James S. Scales, DPM
7375 W 52nd Ave, Suite 350 in the Wells Fargo Building
Arvada, CO 80002
Phone: (303) 421-3668 Fax: (303) 425-0163

Welcome to our office. Please answer the following questions to help us become better acquainted and to provide you with the best possible care. If you require any help, please ask us.

Name: _____ Date of Birth: _____

By what name would you like to be called: _____

Address: _____ Phone: _____H W C

City: _____State: ___ Zip: _____ 2nd Phone #: _____H W C

Email address (will not be shared): _____

Occupation: _____ Employer: _____

Business Address: _____

Spouse or Emergency Contact - Name: _____

Phone: _____ Relationship: _____

Person responsible for payment if other than patient: _____

Medical Insurance: _____

Primary Care Physician: _____ Last Visit: _____

Former Podiatrist: _____ Last Visit: _____

How did you learn about our office?: _____

- Consent to treat: I hereby give my permission for Dr. James S. Scales to administer treatment and perform procedures as may be deemed necessary in the diagnosis and/or treatment of my condition.
- I agree that information may be sent to and received from my primary care physician. I authorize Dr. Scales to release any necessary medical information about me to my insurance company or Medicare as needed.
- I authorize my insurance company and/or Medicare to make payments directly to James Scales, DPM for any services furnished me by Dr. Scales.

Signature of patient or guardian: _____ Date: _____

Print name of patient or guardian: _____

Medical History

IMPORTANT – Please fill this out as completely as possible in order for us to give you the best possible care.

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Shoe Size: _____

Briefly describe your problem: _____

Which foot? Right Left Both How long has this been a problem? _____

What started it or makes it worse? _____

What makes it feel better?_____

Please list any other physicians who have treated your feet and when: _____

_____

What treatment have you had? _____

List all **allergies** or adverse reactions to medications or other medical products: _____

_____

List all **medicines** you take, the dosage and reason for taking: _____

_____

Please list any other doctors you are seeing and why: _____

_____

List major surgeries and hospitalizations: _____

_____

List all previous significant injuries (broken bones, sprains, etc.) and approximate dates: _____

_____

Do you smoke? Yes No Packs per day _____ Cigars or other _____

Do you use smokeless tobacco? Yes No

Do you drink alcohol? Yes No Occasional Drinks per day _____ per week _____

Do you use any recreational/street drugs: Never Rare Daily Type _____

Medical History, page 2

Please note if you have, or have had any or the following:

Past	Now		Past	Now	
___	___	Anemia	___	___	Heart Attack: date(s)_____
___	___	Arthritis: __Rheumatoid __Osteoarthritis	___	___	Hepatitis: A B C or other _____
___	___	Asthma	___	___	High blood pressure
___	___	Back pain	___	___	HIV positive or AIDS
___	___	Bleeding problems	___	___	Immune system problems
		Explain:_____			Explain:_____
___	___	Blood clots/Phlebitis	___	___	Joint pain/stiffness
___	___	Cancer: Type & when _____	___	___	Keloid scars
___	___	Circulation problems	___	___	Kidney problems
		Explain:_____			Explain:_____
___	___	Depression or anxiety	___	___	Lung Disease COPD Emphysema
___	___	Diabetes: date of diagnosis _____	___	___	Muscle weakness
___	___	Digestive problems	___	___	Nerve disorder: Type _____
		Explain:_____	___	___	Numbness: Where _____
___	___	Elevated Cholesterol	___	___	Osteoporosis/Osteopenia
___	___	Eye problems	___	___	Polio
		Explain:_____	___	___	Psychiatric problems
___	___	Frequent Thirst			Explain:_____
___	___	Frequent Urination	___	___	Rheumatic Fever/heart murmur
___	___	Glaucoma	___	___	Seizures
___	___	Gout	___	___	Skin rashes
___	___	Headaches	___	___	Stomach ulcers: Peptic Duodenal
___	___	Healing problems	___	___	Stroke: Date(s)_____
		Explain:_____	___	___	Thyroid Disease
___	___	Hearing problems: Hearing Aid R L Both	___	___	Varicose Veins
___	___	Heart problems			
		Explain:_____			

Any other medical problems not listed? _____

_____

Are you Pregnant? No Yes Due Date: _____ Are you breast feeding? Yes No

Do you have any metal implants, screws, pins, etc.? No Yes Where: _____

Do you have a pacemaker or defibrillator? Yes No

Family History: Please list any diseases common to your family such as diabetes, heart problems, arthritis, genetic problems, etc.

Father: _____

Mother: _____

Siblings: _____

Financial Policy
James S. Scales, DPM

We accept Cash, Checks, and Visa or Mastercard credit card payments.

Insurance Plans:

Your insurance policy is a contract between you and your insurance company. **Many insurance companies now require a referral and/or prior authorization.** If we submit a claim to your insurance company and find out we are not a provider for your plan or that you needed a referral or authorization, you are responsible for the balance due.

A valid insurance card must be presented at the time of service. Co-pays are due at the time of treatment. Deductibles and co-insurance amounts are payable within 30 days of the insurance explanation of benefits determination.

Although we may be a participating provider in a number of plans within an insurance company, there may be plans within that company that preclude us from participation. **It is up to the patient to understand his/her policy and whether or not the physician is a participating, in-network provider.**

Self-Pay Patients: Balance is due at the time of the visit.

Orthotics: Patients are required to pay ½ of the orthotic charge at the time of service and balance when the orthotics are dispensed.

Surgery Patients: We will verify coverage on surgery procedures performed at the outpatient surgery center for the patient's convenience. After verification, deductibles and co-insurance or a deposit maybe required prior to surgery. Payment arrangements may be made on an individual basis.

Canceled or Missed Appointments: Please give us a courtesy call within 24 hours of your scheduled appointment if you cannot make it or any changes need to be made. If we receive no notice of a missed appointment we may charge $45.00 for the missed visit. Please help us to serve you better by keeping appointments or rescheduling them. We understand emergencies come up and are happy to make exceptions or waive the fee on a case-by-case basis.

Copying of Medical Records: The first 20 pages requested are free of charge. For each additional page we will charge twenty cents per page plus postage if required.

I hereby acknowledge and agree that any account that becomes delinquent will be subject to collections service and 12% interest per year. A $25 service charge will be made on all returned checks.

I have read and agree to the Financial Policy:

_____ Date: _____

Signature of patient or responsible party

Narcotic/Opiate Medication Policy

Dr. James Scales
7375 W 52nd Ave Ste 350, Arvada, CO 80002
303-421-3668

Patient Name _____

My use of narcotic (also known as opiate) medication, if needed, will be limited to 3 prescriptions since narcotics can produce dangerous side effects. Use of narcotic pain medication prescribed by this office will be limited to short-term control of "**acute**" pain. I understand Dr. Scales does not manage long-term (greater than 2 months) chronic pain. If my condition requires chronic pain management, I will be referred to a physician specializing in this. It is important to remember that other techniques may be used in place of narcotics such as ice/heat, massage, deep breathing/relaxation or "over the counter" medications such as Extra Strength Tylenol, Ibuprofen, etc., according to label directions. Narcotics should be discontinued as soon as possible.

- If a refill is needed, I will have my pharmacy call Dr. Scales' office at 303-421-3668. Lost prescription slips or pills will NOT be replaced.
- I agree that I will not seek narcotic/opiate prescriptions from other sources.
- If I am unable to successfully discontinue use of narcotic pain medication, I will be referred to a pain management program since Dr. Scales does not manage chronic pain.
- I will not share medicine with any person(s).
- I agree that I will dispose of any medicine that I no longer need to take in a legal, proper manner.
- I will keep my narcotic medication in a safe and secure place

I understand that a breach of this contract could be considered a failure of mutual trust and precipitate my dismissal from Dr. Scales' practice.

My signature below indicates that I understand and agree to the above policies.

_____ _____

Signature of patient or guardian Date

Patient Consent for Use and Disclosure of Protected Health Information
James S. Scales, DPM

Patient Name: _____

I hereby give my consent for James S. Scales, DPM to use and disclose protected health information about me in order to carry out treatment, payment and healthcare operations. Our complete Notice of Privacy Practices provides a more complete description of such uses and disclosures and is available upon request.

I have the right to review the Notice of Privacy Practices prior to signing this consent. James S. Scales, DPM reserves the right to revise the Notice of Privacy Practices at any time. You may obtain a revised Notice by contacting the office.

With this consent, the practice of James S. Scales, DPM may call my home or other alternative locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With this consent, the practice of James S. Scales, DPM may mail or email to my home or other alternative locations any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, health information and patient statements.

I have the right to request that James S. Scales, DPM restrict how it uses my protected health information. However, the practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

By signing this form, I am consenting to James S. Scales DPM's use and disclosure of my protected health information to carry out treatment, payment and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, James S. Scales, DPM may decline to provide treatment to me.

_____ _____

Signature of patient or legal guardian Date