COLORADO PODIATRY CONSULTANTS, PC

Michael Zyzda, DPM
Olivia Stransky, DPM

2727 Bryant Street, Suite 400, Denver, CO 80211
2352 Meadows Blvd, Suite 300, Castle Rock, CO 80109
30940 Stagecoach Blvd., Suite E290, Evergreen, Co.80439
26659 Pleasant Park Rd, Conifer, CO 80433 1930 S Federal Blvd #A, Denver, CO 80219

Welcome to Colorado Podiatry Consultants!

We are Medical and Surgical specialists treating all conditions of the foot and ankle. Our practice has been in existence for over 25 years. The doctors of Colorado Podiatry Consultants have completed years of training along with advanced post residency training (Surgical and Orthopedic Board certification). They have full hospital privileges in many Denver area hospitals and surgery centers. We participate in most major insurance plans. We pride ourselves in our personal touch from attentive, devoted physicians to caring and helpful staff. Check out the medical staff information page on our website, www.cpcdenver.com, for each doctors individual training and background.

Services
Common conditions treated by our doctors include:

- Diabetic Foot and Nail Care
- Sports Medicine
- Heel pain and Plantar Fasciitis
- Ingrown and fungal childrens foot problems
- Bunions
- Hammertoes
- Fractures of the foot and ankle
- Orthotics/Bracing
- Flat Feet
- Arthritis
- Complicated wounds and infections (circulation, pressure, bone and diabetic wounds)
- Ingrown and Fungal nail problems
- Warts (Office CO2 laser)
- Burning feet (Anodyne treatments available in office)

Phone: 720-855-9214 Fax: 720-855-9291
www.cpcdenver.com

COLORADO PODIATRY CONSULTANTS, PC

MICHAEL ZYZDA, DPM OLIVIA STRANSKY, DPM

Personal Information

First Name_______________________________ Middle Initial______ Last Name_________________________

Preferred Name__________________ Birth Date__________ Social Security #______________________

_____ Male ______Female ____Minor _____ Single _____Married _____ Other

Home Phone: ______________________ Cell Phone: ______________________ Work Phone: ____________________

Email:_____________________________________ Preferred Method of Contact:______________

Address____ City,State,Zip______________________________________

Employer____ Occupation: ______________________________

***Primary Care Physician*:________________________ Telephone #___________________ Date Last Seen___/___/___**

Primary Insurance Company____

Claims/Insurance Company Address____

Member ID #_____________________________ Group #___________________Phone#: ______________________

Secondary Insurance Company____

Claims/Insurance Company Address____

Member ID #_____________________________ Group #___________________Phone#: ______________________

Name of Insured / Responsible Party if other than patient:

First Name____________________________ Middle Initial_____ Last Name______________________

Relationship to Patient_______________ Birth Date_____________ SocialSecurity#___________________

Address_________________________________ City_________________ State_________ Zip_________

Employer____

What brought you to our office? Doctor referral **– **please list the doctors name**:**_______________________________________

Internet___ Friend___ Other**:**____

Consent: I understand that responsibility for payment of medical services in this office for myself and my dependents is mine; due and payable at the time services are rendered unless financial arrangements have been made. I understand that I am responsible for all costs of collection including attorney fees, collection fees of 30% and court costs. I acknowledge that I am required to give a 24 hour cancellation notice or a $75.00 fee will be assessed. I understand that any unpaid balance will be assessed interest at the rate of 18.00%(1.5%monthly) *Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid*. I fully understand that I am responsible for payment of fees not covered by insurance. I also assign all benefits to Colorado Podiatry Consultants PC. I authorize the physician to release any information necessary in the processing of all insurance claims and/or the collection of my account. I give my authorization and consent for treatment after having a full explanation of proposed treatment, alternatives and risks by the doctor. I have been advised of my privacy rights as provided by the Healthcare Information Portability and Accountability Act of 1996. I hereby authorize the Provider/Covered Entity and its employees, agents and assignees to contact me via e-mail, text messaging and to my cellular devices.

Responsible Party's Signature_______________________________________ **Date**____________

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MICHAEL ZYZDA, DPM OLIVIA STRANSKY, DPM

Medical History

Name:____ Today's Date:________________

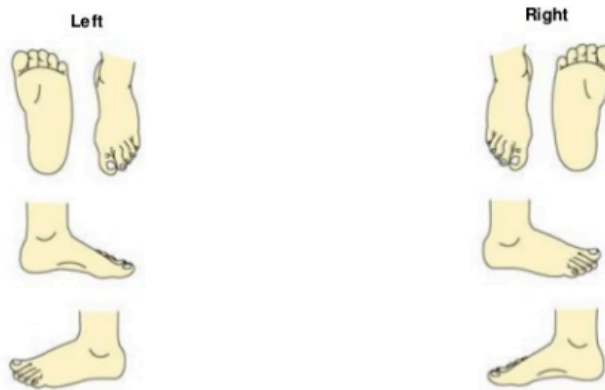
Date of Birth:_____________ Age:_________ Sex: **Female** **Male**

Describe the problems you are having with your foot (feet) and/or ankle(s).

____

____

On the diagram, please mark the place(s) where you are experiencing pain your feet.



How long has it been painful?_______________ When did it begin?____________________

If this was caused by an injury or accident, please indicate if this was work related or the result of a car accident. **Work Accident** **Auto Accident** **Date of Accident**______________

What treatment have you received from the other Dr.'s and/or how have you treated the condition at home?

____

____

REVIEW OF SYSTEMS Have you had or have any of the following medical problems?

Please check all that apply to you.

Diabetes
Heart attack or heart trouble
Leg or foot circulation problems
High blood pressure
Heart murmur
Mitral valve prolapse
Stroke
Excessive bleeding
Leg or lung blood clots
Shortness of breath
Transplant patient
(heart,lung,liver,kidney,etc)

Frequent infections
Allergies or hay fever
Stomach ulcers
Bleeding ulcers
Liver or kidney disease
Frequent urinary tract infections
Hepatitis
Arthritis
Numbness or weakness
Low pain tolerance
Chronic leg sores or foot sores
Foot or toe amputations
Constipation

HIV positive (AIDS)
Gout
Tendonitis
Chronic back pain
Artificial joint
Nerve pain
Skin diseases / rashes
Slow/difficult healing
Easily scar
High or low thyroid
Asthma
Pacemaker

*Patient's Name:*____ *DOB:*____________ *AGE:*_____

Please give details about the marked conditions. Please also list any medical problems that are not listed.

____

List all previous surgeries and/or serious illnesses or accidents.

____

____

Are you currently taking any medications? **Yes** **No** (Circle answer that applies.)

Please mark below any that apply to you:

Antibiotics or sulfa medications Blood thinners Water pills Aspirin Insulin
Tranquilizers/sedatives Cortisone/steroids Sleeping pills Estrogen/hormones
High blood pressure medication Nitroglycerin Oral diabetes medication
Heart medication Thyroid medication Birth control pills
Arthritis or gout medication

Please list the name and dosage of each medication you are currently taking. If you have a list already written, we will make a copy for our records.

____

____

What is the name and telephone number of your pharmacy?____________________________________
Are you <u>**ALLERGIC**</u> to or have you had a bad reaction to any medication? **Yes** **No** (Circle answer)
Please mark below any that apply:
Local anesthetics penicillin or other antibiotics sulfa medication sedatives or sleeping pills
aspirin iodine adhesive tape pain medications.
Please list all medication names that you are allergic to. Please include what type of allergic reaction you have (difficulty breathing, upset stomach, hives):

____

____

Are you currently under the care of a physician for any of the previous mentioned conditions? Please print their name and telephone number below.

____

Family History/Social History: Is there a family (blood relative) history of: (Please mark all that apply)
Heart disease arthritis bleeding disorder neurological disorder stroke bunions
hammertoes flat feet circulation problem of the feet or legs diabetes

Please list any other conditions that are not listed above:

____

Please describe your type of employment:

____

Average activity or amount of time on your feet during the day___________________________________

Do you drink alcohol or beer? Yes No Amount of use: Daily Occasionally Frequently
Do you smoke?Yes No # of packs per day____ Previously smoked? Yes No # of years___

Are you /could you be pregnant? Yes No Have you ever had a blood transfusion? Yes No

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Patient Responsibility: Our practice is committed to providing the best treatment for our patients. Patients are responsible for all charges resulting from treatment provided by their physician. As a service to you, we will bill most insurance carriers directly. However, primary responsibility for the account is yours. Providing correct insurance billing information is the responsibility of the patient. If your insurance changes, please present your insurance card at your next visit. All patients must complete our patient registration form before seeing the doctor.

_____________**(Initial)**

Payment Arrangements: New and Established Patients: The portion that insurance will not pay is due at the time of visit. Insurance companies do not guarantee payment. If there is a balance due after insurance pays, payment is due within 30 days of the first billing. Accounts with balances over 90 days will be assessed a processing fee each month.

HMO/PPO co-payments and deductibles, if required by your plan are due at the time of each visit.
We accept VISA, MASTERCARD, DISCOVER, CARE CREDIT, CHECKS, CASH AND MONEY ORDERS. _____________**(Initial)**

Referrals: Many insurance carriers require a referral from your Primary Care Physician before you receive care from a specialist; it is your responsibility to obtain a referral or prior authorization if your medical coverage requires it. A phone will be provided for your call, please get the name of the person who authorizes your visit.

_____________**(Initial)**

Insurance Billings: Please be aware that some or perhaps all of the services you receive may be non-covered services and not considered reasonable and necessary under your insurance plan. In this instance, you will be responsible for payment. We will submit the claim to your insurance carrier on your behalf with necessary information. If we are non-participating with your insurance, you must pay for services upfront and acknowledge you are being told we are non-participating with your insurance. We will still submit the claim for you if need be.

_____________**(Initial)**

Appointments & No show Policy: We make every effort to provide prompt medical care to all of our patients. If you are unable to keep a scheduled appointment, please let us know **in advance**. A **NO SHOW** is when a patient fails to keep a scheduled appointment. A NO SHOW will generate a **$75.00** fee and three no shows may require that you seek your medical care elsewhere. In the event that you have a special circumstance regarding your missed appointment, please contact our office. We understand that there may be issues beyond your control and want to be understanding of special circumstances.

If you are delayed and cannot make an appointment on time, please call to advise us of your situation and provide an estimated time of arrival. Any significant delay may require the visit to be rescheduled. _____________**(Initial)**

MEDICARE: Our physicians are participating providers. We bill Medicare as your primary insurer and we will forward onto your secondary. Please be sure to give us correct information concerning your primary and secondary insurance. Also be prepared to provide the name of your Primary Care Doctor and the last date seen, this information is required at EVERY appointment. _____________**(Initial)**

Completion of **FMLA certification** as well as any other paperwork requests requires a separate appointment (copays will apply) for the doctor to complete the paperwork with the patient. For expedited forms to be completed within 24-48 hours without an office visit a $50.00 prepaid charge will apply. _____________**(Initial)**

I have read and accept this Credit Policy.

____ ____________________

Signature of patient or guardian **Date**

Notice of Privacy Practices for Protected Health Information (PHI) Colorado Podiatry Consultants, PC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY! *Effective date: January 1, 2016*

The Practice of Colorado Podiatry Consultants, PC is required by applicable federal and state laws to maintain the privacy of your health information. Protected health information (PHI) is the information we create and maintain in the course of providing our services to you. Such information may include documentation of your symptoms, examination and test results, diagnoses and treatment protocols. It also may include billing documents for those services. We are permitted by federal privacy law (the Health Insurance Portability & Accountability Act of 1996 (HIPAA), to use and disclose your PHI, without your written authorization, for purposes of treatment, payment, and health care operations.

Examples of Using Your Health Information for Treatment Purposes:

- Our nurse obtains treatment information about you and records it in your medical record.
- During the course of your treatment, the physician determines he will need to consult with a specialist. He will share the information with the specialist and obtain his/her input.
- We may contact you by phone, at your home, if we need to speak to you about a medical condition or to remind you of medical appointments.

Example of Using Your Health Information for Payment Purposes:

- We submit requests for payment to your health insurance company. We will respond to health insurance company requests for information about the medical care we provided to you.

Example of Using Your Information for Health Care Operations:

- We may use or disclose your PHI in order to conduct certain business and operational activities, such as quality assessments, employee reviews, or student training. We may share information about you with our Business Associates, third parties who perform these functions on our behalf, as necessary to obtain their services.

Your Health Information Rights

The health and billing records we maintain are the physical property of the Practice. The information in them, however, belongs to you. You have a right to:

- Obtain a paper copy of our current Notice of Privacy Practices for PHI ("the Notice")
- Receive Notification of a breach of your unsecured PHI
- Request restrictions of certain uses and disclosures of your health information. We are not required to grant most requests, but we will comply with any request with which we agree. We will, however, agree to your request to refrain from sending your PHI to your health plan for payment or operations purposes if at the time an item or service is provided to you, you pay in full and out-of-pocket;
- Request that you be allowed to inspect a copy of the information about you that we maintain in the Practice's designated record set. You may exercise this right by delivering your request, in writing, to our Practice;
- Appeal a denial of access to your PHI, except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our Practice. We may deny your request if you ask us to amend information that (a) was not created by us (unless the person or entity that created the information is no longer available to make the amendment)., (b) is not part of the health information kept by the Practice, (c) is not part of the information that you would be permitted to inspect and copy, or (d) is accurate and complete. If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be placed in your record;
- Request that communication of your health information be made by alternative means or at alternative locations by delivering a written request to our Practice;
- If we engage in fundraising activities and contact you to raise funds for our Practice, you will have the right to opt-out of any future fundraising communications;
- Obtain a list of instances in which we have shared your health information with outside parties, as required by the HIPAA Rules.
- Revoke any of your prior authorizations to use or disclose information by delivering a written revocation to our Practice (except to the extent action has already been taken based on a prior authorization).

Our Responsibilities : The Practice is required to:

- Maintain the privacy of your health information as required by law;
- Notify you following a breach of your unsecured PHI;
- Provide you with a notice ("Notice") describing our duties and privacy practices with respect to the information we collect and maintain about you and abide by the terms of the Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,

Accommodate your reasonable requests regarding methods for communicating with you about your health information and comply with your written request to refrain from disclosing your PHI to your health plan if you pay for an item or service we provide you in full and out-of-pocket at the time of service.We reserve the right to amend, change, or eliminate provisions of our privacy practices and to enact new provisions regarding the PHI we maintain about you. If our information practices change, we will amend our Notice. You are entitled to receive a copy of the revised Notice upon request by phone or by visiting our website or Practice.

Other Uses and Disclosures of your PHI

Communication with Family

- Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment for care, if you do not object or in an emergency. We may also do this after your death, unless you tell us before you die that you do not wish us to communicate with certain individuals.

Notification

- Unless you object, we may use or disclose your PHI to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care about your location, your general condition, or your death.

Research

- We may disclose information to researchers if an institutional review board has reviewed the research proposal and established protocols to ensure the privacy of your PHI. We may also disclose your information if the researchers require only a limited portion of your information.

Disaster Relief

- We may use and disclose your PHI to assist in disaster relief efforts.

Organ Procurement Organizations

- Consistent with applicable law, we may disclose your PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation/transplant.

Food and Drug Administration (FDA)

- We may disclose to the FDA your PHI relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers' Compensation

- If you are seeking compensation from Workers Compensation, we may disclose your PHI to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

- We may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; or to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

As Required by Law

- We may disclose your PHI as required by law, or to appropriate public authorities as allowed by law to report abuse or neglect.

Employers

- We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances we will give you written notice of the release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of information to your employer.

Law Enforcement

- We may disclose your PHI to law enforcement officials (a) in response to a court order, court subpoena, warrant or similar judicial process; (b) to identify or locate a suspect, fugitive, material witness, or missing person; (c) if you are a victim of a crime and we are unable to obtain your agreement; (d) about criminal conduct on our premises; and (e) in other limited emergency circumstances where we need to report a crime.

Health Oversight

- Federal law allows us to release your PHI to appropriate health oversight agencies or for health oversight activities such as state and federal auditors.

Judicial/Administrative Proceedings

- We may disclose your PHI in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

For Specialized Governmental Functions or Serious Threat

- We may disclose your PHI for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, to public assistance program personnel, or to avert a serious threat to health or safety. We may disclose your PHI consistent with applicable law to prevent or diminish a serious, imminent threat to the health or safety of a person or the public.

Correctional Institutions

- If you are an inmate of a correctional institution, we may disclose to the institution or its agents the PHI necessary for your health and the health and safety of other individuals.

Coroners, Medical Examiners, and Funeral Directors

- We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about our patients to funeral directors as necessary for them to carry out their duties.

Website: You may access a copy of this Notice electronically on our website.

Other uses and disclosures of your PHI not described in this Notice will only be made with your authorization, unless otherwise permitted or required by law. Most uses and disclosure of psychotherapy notes, uses and disclosures of your PHI for marketing purposes, and disclosures of your PHI that constitute a sale of PHI will require your authorization. You may revoke any authorization at any time by submitting a written revocation request to the Practice (as previously provided in this Notice under "Your Health Information Rights").

To Request Information, Exercise a Patient Right, or File a Complaint

If you have questions, would like additional information, want to exercise a Patient Right described above, or believe your (or someone else's) privacy rights have been violated, you may contact the Practice's Privacy Officer at (720) 855-9214, or in writing to us at:

Anath Gardenswartz
Colorado Podiatry Consultants, PC
2727Bryant St., Suite 400
Denver, Colorado 80211

Please note that all complaints must be submitted in writing to the Privacy Officer at the above address. You may also file a complaint with the Secretary of Health and Human Services (HHS), Office for Civil Rights (OCR). Your complaint must be filed in writing, either on paper or electronically, by mail, fax, or e-mail. The address for the Colorado regional office is: Office for Civil Rights, U.S. Department of Health and Human Services, 999 18th Street, Suite 417, Denver, CO 80202; or call (800) 368-1019. More information regarding the steps to file a complaint can be found at: www.hhs.gov/ocr/privacy/hipaa/complaints.

- ☐ We cannot, and will not, require you to waive the right to file a complaint with the Secretary of HHS as a condition of receiving treatment from the Practice.

- ☐ We cannot, and will not, retaliate against you for filing a complaint with the Secretary of HHS.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with a copy of the Practice's Notice of Privacy Practices.

____
Print Name

____ __________________
Patient (or Patient Representative*) Signature Date

For Practice Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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*If Patient Representative is signing, legal documentation must be included designating authority to sign or receive information. This form must be maintained for 6 years