

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): _____

Preferred method of communication for appointment reminders: ___ email or ___ phone call

Occupation: _____ Employer: _____

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

- Anemia
- Arthritis: Rheumatoid Osteoarthritis
- Asthma
- Back pain
- Bleeding problems
- Explain: _____
- Blood clots/Phlebitis
- Cancer: Type & when _____
- Circulation problems
- Explain: _____
- Depression or anxiety
- Diabetes: date of diagnosis _____
- Digestive problems
- Explain: _____
- Elevated Cholesterol
- Eye problems
- Explain: _____
- Frequent Thirst
- Frequent Urination
- Glaucoma
- Gout
- Headaches
- Healing problems
- Explain: _____
- Hearing problems: Hearing Aid R L Both
- Heart problems
- Explain: _____

Past Now

- Heart Attack: date(s) _____
- Hepatitis: A B C or other _____
- High blood pressure
- HIV positive or AIDS
- Immune system problems
- Explain: _____
- Joint pain/stiffness
- Keloid scars
- Kidney problems
- Explain: _____
- Lung Disease COPD Emphysema
- Muscle weakness
- Nerve disorder: Type _____
- Numbness: Where _____
- Osteoporosis/Osteopenia
- Polio
- Psychiatric problems
- Explain: _____
- Rheumatic Fever/heart murmur
- Seizures
- Skin rashes
- Stomach ulcers: Peptic Duodenal
- Stroke: Date(s) _____
- Thyroid Disease
- Varicose Veins

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: If you would like us to submit a claim to your insurance plan, coverage must be active at the time of service and if a referral is required, it must be in place prior to your visit. Co-pays are due at check-in. Deductibles and co-insurance amounts will be billed to you by our third-party billing service. Payment of bills should be sent to our office or we can take a credit card payment by phone.

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

Orthotics: Self-pay patients are required to pay ½ of the orthotic charge when order is placed and balance when the orthotics are dispensed. If orthotics are a covered benefit of your insurance plan, we may require a deposit at time of order if deductible has not been met. We may also wait to dispense the orthotics until the insurance claim processes and may require payment of patient portion at the time orthotics are dispensed.

Surgery Patients: We will verify coverage on surgery procedures performed at the outpatient surgery center. 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 at least 24 hours before your scheduled appointment if you cannot make it or need to reschedule the appointment. 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. Please reschedule your appointment if you have a contagious illness, you will not be charged a missed appointment fee.

Check-in time: Please check in a few minutes before your appointment time. We reserve the right to reschedule your appointment if you are running late. If you are a new patient, please check in at least 10 minutes early if bringing a completed new patient packet and at least 20 minutes early if filling out the paperwork at check-in.

I hereby acknowledge and agree that any account that becomes delinquent may 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:

Signature of patient or responsible party

Date: _____

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