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 or vape tobacco? Yes No Packs per day ___________ Cigars ____________

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 of 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:

____ Date: ______________________

Signature of patient or responsible party

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.

With this consent, the practice of James S. Scales, DPM may call my home or other alternative locations and leave a message on voicemail 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