS

We will provide a copy of your medical records once at no cost, per course of treatment, upon receipt of a signed Medical Records Release. There will be a charge of $50.00 for additional requests and must be paid at the time the records are released. The patient needs to make an appointment for FMLA forms to be completed and the form will be a charge of $50.00.

ORTHOTIC REPAIR/ MODIFICATION

There will be a $175.00 charge for any and all repairs/modifications after the 30 day warranty has expired, beginning the day of dispensement.

Patient Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICE

I understand that, under the Health Insurance and Portability & Accountability Act of 1996 (HIPAA), I have certain rights regarding the protected health information. I understand that this information can and will be used to:

- Conduct, Plan and Direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. 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 that you are not required to agree to my requested restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Persons Authorized to Access My Information

1. Name / Relationship: _____
2. Name / Relationship: _____
3. Name / Relationship: _____

Late Policy

Existing patients have a check in time of 15 minutes prior to appointment with the doctor. New patients have a check in time of 30 minutes, prior to appointment with the doctor. Anything past 10 minutes, will be considered late and will be canceled & rescheduled.

Treatment Consent

I hereby consent and give my permission to the doctor(s) (and the doctor's assistants or designated replacement) to administer and perform such procedures or treatment upon me as the doctor has suggested and that I have agreed to.

Medical Research Disclosure

Rocky Mountain Foot and Ankle is partnered with Advanced Specialty Research and participates in medical research opportunities. As a patient you may be called in the event one of our physicians identifies a trial you may qualify for. You are not required to participate in medical research as a patient of Rocky Mountain Foot and Ankle.

Patient Signature: _____ Date: _____