FRONT RANGE PODIATRY
8151 Southpark Lane, Unit 250
Littleton, CO 80120
Phone: (720) 662-7184 | Fax: (720) 662-7616 | www.frontrangepodiatry.com

DISCLOSURE AND RELEASE AUTHORIZATION FORM

Form is to be completed by adult patient or patient's parent / legal guardian / acting power of attorney.

CONSENT TO TREAT: I request and give consent to my Front Range Podiatry, PLLC physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as my physician, in his/her professional judgement, deems necessary or beneficial. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INSURANCE BENEFITS: I authorize Front Range Podiatry, PLLC and my physician to release information from my medical records to my insurance carrier(s), government agencies, or my employer in the case of work-related injuries, for the purpose of processing claims for medical/workers compensation benefits and state on such claims that my signature is on file. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to Front Range Podiatry, PLLC, or my physician, on my behalf.

FINANCIAL AGREEMENT: I understand and agree to all of the following: a. All accounts are the full responsibility of the patient and/or the patient's responsible party guarantor. b. No conditional payments accepted and payments with attempted conditions will be applied to any amounts owed. c. I have provided complete information regarding my/the patient's primary and secondary health insurance, as applicable. d. I am responsible to make sure insurance payments are processed and paid promptly to Front Range Podiatry, PLLC, and for my prompt payment of any amounts owed to Front Range Podiatry, PLLC that are deemed "Patient Responsibility" under my insurance contract (for those payors with which Front Range Podiatry, PLLC is a participating provider or "in-network"). I understand that all charges that are denied by my insurance company, whether Front Range Podiatry is in-network or out-of-network, are my responsibility. e. In the case of default payment, I promise to pay any legal interest on the balance due. I understand that I am responsible for all costs of collection including attorney fees, collection fees of 30% and court costs. I understand that any unpaid balance will be assessed interest at the rate of 18.00% (1.5% monthly). f. Arapahoe County, Colorado, shall be the preferred venue for any legal action related to this financial agreement and I agree to waive my right to a trial by jury. g. This financial agreement is being entered into individually and as an authorized agent for my spouse, if any. This financial agreement may be assigned by Front Range Podiatry, PLLC to an attorney who purchases Front Range Podiatry, PLLC's delinquent accounts and the terms of this agreement shall remain binding.

TELEPHONE CONTACTS: I authorize Front Range Podiatry, PLLC and its affiliates and agents to contact me at the phone numbers and email I have provided (whether such is a cell phone or a landline), including providing me with automated appointment and billing reminder calls, text messages, and email and other automated messaging related to the services provided to me. If a machine or voicemail is reached, I understand and agree that a message may be left for me and that this message may contain protected health information.

COLORADO LAW AND JURISDICTION: I understand that I am being provided treatment in the State of Colorado and I agree that if I should have any claim with regard to my care or treatment, such will be decided in accordance with Colorado law and such action will be brought and decided in a Court in the State of Colorado.

NOTICE OF NONDISCRIMINATION: Front Range Podiatry, PLLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex or gender identity.

OTHER PROVIDERS: I understand in addition to the attending physician, other physicians, such as radiologists, pathologists or medical/podiatry residents, and other providers such as laboratories and other medical professionals, may be involved in my care, and may separately bill me for their services.

Printed Patient Full Name _____

PHOTO CONSENT: I consent to have my photographs taken by the provider or designated associate if required, and permit use of photographs for medical records, education, and lectures.

CANCELLATIONS OR MISSED APPOINTMENTS: A fee may be charged for any appointments not canceled at least twenty-four (24) hours in advance or missed for any other reason. These are generally not payable by insurance. **There is a $100 charge for missed appointments with no prior notice. There is a $150 charge for cancelled or rescheduled surgery within 7 days and a $500 charge for missed surgeries with no prior notice.**

MEDICARE CERTIFICATION: (IF APPLICABLE) I certify that the information given by me, or by Front Range Podiatry, PLLC on my behalf, in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my treating physician to release information from my medical record to the Social Security Administration and/or Medicare program or its intermediaries or carriers, or the Professional Standards Review Organizations for the purpose of processing claims for medical benefits and state on such claims that my signature is on file. I request that payment of such authorized benefits be made directly to Front Range Podiatry, PLLC on my behalf.

E-PRESCRIBING CONSENT: I consent that Front Range Podiatry, PLLC physicians can request and use my prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I have received the Front Range Podiatry, PLLC's Notice of Privacy Practices and understand that my protected health information may be used by Front Range Podiatry, PLLC as described in the notice.

MARKETING: I give consent to receive periodic marketing communications from Front Range Podiatry, PLLC.

BALANCE BILLING: I have read, understood, and received a copy of the federal and Colorado balance billing disclosure forms.

MEDICAL SCRIBES: I consent to the use of medical scribes, whether they be in-person, virtual, or computer based artificial intelligence. I understand the purpose of a medical scribe is to help the Front Range Podiatry physicians with documentation of the clinical encounter and that these scribes are held to the same confidentiality standards as your physicians are.

I have read, understood, and agree to the above terms.

Printed Patient Full Name _____ Date _____

Signature of Patient / Parent / Legal Guardian / Acting Power of Attorney _____

Relationship to Patient (if applicable) _____

FRONT RANGE PODIATRY

Katherine R. Kloberdanz, DPM and David M. Shain, DPM
Phone: (720) 662-7184 | Fax: (720) 662-7616 | frontrangepodiatry.com

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Important Office Policies

PLEASE READ THESE POLICIES IN DETAIL

Cancellation/Reschedule Policy:
If you are not able to attend your appointment, please give us 24 hour notice. There is a $25 fee that will be assessed for late cancellations/reschedules. For Monday appointments, cancellations/reschedules will be considered late if they are not received by the preceding Friday at noon.

No-Show Policy:
If you do not show up to your appointment and do not provide **prior** notice, you will be charged a $100 no-show fee. This fee will only be waived under extenuating circumstances and is legally enforceable. If you no-show, you will only be rescheduled if the fee is paid. If you no-show multiple times, you may be excused from the practice. The following are considered no-shows:

- Failing to show up to your appointment with no prior notice.
- Canceling your appointment **after** your scheduled appointment time.
- Showing up to your appointment so late that we are unable to see you (5 minutes for new patients and 10 minutes for established patients), or if we are unable to see you for any other reason.

Billing Policy (in addition to Disclosure and Release Authorization Form):
We will submit claims to your insurance company as a courtesy. If a claim is denied, we will appeal it on your behalf one time, unless it is apparent that the claim will not be approved under any circumstances, or if other extenuating circumstances exist. Whether or not a particular service is covered by your insurance company is your responsibility to know. We will do our best to help you with this, but it is impossible for us to be aware of all the benefit policies of the numerous insurance plans we take.

Verbal Abuse Policy:
Verbal abuse will not be tolerated at our practice. Verbal abuse includes profanity, yelling, unconstructive criticism, intimidation, and threats. If you verbally abuse any of our staff members, you will be excused from the practice.

I have read, understand, and agree to the above policies.

Printed Patient Name: _____

Patient **Signature**: _____ Date:_____

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MEDICAL HISTORY FORM
Form is to be completed by adult patient or patient's parent/legal guardian/power of attorney.

Demographics

Patient Full Name _____ DOB _____

Street Address _____ Unit_____

City _____ State _____ Zip Code _____

Home Phone Number _____ Mobile Phone Number _____

Email Address (please print clearly) _____

Primary Care Physician _____

Language_____ Race_____

Ethnicity

☐ Central American
☐ Cuban
☐ Dominican
☐ Hispanic or Latino/Spanish
☐ Mexican
☐ Puerto Rican
☐ South American
☐ Spaniard
☐ Latin American / Latin, Latino
☐ Not Hispanic or Latino

Marital Status

☐ Married
☐ Single
☐ Divorced
☐ Separated
☐ Widowed
☐ Partner

How did you hear about us?

☐ Google
☐ Other Online Source (Where? _____)
☐ Patient in the Practice/Word of Mouth
☐ Hospital
☐ Primary Care Physician (Who? _____)
☐ Insurance Company
☐ Specialist Physician (Who? _____)
☐ Other, please specify _____

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Circle any medical conditions that you have or have had in the past

AIDS/HIV	Edema	Organ Transplant
Anemia	Fibromyalgia	Osteoporosis
Arthritis	Foot Deformity	Pacemaker
Artificial Joints	Frost Bite	Peripheral Vascular Disease (PVD)
Asthma	Gout	Polio
Back Pain	Headaches	Pulmonary Embolism (PE)
Bleeding Disorder	Heart Disease	Raynaud's Disease
Blood Clot	Hepatitis	Rheumatoid Arthritis (RA)
Cancer	Hernia	Seizures/Epilepsy
Coronary Artery Disease (CAD)	Hypertension	Stroke
Deep Vein Thrombosis (DVT)	Kidney Disease	Substance Abuse
Diabetes	Leg or Foot Ulcers	Thyroid Problems
Dialysis	Liver Disease	Tuberculosis
Dyslipidemia	Lung Disease	Varicose Veins

List all surgeries in the past 10 years with approximate dates (fill in below) or ☐ None

_____ _____

_____ _____

_____ _____

List all medications along with dosage. Attach additional forms if more space is needed or ☐ None

_____ _____

_____ _____

_____ _____

Check all allergies that apply:

☐ **None** ☐ Codeine ☐ Nickel ☐ Demerol ☐ Cipro ☐ Sulfa ☐ Aspirin ☐ Penicillin

☐ Latex ☐ Iodine ☐ Eggs ☐ Bees/Wasps ☐ Local Anesthetic ☐ Food _____

☐ Other _____

Social History:

Is there a possibility of being pregnant? ☐ Yes ☐ No Are you currently breastfeeding? ☐ Yes ☐ No Do you use tobacco? ☐ No ☐ Cigarette ☐ Vape How many per day? _____ How many years? _____ ☐ Formerly, quit _____ years ago	Do you drink alcohol? ☐ Yes ☐ No How much? _____ How often? _____ Do you use recreational drugs? ☐ Yes ☐ No If yes, which drugs? _____	Shoe Size _____ ☐ Men's ☐ Women's ☐ Child's ☐ Narrow ☐ Medium ☐ Wide Height _____ Weight _____