



MOUNTAIN
PODIATRY

YOUR APPOINTMENT IS SCHEDULED FOR:

DAY OF WEEK: _____

DATE OF APPOINTMENT: _____

TIME OF APPOINTMENT: _____

TO OUR NEW PATIENT:

I WOULD LIKE TO PERSONALLY THANK YOU FOR CHOOSING MOUNTAIN PODIATRY AND WELCOME YOU TO OUR FACILITY. WE ARE LOCATED AT 653 NORTH TOWN CENTER DRIVE, SUITE #118, LAS VEGAS, NEVADA 89144. OUR OFFICE IS ON THE FIRST FLOOR OF THE MEDICAL OFFICE BUILDING, LOCATED ADJACENT TO THE SUMMERLIN HOSPITAL MEDICAL CENTER.

IN ORDER TO ASSIST YOU IN YOUR TIMELY PROCESS PRIOR TO YOUR APPOINTMENT, PLEASE FIND THE ENCLOSED REGISTRATION PACKET. YOU MAY BRING THIS PACKET WITH YOU AT THE TIME OF YOUR APPOINTMENT, OR YOU MAY FAX OVER THIS REGISTRATION PACKET IN PRIOR TO YOUR APPOINTMENT TO OUR OFFICE AT (702)-240-2256. PLEASE INCLUDE A COPY OF YOUR IDENTIFICATION AND HEALTH INSURANCE CARDS.

PLEASE VERIFY WITH YOUR PRIMARY CARE PHYSICIAN OR INSURANCE CARRIER IF YOU MIGHT NEED A REFERRAL OR A PRIOR AUTHORIZATION BEFORE YOUR APPOINTMENT. IF YOU ARE HAVING DIFFICULTY, PLEASE CONTACT OUR OFFICE AT (702)-240-8038, AND MY PATIENT CARE COORDINATORS WILL ASSIST YOU.

PLEASE BE SURE TO BRING ALONG WITH YOU ON THE DAY OF YOUR APPOINTMENT YOUR INSURANCE CARD, PICTURE IDENTIFICATION SUCH AS A DRIVERS LICENCE, ANY RECENT X-RAYS, TESTS, SCANS, REPORTS OR ANY OTHER PERTINENT INFORMATION OR ITEMS THAT MAY ASSIST US IN YOUR CARE.

PLEASE COMPLETE AND SIGN ALL FORMS, INCLUDING THE INJURY/ACCIDENT REPORT FORM AS THIS IS REQUIRED BY YOUR INSURANCE CARRIER. IF THIS DOES NOT APPLY TO YOU, JUST MAKE A CHECK MARK WITHIN THE "NO" CIRCLE. PLEASE SIGN THE HIPAA FORM AS THIS IS A FEDERAL REQUIREMENT TO PROTECT YOU FOR ALL DISCLOSURE OF YOUR HEALTH INFORMATION.

DUE TO THE NATURE OF MY SPECIALIZED PRACTICE, EXTENDED WAITING PERIODS MAY OCCUR. I APOLOGIZE IN ADVANCE FOR ANY INCONVENIENCE. MY STAFF AND I ARE TRYING TO PROVIDE THE BEST MEDICAL CARE FOR EACH INDIVIDUAL PATIENT. I AM LOOKING FORWARD TO TAKING CARE OF ALL YOUR NEEDS. THANK YOU FOR YOUR TIME AND PATIENCE.

SINCERELY,

DR. JODI S. POLITZ



WELCOME TO MOUNTAIN PODIATRY
PATIENT REGISTRATION FORM

PLEASE HAVE YOUR INSURANCE AND IDENTIFICATION CARDS AVAILABLE

TODAY'S DATE: _____ PATIENT'S NAME: _____ SS#: _____
ADDRESS: _____ CITY: _____ ST. _____ ZIP _____
AGE: _____ DATE OF BIRTH: ____/____/____ GENDER: MALE FEMALE
RACE: CAUCASIAN / ASIAN / AFRICAN AMERICAN / PACIFIC ISLANDER / OTHER
ETHNICITY: NON-HISPANIC HISPANIC LANGUAGE SPOKEN: _____
HOME#: _____ CELL#: _____ WORK #: _____
E-MAIL: _____ OCCUPATION: _____ EMPLOYER: _____
SPOUSE/PARENT NAME: _____ SS#: _____
OCCUPATION: _____ EMPLOYER: _____ PHONE #: _____
FAMILY PHYSICIAN: _____ PHONE#: _____
EMERGENCY CONTACT: _____ PHONE#: _____
HOW WERE YOU REFERRED TO OUR OFFICE? FRIEND FAMILY INSURANCE
 WEBSITE ANOTHER DOCTOR: (NAME) _____
 OTHER: _____

HEALTH INSURANCE INFORMATION:

PRIMARY INS. COMPANY: _____ PHONE# _____
INSURED'S NAME: _____ DOB#: ____/____/____ GENDER: M F
SS# OR ID#: _____ GROUP#: _____
SECONDARY INS.: _____ PHONE# _____
INSURED'S NAME: _____ DOB#: ____/____/____ GENDER: M F
SS# OR ID#: _____ GROUP#: _____

I hereby authorize my insurance carrier to pay medical and/or surgical benefits directly to Mountain Podiatry, and associated medical providers. I authorize Mountain Podiatry to release any information acquired in the course of my treatment needed for this medical insurance claim. A photocopy of this authorization is to be considered as valid as the original until revoked by me in writing. I understand that I am financially responsible for all charges made to my account whether or not an insurance company, attorney or other third party payor is involved with payment. I am responsible for all co-payment and co-insurance amounts, non-covered supplies and services and yearly deductibles. I agree to pay all collection expenses including a \$25.00 returned check fee, attorney's fees, court costs, filing fees, including charges that may be assessed by any collection agency ranging from 35%-50% retained to pursue this matter. Payment for these services is expected at the time services are rendered. If Mountain Podiatry doctors and associated medical providers are Preferred Providers of your insurance company, we are required by your insurance company to collect your financial portion at the time services are rendered. You be responsible to pay a 24 hours No Show/ Cancellation Fee of \$25.00 for an office visit and \$50.00 for any scheduled surgical procedure.

Patient/Guardian Signature: _____ Date: _____



MOUNTAIN
PODIATRY

HIPAA FORM
PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH
INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS
AS REQUIRED BY THE FEDERAL GOVERNMENT

I, _____, UNDERSTAND THAT AS A PART OF MY HEALTHCARE, MOUNTAIN PODIATRY ORIGINATES AND MAINTAINS PAPER AND/OR ELECTRONIC RECORDS DESCRIBING MY HEALTHCARE HISTORY, SYMPTOMS, TEST RESULTS, EXAMINATION, DIAGNOSES, TREATMENT AND ANY PLANS FOR FUTURE CARE OR TREATMENT. I UNDERSTAND THAT THIS INFORMATION SERVES AS:

- BASIS FOR PLANNING MY CARE AND TREATMENT,
- MEANS OF COMMUNICATION AMONG THE MANY HEALTHCARE PROFESSIONALS WHO CONTRIBUTE TO MY CARE,
- SOURCE OF INFORMATION FOR APPLYING MY DIAGNOSIS AND SURGICAL INFORMATION TO MY BILL,
- MEANS BY WHICH A THIRD PARTY PAYER CAN VERIFY THAT SERVICES BILLED WERE ACTUALLY PROVIDED AND,
- TOOL FOR ROUTINE HEALTHCARE OPERATIONS SUCH AS: ASSESSING QUALITY AND REVIEWING THE COMPETENCE OF HEALTHCARE PROFESSIONALS.

I UNDERSTAND AND HAVE RECEIVED A NOTICE OF INFORMATION PRACTICES, THAT PROVIDES A MORE COMPLETE DESCRIPTION OF INFORMATION USES AND DISCLOSURES. I UNDERSTAND THAT I HAVE THE FOLLOWING RIGHTS AND PRIVILEGES:

- THE RIGHT TO REVIEW THE NOTICE PRIOR TO SIGNING THIS CONSENT,
- THE RIGHT TO OBJECT TO THE USE OF MY HEALTH INFORMATION DIRECTORY PURPOSES, AND
- THE RIGHT TO REQUEST RESTRICTIONS AS TO HOW MY HEALTH INFORMATION MAY BE USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS.

I UNDERSTAND THAT MOUNTAIN PODIATRY IS NOT REQUIRED TO AGREE TO THE RESTRICTIONS REQUESTED. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT IN WRITING, EXCEPT TO THE EXTENT THAT THE ORGANIZATION HAS ALREADY TAKEN ACTION IN RELIANCE THEREON.

I ALSO UNDERSTAND THAT BY REFUSING TO SIGN THIS CONSENT OR REVOKING THIS CONSENT, THIS ORGANIZATION MAY REFUSE TO TREAT ME AS PERMITTED BY SECTION 164.506 OF THE CODE OF FEDERAL REGULATIONS.

I FURTHER UNDERSTAND THAT MOUNTAIN PODIATRY RESERVES THE RIGHT TO CHANGE THEIR NOTICE AND PRACTICES, AND PRIOR TO IMPLEMENTATION, IN ACCORDANCE WITH SECTION 164.520 OF THE CODE OF FEDERAL REGULATIONS. SHOULD MOUNTAIN PODIATRY CHANGE THEIR NOTICE, THEY WILL SEND A COPY OF ANY REVISED NOTICE TO THE ADDRESS I HAVE PROVIDED.

I WISH TO HAVE THE FOLLOWING RESTRICTIONS TO THE USE OR DISCLOSURE OF MY HEALTH INFORMATION: _____.

I UNDERSTAND THAT AS A PART OF THIS ORGANIZATIONS TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS, IT MAY BECOME NECESSARY TO DISCLOSE MY PROTECTED HEALTH INFORMATION TO ANOTHER ENTITY, AND I CONSENT TO SUCH DISCLOSURE FOR THESE PERMITTED USES, INCLUDING DISCLOSURES VIA FAX AND/OR E-MAIL.

I FULLY UNDERSTAND AND: ACCEPT DECLINE THE TERMS OF THIS CONSENT.

PATIENT'S SIGNATURE

DATE

RECEIVED BY: _____ ON _____ PATIENT REFUSED CONSENT /TREATMENT REFUSED: _____



**MOUNTAIN
PODIATRY**

INJURY ACCIDENT REPORT FORM
REQUIRED BY ALL INSURANCE COMPANIES

TODAY'S DATE: _____

PATIENT'S NAME: _____ SS#: _____

IS THIS DUE TO AN INJURY? YES NO (IF NO, CONTINUE TO BOTTOM OF PAGE, SIGN & DATE)

DATE OF INJURY? ____/____/____

HAVE YOU NOTIFIED YOUR EMPLOYER? YES NO

EMPLOYER AT TIME OF INJURY? _____

ARE YOU CURRENTLY WORKING? YES NO

DESCRIBE HOW THE INJURY OCCURRED: _____

LOCATION OF ACCIDENT: _____

PLEASE DESCRIBE WHAT PART OF THE BODY WAS INJURED: _____

WAS A POLICE REPORT COMPLETED? YES NO

WHO CAUSED OR MAY HAVE CAUSED THIS ACCIDENT?

NAME	ADDRESS	INSURANCE COMPANY
HAVE YOU NOTIFIED YOUR INSURANCE COMPANY? <input type="radio"/> YES <input type="radio"/> NO		
AUTO INSURANCE COMPANY: _____		PHONE# _____
AUTO INSURANCE ADDRESS: _____		
POLICY #: _____		CLAIM #: _____
ADJUSTER NAME: _____		PHONE#: _____
DO YOU HAVE AN ATTORNEY? <input type="radio"/> YES <input type="radio"/> NO		
ATTORNEY'S NAME: _____		PHONE#: _____
ADDRESS: _____		

I HEREBY VERIFY THAT THE ABOVE INFORMATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

PATIENT/PARENT/GUARDIAN'S SIGNATURE

DATE



MEDICAL HISTORY QUESTIONNAIRE

Name: _____ DOB: ____/____/____ Date: _____

HISTORY OF INJURY/FOOT PROBLEM:

Did the problem result from a specific injury? Yes No Injury/Accident Date: ____/____/____

Did your problem begin following: Work Injury? Motor Vehicle Accident? Daily Regimen? Nothing?

Where is your pain located? Toe Heel Ankle Ball of Foot Arch Leg Knee Back Hip
 Left Right Both Central Inside Outside Under Top

Other: _____

What is your complaint? _____

How long have you had this problem and/or condition? _____

Please rate your pain on a scale of 1 to 10 (10 being the most painful):

At rest: 1 2 3 4 5 6 7 8 9 10 At its Worst: 1 2 3 4 5 6 7 8 9 10

Is the Pain: Constant Occasional Sharp Dull Aching Stabbing Throbbing Traveling

Other: _____

What symptoms are you experiencing?

Locking Numbness Giving Away Popping Tingling Grinding Swelling Bruising

Other: _____

Does anything make your symptoms feel better? _____

Does anything make your symptoms feel worse? _____

Have you seen another Physician for this problem? Yes No Name of Dr. _____

What treatments have you tried? Nothing Physical Therapy Injections Bracing Icing Compression

Medications Other: _____

Have you had any of the following tests/studies?

Tests	Date (month/year)	Facility?
X-Rays		
MRI scan		
Nerve Studies		
Blood Tests		
Other:		

Recreational Activities/Exercise Program: _____

Practitioner's Initials / Date: _____



MOUNTAIN
PODIATRY

Name: _____ DOB: ____ / ____ / ____ Date: _____

SOCIAL HISTORY:

Marital Status: Married Single Divorced Widowed Living Alone Living with Other/s

Special Diet: Yes No Any Restrictions? _____

Tobacco use: Yes No _____ Type: _____ Duration: _____ Quit Date: _____

Alcohol use: Yes No Frequency: _____

Caffeine use: Yes No Frequency: _____

Recreational Drug use: Yes _____ No Type and Frequency: _____

PAST SURGICAL HISTORY: Please list all surgeries you have had in the past: None

Type of Surgery	Date	Surgeon/State

ALLERGIES:

Are you allergic to any medication/s? Yes No No known drug allergies

Are you Allergic to:	Yes	No
Iodine/Betadine		
Shellfish		
Penicillin		
Sulfa Drugs		
Levaquin		
Cipro		
Latex		
Steroids		
Motrin/Advil/Ibuprofen		
Aspirin		
Tape		
Eggs		

Other Allergies: _____

Practitioner's Initials / Date: _____



Name: _____ DOB: ____ / ____ / ____ Date: _____

PAST MEDICAL HISTORY:

Check if you currently suffer or have previously suffered from: None

High Blood Pressure	Osteoporosis
Diabetes	Kidney Disease/Problem
Liver Disease	Seizures
Heart Disease or Attack	Arthritis
Stroke	Thyroid (Hyper/Hypo)
Cancer	Parkinson's Disease
High Cholesterol	Psoriasis
Ulcer Disease (GI)	Multiple Sclerosis
HIV	Rheumatic Fever
Reflux Disease (GERD)	Gout
Asthma	Depression
Hepatitis	Lung Disease

Others, please list: _____

MEDICATIONS: (Please complete or provide us your medication list so that we may make a copy) None
 List located in EMR and reviewed with patient

Medications	Dosage	Frequency

FAMILY HISTORY: Please check all that apply: None

Diabetes	High Blood Pressure
Blood Clots	Rheumatoid Arthritis
Cancer	Heart Disease
Osteoporosis	Stroke/Seizures

Please describe any immediate family history medical problems:

SIGNATURE: _____ TODAY'S DATE: _____

Practitioner's Initials / Date: _____



REVIEW OF SYSTEMS

GENERAL OVERALL: Weight Change Chills Fever Weakness/Fatigue None
Other: _____

HEAD: Frequent Headaches Memory Loss None
Other: _____

EYES: Vision Change Glasses/Contacts Cataracts Glaucoma None
Other: _____

EARS/NOSE/THROAT: Hearing Loss Earache Ringing Hoarseness None
Other: _____

CARDIOVASCULAR: Chest Pain Leg Swelling Shortness of Breath None
Other: _____

RESPIRATORY/LUNGS: Shortness of breath Asthma/Wheezing Cough None
Other: _____

GASTROINTESTINAL: Heartburn Acid Reflux Nausea/Vomiting None
Other: _____

MUSCULOSKELETAL: Arthritis/Joint Pain Muscle Aches Joint Swelling None
Other: _____

SKIN: Rash Ulcers Abnormal Scars Sores Non-Healing Wounds None
Other: _____

NEUROLOGICAL: Headaches Fainting Dizziness Numbness/Tingling None
Other: _____

PSYCHIATRIC: Depression Anxiety Nervousness Mood Swings None
Other: _____

ENDOCRINE: Excessive Thirst Hot/Cold Intolerance Hot Flashes None
Other: _____

HEMATOLOGY: Easy Bruising Easy Bleeding Anemia None
Other: _____

DUE TO THE NATURE OF OUR SPECIALIZED PRACTICE, EXTENDED WAITING PERIODS MAY OCCUR.
WE APOLOGIZE IN ADVANCE FOR ANY INCONVENIENCE. WE ARE TRYING TO PROVIDE THE BEST MEDICAL
CARE FOR EACH INDIVIDUAL PATIENT.

SIGNATURE: _____ TODAY'S DATE: _____

PRINT NAME: _____

Practitioner's Initials / Date: _____