



Stilwell Foot & Ankle

www.stilwellfeet.com

J. Gregory Stilwell, DPM

Board Certified Foot & Ankle Surgeon

PATIENT INFORMATION:

Patient's Full Name: _____ Age: _____

Name you wish to be called: _____

Mailing Address: _____ City _____ State _____ Zip _____

Street Address (if different): _____

Home phone: _____ Cell: _____ Work Phone: _____

Social Security #: _____ Sex: M F Date of Birth: _____

***Required**

E-mail address: _____ Occupation: _____

Marital Status: S M W D Sep. Employed: Y N Student: Y N Retired: Y N

Emergency Contact: _____ Contact Phone: _____

INSURANCE/FINANCIAL INFORMATION:

Insurance: _____ Name of Policy Holder: _____

Policy Holder's Date of Birth: _____ Relationship to Patient: _____

Policy Holder's Social Security #: _____ Policy Holder's Employer: _____

***Required**

Responsible Party for acct: _____ Relationship to patient: _____

Responsible party's address & phone: _____

Responsible party's Social Security #: _____ Responsible party's DOB: _____

Whom may we thank for referring you to our office ? _____

I hereby consent to medical treatment and diagnostic testing that is deemed medically necessary by Dr. Stilwell to treat my podiatric condition. I also consent to having my picture taken for identification purposes only.

Signature of Patient or Guardian

Date



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Patient Health History

Patient Name: _____

Date: _____

Height: _____

Weight: _____

Shoe Size & Width: _____

Is your General Health: Good Fair Poor

Do you Smoke?: No Yes _____ packs per day _____ years smoking _____ years stopped smoking

Do you drink Alcohol?: No Yes Amount per day/week/month _____

Do you have any allergies to medications/foods?: _____

Please list any Medications you take now and the dosage (including vitamins, diet pills, aspirin, etc):

Name of Medication	Reason	Dose	Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Who is your Primary Care doctor: _____ Date last seen: _____

Fitness Activities you participate in and frequency: _____

Have you ever had any of the following? Yes No If yes, please indicate:

- Arthritis Asthma Back Problems Bleeding/Bruising problems Blood Disease Cancer
- Carpal Tunnel Syndrome Circulatory Disease Diabetes Frostbite Gout Heart Trouble
- High Blood Pressure Kidney Trouble Liver Trouble Nerve Disorder Stomach Ulcers Stroke Thyroid Problems

Have you ever broken any bones? NO YES

- Arm/Wrist/Hand RT LT When? _____ Treatment: _____
- Leg/Ankle/Foot RT LT When? _____ Treatment: _____
- _____ When? _____ Treatment: _____
- _____ When? _____ Treatment: _____

How many pregnancies have you had? _____ How many live births: _____

List any surgeries you have had: surgery: _____ date: _____
surgery: _____ date: _____ surgery: _____ date: _____

Family History, please check if any of your immediate blood relatives have or have had any of the following: (please indicate who, when and if they are deceased)

- Cancer _____ Circulation Problems _____ Diabetes _____
- Foot Problems _____ Heart Problems _____ Other _____



Stilwell Foot & Ankle, LLC

575 RiverGate Ln. #95

Durango, CO 81301

970-259-5303

www.stilwellfeet.com

HIPAA

Special care is given by our office to protect your health information. Today the State and Federal laws also attempt to ensure the confidentiality of your very sensitive information.

The Federal Government has published regulations designed to protect the privacy of your health information through **the Health Insurance Portability and Accountability Act of 1996 (HIPAA)**. All health information including paperwork, oral communication, and electronic formats are protected by this rule.

Consent of Disclosure

I hereby give consent to Stilwell Foot and Ankle, LLC/Dr. J. Gregory Stilwell and his office staff to use and disclose my Protected Health Information (**PHI**) for the purposes of Treatment, Payment, and general health care Operations (**TPO**).

I understand that I have the right to review the offices Notice before I sign this consent. I understand further that I have the right to obtain a copy of the offices Notice of Privacy Practices if I so choose; a copy may be obtained by contacting the office at (970) 259-5303; we reserve the right to amend this Notice at any time.

I have the right to request, in writing, restriction on the usage and disclosure of my PHI. I further have the right to cancel this consent in writing except to the extent that Dr. Stilwell has already made disclosures in reliance upon my prior requests.

If this consent is not signed, I understand that Dr. Stilwell may decline to provide treatment to me.

Printed Patient Name

Patient/Guardian Signature

Date

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FINANCIAL POLICY

Thank you for choosing our office for your foot & ankle health care needs. We are committed to your *treatment* being successful. Please understand that payment of your bill is considered part of your treatment. If you have any questions in regards to our financial policy, please contact our office at 970.259.5303.

Charges for medical services are due and payable at the time services are rendered. Charges for medical care provided by this medical practice will be billed through our office and should not be confused with charges for medical care provided by the hospital. We accept Visa, MasterCard, Discover, American Express, and Care Credit as well as personal checks, money orders and cash.

Contracted Insurance: We directly contract, through physician organizations or independently, to provide service for some insurance companies; contact our office if you have questions in regards to our office being contracted with your insurance company. If we are contracted with your insurance company you will be responsible for your co-pay, co-insurance, deductible and any non-covered items/supplies *due at the time of service*. Any balance remaining after the insurance payment is made is due to our office within 30 days.

Non-contracted Insurance: Patients who have policies with non-contracted insurance companies will be responsible for payment in full for all office visits/procedures at the time service is rendered. We will bill your insurance company and you should be reimbursed directly. **We do not participate TRI/CARE Insurance WPS TRI West, however we bill using the Government Fee Schedule.**

Medicare: We are not contracted with Medicare. Patients who have Medicare will be responsible for payment at the time of service. We will only charge the Medicare allowed fees and submit your claim to Medicare, you should be reimbursed directly from Medicare.

We do not bill secondary insurances.

Self Pay/No-Insurance Patients: We will offer a 30% discount off of services rendered with the exception of supplies to all cash paying patients. We make no arrangements for long-term payments on patient balances.

I understand that if, 45 days after billing, my insurance has not paid, my account will be due and payable by me. In the event my account becomes past due, my balance will accrue interest at the rate of 18% per month. In addition, I will be responsible for collections costs, attorney fees, court costs and any other miscellaneous fees. I consent to have the collection agency obtain my credit report for the purposes of collection on my account.

In accordance with guidelines set forth by Colorado State Board of Medical Examiners, if further action must be taken on my account, I may be discharged from this practice and be required to seek further care elsewhere.

Returned Check Fee: We will assess a \$20.00 fee plus any additional charges allowed by CRS 13-1-109 for any returned check. All payments thereafter must be made with cash or credit cards.

I understand that certain services may be sent to an outside source such as lab, pathology and diagnostic services and thus will be billed separately for those services.

Missed Appointments: Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at \$72.00.

We will work with patients in any way we can to ensure that their medical care is the finest available and that this care does not become a financial burden. Please sign and date this form, acknowledging that you have read and understood our financial policy. Thank you.

I have read the financial policy above and understand and agree to these arrangements.

Print Patient Name

Signature of responsible party

Date