Kara L. Montes, D.P.M., P.C.

302 El Camino Real, Suite 10A · Sierra Vista, AZ 85635 · (520) 459-3339 · Fax (520) 459-3342

Patient Name:_____

Acknowledgement of Receipt of Notice

The Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care services will in no way be conditioned upon your signed acknowledgement. If you decline to provide a signed acknowledgement, we will continue to provide treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

COMPLETE NOTICE IS AVAILABLE AT YOUR REQUEST

I acknowledge receipt of the Notice:

_____ _____

Responsible Party Signature Date

****

CONTACT CONSENT

Home Phone Number:_____ Alternate Number:_____

May our office staff leave any messages on your home answering machine regarding appointments, billing questions or prescription information?

Yes_____ No_____

May our staff leave a message at your work place?

Yes____ No_____

Please list the names of any individuals that our office staff has permission, which is given by you, to speak with:

_____ _____ _____

Name Relationship Phone #

_____ _____ _____

Name Relationship Phone#

Responsible Party Signature:_____ Date:_____

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Financial Policy

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to us. Please ask if you have any questions about our fees, financial policy or your responsibility. All patients must complete our Patient Information form prior to seeing the physician. It is your responsibility to notify us of any change of address or insurance coverage.

Payments of cash, check, credit card or money order are accepted. If payment cannot be made at the time of service, prior arrangements will need to be made with the office.

Your Insurance

The office has made prior arrangements with some insurers and other health plans to accept assignment of benefits. We will bill those plans for whom we have an agreement with and will only require you to pay the authorized co-payment and deductibles at the time of service. There is a contractual obligation to collect the co-payment when you arrive for your appointment.

If you have insurance coverage with a plan that we do not have a prior agreement with, we will prepare and send the claim for you on an assigned basis. Please remember that your medical insurance is a contract between you and your insurance company. We file insurance claims as a courtesy to our patients. You are responsible for timely payment on your account. If your insurance company has not paid the full balance within 60 days, you will then have 15 days to pay the balance in full.

Self Pay (No Insurance)

All patients who are self-pay are expected to pay their balance in full at the time of service, unless other arrangements are made with the office. Patients who pay their balance in full at the time of their visit are eligible for a 20% discount for treatment, except for durable medical equipment or medications.

Cancellation/No Show Appointments

We ask that if you have to cancel or reschedule an appointment to please let the office know at least **24 hours in advance**. If notice is not given, you will be charged a $25.00 fee that is not covered by your insurance. Our office does **NOT** confirm appointments. You are responsible for remembering your appointments.

Returned Checks

Kara L. Montes, D.P.M., P.C. charges $25.00 for all returned checks.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

Responsible Party Signature: _____ Date: _____

Patient Name: _____ Relationship to Patient: _____

Kara L. Montes, D.P.M., P.C.

(Please Print)

PATIENT INFORMATION (including minors)				
PATIENT NAME Last First MI **NICKNAME** ( )	**BIRTH DATE** / /	**SEX** ☐ Male ☐ Female	**Marital Status**(CIRCLE) M D S W	
STREET ADDRESS **MAILING ADDRESS (PO BOX)**			**HOME PHONE** ( )	
CITY , STATE , ZIP	**SOCIAL SECURITY NUMBER**		**CELL PHONE** ( )	
EMPLOYER	**EMPLOYER ADDRESS**	**BEST METHOD OF CONTACT(circle)** HOME CELL EMPLOYER OTHER	**EMPLOYER PHONE** ( )	
PRIMARY LANGUAGE	**RACE (circle #)** (1) White (2) Black or African America (3) Asian (4) American Indian or Alaska Native (5) Native Hawaiian or Pacific Islander (6) Other	**ETHNICITY (circle #1 or #2)** (1)Hispanic or Latino (2)Non Hispanic or Latino	**EMAIL ADDRESS**	

RESPONSIBLE PARTY *(If different from above or patient is a minor)*			
RESPONSIBLE PARTY NAME Last First MI	**BIRTH DATE** / /	**RELATIONSHIP TO PATIENT** ☐Parent ☐Guardian ☐Other _____	**SEX** ☐Male ☐Female
STREET ADDRESS (if different from above)	**CITY, STATE, ZIP**		**HOME PHONE** ( )
SOCIAL SECURITY NUMBER	**EMPLOYER**	**EMPLOYER ADDRESS**	**WORK PHONE** ( )

PRIMARY INSURANCE			SECONDARY INSURANCE		
INSURANCE CARRIER NAME			**INSURANCE CARRIER NAME**		
ID #	**GROUP #**	**COPAY**	**ID #**	**GROUP #**	**COPAY**
INSURED'S NAME Last First MI			**INSURED'S NAME** Last First MI		
INSURED'S DATE OF BIRTH	**INSURED'S S.S. #**	**INSURED'S EMPLOYER**	**INSURED'S DATE OF BIRTH**	**INSURED'S S.S. #**	**INSURED'S EMPLOYER**
PATIENT-INSURED RELATIONSHIP ☐ Self ☐ Spouse ☐ Dependent ☐ Other _____			**PATIENT-INSURED RELATIONSHIP** ☐ Self ☐ Spouse ☐ Dependent ☐ Other _____		

IN CASE OF EMERGENCY			
NAME OF FRIEND OR RELATIVE (not living with you or with different phone #)	**RELATIONSHIP TO PATIENT**	**HOME PHONE**	**WORK PHONE**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for services not covered by my insurance company. I also authorize Kara L. Montes, D.P.M., P.C. to release any information required to process my claims for payment. I permit a copy of this authorization to be used in place of the original.

_____ _____

Patient/Guardian signature ***Date***

Kara L. Montes D.P.M.

Patient Personal/Medical History

Patient Name: _____ Date of birth: _____ Date: _____

Primary Care Physician:_____ Pharmacy:_____

How did you hear about us? Please let us know: [ ]Dr._____ [ ]Newspaper [ ]Dex Phone Book
[ ]Internet [ ]Friend/Relative [ ]While you Wait Ad [ ]The Local Pages book [ ]Scout [ ]Bingo Card
[ ]MyBaseGuide [ ]SVRHC Guide [ ]Home and Health Magazine [ ]Buena Banner [ ] SV Chamber
[ ]Other:_____

Shoe Size:_____ Height:_____ Weight:_____

Allergies: None Known [ ]
[ ]Penicillin [ ]Morphine [ ]Tape_____ [ ] Sulfa Drugs [ ]Antibiotics_____ _____ [ ]Any foods_____ [ ]Aspirin
[ ]Codeine [ ] Other drugs_____

Medical History: Please indicate if you currently **or** have ever had any of the following.

[ ] **None**	[ ] Diabetes Type 1	[ ] Hepatitis or [ ] Jaundice	[ ] Osteoarthritis
[ ] Acid reflux	[ ] Diabetes Type 2	[ ] High Blood Pressure	[ ] Peripheral Vascular Disease
[ ] Anemia	[ ] Diabetes Neuropathy	[ ] High Cholesterol	[ ] Respiratory Problems
[ ] Arthritis	[ ] Dialysis	[ ] HIV	[ ] Rheumatoid Arthritis
[ ] Asthma	[ ] Epilepsy	[ ] Kidney Disease	[ ] Sickle Cell Disease
[ ] Back Problems	[ ] Fibromyalgia	[ ] Kidney Stones	[ ] Skin Disease:_____
[ ] Bleeding Disorders	[ ] Gastric Ulcers	[ ] Leg or Foot Ulcer/Sore	[ ] Stroke
[ ] Bone/Muscle Problem_____	[ ] Gout	[ ] Liver Disease	[ ] Thyroid Disease
[ ] Cancer (type):_____	[ ] Head/Brain Injury	[ ] Low Blood Pressure	[ ] Tuberculosis
[ ] Circulatory Problems	[ ] Hearing impaired	[ ] Lupus	[ ] Varicose Disease
[ ] COPD	[ ] Hemophilia	[ ] Mental Health Problems	[ ] Venereal Disease
[ ] Currently Pregnant	[ ] Heart Disease	[ ] Multiple Sclerosis	[ ]

Past surgeries: [ ] None [ ] See attached
_____
_____
_____

Social History Occupation:_____
Tobacco Use: [ ] Never [ ] Past [ ]Current-How much?_____
Alcohol Use: [ ] No [ ] Yes If yes [ ] Occasional [ ] Daily
Illicit Drug Use: [ ] Never [ ] Past [ ] Current-What?_____

Family History:

[ ] No Medical Problems	[ ] Leg or foot ulcers	[ ] Stroke
[ ] Don't know	[ ] Cancer	[ ] Respiratory Problems
[ ] Arthritis	[ ] Heart Disease	[ ] High Blood Pressure
[ ] Gout	[ ] Liver Problems	[ ] Sickle Cell Disease
[ ] Kidney Problems	[ ] Circulatory Problems	[ ] Diabetes

Current medications: [ ] None [ ] See attached
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Patient Name: _____ Date of birth: _____ Date: _____

Review of systems: Please check items in each category that **PRESENTLY** apply to you.

General	Eyes	Musculoskeletal	Hematologic
[ ]Recent Weight change [ ]Fever [ ]Fatigue [ ]Night Sweats [ ]Other	[ ]Eye strain [ ]Eye pain [ ]Vision problem [ ]Other	[ ]Joint pain [ ]Muscle pain [ ]Stiffness [ ]Frequent sprains [ ]Other	[ ]Take aspirin [ ]Take Coumadin [ ]Other

Ears, Nose and Throat	Genitourinary	Cardiovascular	Neurological
[ ]Ear pain [ ]Hearing loss [ ]Nose discharge/obstruction [ ]Nose pain [ ]Breathing difficulty [ ]Sore throat [ ]Ear discharge [ ]Nose bleeding [ ]Sore gums [ ]Hoarseness [ ]Other	[ ]Frequency of urination [ ]Blood in urine [ ]Difficulty urinating [ ]Bladder trouble [ ]Painful urination [ ]Prostate problems [ ]Excessive urination [ ]Discolored urine [ ]Other	[ ]Chest pain [ ]Heart Attack [ ]Varicose veins [ ]Tiredness [ ]Heart problems [ ]Rapid heart beat [ ]Pain over heart [ ]Circulatory problems [ ]Weakness [ ]Other	[ ]Numbness [ ]Dizziness [ ]Muscle jerking [ ]Confusion [ ]Loss of feeling [ ]Fainting [ ]Convulsions [ ]Headaches [ ]Tingling in legs/feet [ ]Other

Gastrointestinal		Respiratory	Skin
[ ]Poor appetite	[ ]Belching	[ ]Shortness of breath	[ ]Itching
[ ]Difficulty swallowing	[ ]Abdominal pain	[ ]Persistent cough	[ ]Skin rash
[ ]Nausea	[ ]Black stool	[ ]Lung problems	[ ]Moles
[ ]Vomiting	[ ]Gas	[ ]Coughing phlem	[ ]Hives
[ ]Constipation	[ ]Indigestion	[ ]Wheezing	[ ]Abrasions
[ ]Diarrhea	[ ]Other	[ ]Difficulty breathing	[ ]Discolorations
[ ]Bloody stool		[ ]Coughing blood	[ ]Bruises
[ ]Hemorrhoids		[ ]Other	[ ]Sores
[ ]Stomach trouble			[ ]Poor wound healing
			[ ]Other

What is your main foot complaint?_____

Have you ever had a foot/ankle surgery? [ ] YES [ ]NO

If yes, what was the surgery?_____

Who was your foot doctor?_____

_____ _____

Responsible party signature **Date**

Relationship to patient: [ ] SELF [ ] POA [ ] PARENT [ ]other_____

Name:_____