

Foot & Ankle Care of Boulder

Thomas E Shonka, DPM

1400 28th Street, Suite 2
Boulder, CO 80303
Office: (303) 449-2000
Fax: (303) 449-9475
www.facboulder.net

PLEASE PRINT LEGIBLY IN INK

Date: _____

Last Name: _____ First (Legal): _____ Middle Initial _____

Mailing Address: _____
(City) (State) (Zip)

Home Phone: () _____ Social Security #: _____ Cell/Pager #: () _____

Preferred Name: _____ Birth date: _____ Sex: M F Marital Status: M S W O

Height _____ Weight _____ Shoe Size _____

Employer: _____ Occupation: _____ Work Phone: () _____ ext _____

Spouse: _____ Primary Care Physician: _____ Phone #: () _____

May we contact you at your home #? Y N If no, please indicate which # you would like us to contact you () _____

Emergency Contact: _____ Relationship: _____ Phone #: () _____

Primary Insurance Information:

Insurance: _____ Policy Holder: _____ Relationship: _____ DOB _____

Policy Holder's Address: _____
(if different than above) (City) (State) (Zip)

Home Phone: () _____ Work Phone: () _____ Cell/Pager #: () _____

Employer: _____ Subscriber#: _____ Group#: _____

Secondary Insurance Information:

Insurance: _____ Policy Holder: _____ Relationship: _____ DOB _____

Policy Holder's Address: _____
(if different than above) (City) (State) (Zip)

Home Phone: () _____ Work Phone: () _____ Cell/Pager #: () _____

Employer: _____ Subscriber#: _____ Group#: _____

Person Responsible for Bill:

Name: _____ Relationship: _____

Mailing Address: _____
(if different than above) (City) (State) (Zip)

Home Phone: () _____ Work Phone: () _____ Cell/Pager #: () _____

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I hereby acknowledge and agree that if my account becomes delinquent it will be subject to collection service. I agree to pay all court costs and reasonable attorney fees for collection of all past due amounts owed, plus interest thereon on all such amounts outstanding. I certify that the information provided is correct to the best of my knowledge. I authorize the release of any pertinent information regarding my medical care, and assignment of benefits from my insurance company to my Physician.

Signature: _____ Date: _____

Parent or Guardian (if minor): _____ Date: _____

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EXERCISE SURVEY

Name: _____

Age: _____

1. Activities / Exercises Done Regularly:

2. Frequency of Above Activities:

3. Do you use pads, arch supports or orthotics currently? YES NO

If yes, which do you use? _____

4. What is the longest period of rest from exercise you have had in the past year?

5. What are your short and long-term goals?

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MEDICAL HISTORY

(Confidential Information-Important for Our Files and Your Health)

Family Physician: _____

Has He/She referred you to our office? _____

Have you seen another Podiatrist? YES NO Name: _____

Why did you see your former Podiatrist? _____

What is the reason for your visit to our office? _____

What treatments have been done up to this point (including orthotics/arch supports)?

Please list all medicines that you use: _____

Please list all medicines that you are ALLERGIC to: _____

FOR WOMEN ONLY: Are you pregnant? YES NO If yes, how many months _____

Indicate which of your immediate relatives have had any of the following diseases:

Cancer _____ Diabetes _____

Heart Trouble _____ High Blood Pressure _____

Kidney Disease _____ Mental/Emotional Illness _____

Stroke _____ Arthritis _____

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Please check "Yes" or "No" to indicate if you have had any of the following problems:

YES	NO	NATURE OF PROBLEM	COMMENTS AND GIVE APPROXIMATE DATE
		Recent Weight Loss	
		Headaches	
		Trouble with Hearing/Vision	
		Allergies/Hay Fever	
		Asthma	
		Thyroid	
		Diabetes	
		Skin	
		Anemia	
		Heart	
		Mitral Valve Prolapse/Heart Murmur	
		Chest Pain	
		High Blood Pressure	
		Circulation	
		Swelling in Feet or Ankles	
		Lungs (Pneumonia, TB, etc.)	
		Shortness of Breath(Cough, Pleurisy, Wheezing)	
		Liver Disease, Gall Bladder Disease or Jaundice	
		Stomach Trouble	
		Arthritis	
		Gout	
		Kidney Disease or Stones	
		Cancer	
		Bleeding Tendency	
		Scarring Tendency	
		Joint Pain or Stiffness	
		Numbness in Feet or Legs	
		Cramps in Feet or Legs	
		Low Back Pain	
		Do You Smoke? How much?	
		Do You Take Any Drugs? (Illegal or Legal?) How Much	
		Psychiatric	
		Sleep Apnea	

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YES	NO	NATURE OF PROBLEM	COMMENTS/APPROXIMATE DATE
		Fainting or Convulsions	
		Strokes	
		Pain in Other Areas	
		Other Illnesses or Problems	
		HIV Positive	
		Do you drink alcohol? How much?	

Please give detail of any:

OPERATIONS/SERIOUS INJURIES	APPROX. DATE	PHYSICIAN	HOSPITAL

7. Have you had physical therapy? When? Where? For what condition? _____

8. Is there anything you wish to tell the doctor privately? Yes _____ No _____

Additional Information: _____

Patient Signature _____

Date _____

Witness _____

Date _____

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND, HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

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For your protection all requests must be submitted in writing.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not to be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information as of April 14, 2003.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of Our Privacy Practices:

Print

Signature

Date

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