2350 So. Carson Street, Suite 3
Carson City, NV 89701

775-783-8037
www.SierraFootAnkle.com

Sierra Foot & Ankle™

Welcome to Sierra Foot & Ankle,

Our motto: *It all starts with the feet.* Your podiatry team at Sierra Foot & Ankle believes that nothing is more important than helping you keep doing the things that you love to do.

Our Process for Scheduling New Patents:

1) Please complete the New Patient Registration Forms

2) New Patient Registration forms have protected patient information. For HIPPA Compliance, please return New Patient Registration forms to our office either:
    i) In Person Drop Off
    ii) Fax to Sierra Foot & Ankle (775) 782-3787
    iii) Mail

3) If you are Billing your Insurance, also provide the follow documents:
    i) Front Copy of Photo ID for Verification
    ii) Front and Back Copy of the Insurance Card
4) Once we receive the required documents above our office contact within 1 business day to complete your appointment date and time. If you do not hear from our office in a timely manner, please contact the office.

5) For simple office communication that does not involve protected patient information our office highly recommends text messages at (775) 783-8037.

Sincerely,

Dr Victoria Melhuish, DPM, FACFAS
and the entire staff at Sierra Foot & Ankle

Sierra Foot & Ankle

Patient Registration

Patient Information

Date _____ Birthdate _____

Last Name _____ First Name _____ Middle Initial _____

Address _____

Home Phone _____ Cell Phone _____ E-Mail _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ Business Phone _____ Extension _____

Occupation _____

Whom may we thank for referring you? _____ _____
First Name Last Name

In case of emergency who should we contact? _____ Phone _____

Patient's Doctors

Family/ Primary _____

Specialist _____

Other Podiatrist _____

Insurance Information

PRIMARY Insurance Company _____ Subscriber I.D. _____

SECONDARY Insurance Company _____ Subscriber I.D. _____

Assignment & Release:

Insurance Authorization & Assignment: I hereby authorize **Sierra Foot & Ankle** to furnish information to insurance carriers concerning my illness and treatments and to my referring physicians if so requested. I hereby assign to the physician all payments for medical services rendered to myself or to my dependents. I understand that I am responsible for any amount not covered by insurance. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____
(Parent or Guardian if Minor)

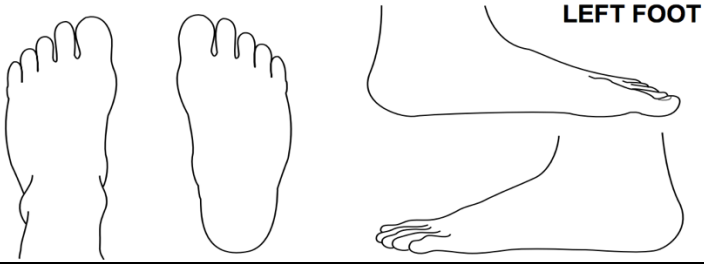
Tell me where it hurts

Please mark the location of your first problem or pain on the diagram below. Indicate the pain level with the appropriate face. Describe your problem below and its cause if you know it. Briefly describe your problem: _____

_____

Previous medical treatments/remedies? _____

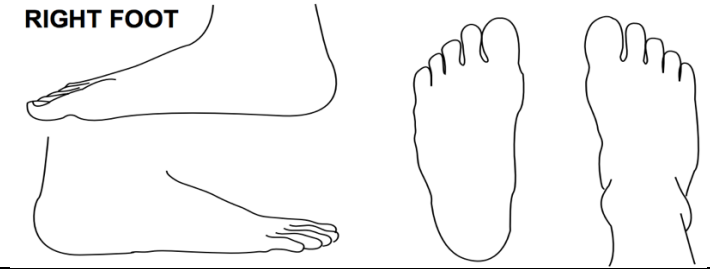
Is this problem work related? ☐ Y ☐ N Date of injury: _____ Date reported to employer: _____



Type of pain: ☐ Shooting ☐ Throbbing ☐ Aching ☐ Tenderness ☐ Sharp ☐ Burning ☐ Itching ☐ Dull ☐ Tingling ☐ Numbness

Happens: ☐ Walking≈ ☐ Not Walking

Started: _____ ☐ Days ☐ Weeks ☐ Months ☐ Years ago



Type of pain: ☐ Shooting ☐ Throbbing ☐ Aching ☐ Tenderness ☐ Sharp ☐ Burning ☐ Itching ☐ Dull ☐ Tingling ☐ Numbness

Happens: ☐ Walking≈ ☐ Not Walking

Started: _____ ☐ Days ☐ Weeks ☐ Months ☐ Years ago

Patient Name: _____

Date: _____

Issues in the past 6 months

CONSTITUTIONAL: ☐ **none**
☐ fever ☐ chills ☐ nausea ☐ vomiting
☐ weight gain ☐ weight loss ☐ fatigue

EYES: ☐ **none**
☐ eye disease ☐ impaired sight ☐ dry eyes ☐ double vision

HEAD/EARS/NOSE/THROAT: ☐ **none**
☐ headache ☐ sinus problems ☐ speech difficulty
☐ ear ringing ☐ swallowing difficulty ☐ hearing loss ☐ vertigo

CARDIOVASCULAR: ☐ **none**
☐ chest pain ☐ rapid heart rate ☐ heart murmur
☐ leg pain with walking ☐ leg pain @ night sleeping
☐ cold feet

RESPIRATORY: ☐ **none**
☐ shortness of breath ☐ rapid breathing
☐ chronic/persistent cough ☐ sleep apnea

GASTROINTESTINAL: ☐ **none**
☐ diarrhea ☐ constipation ☐ black stool
☐ stomach ulcers ☐ liver problems

GENITOURINARY: ☐ **none**
☐ painful urination ☐ difficulty urinating
☐ urinary incontinence ☐ blood in urine

MUSCULOSKELETAL: ☐ **none**
☐ muscle weakness ☐ chronic back pain
☐ sciatica ☐ joint pain ☐ joint swelling

INTEGUMENTARY: ☐ **none**
☐ acute skin rash ☐ itching ☐ skin cancers
☐ history of skin ulcers ☐ nail irregularities

NEUROLOGICAL: ☐ **none**
☐ numbness ☐ paralysis ☐ memory loss ☐ confusion

PSYCHIATRIC: ☐ **none**
☐ claustrophobia ☐ anxiety ☐ insomnia
☐ agitation ☐ hallucination

ENDOCRINE: ☐ **none**
☐ heat intolerance ☐ cold intolerance ☐ frequent urination
☐ always thirsty

HEMATOLOGIC: ☐ **none**
☐ bruise easily ☐ use of anticoagulant

ALLERGIC/IMMUNOLOGIC: ☐ **none**
☐ food allergy ☐ organ transplant

Foot History

Shoe Size	Weight:	Height:

☐ Corns/Calluses ☐ Warts ☐ Athlete's Foot
☐ Leg/Foot Ulcers ☐ Fungal Nails ☐ Ingrown toenails
☐ Broken Foot Bones ☐ Neuroma ☐ Foot Numbness
☐ Hammer/Mallet toes ☐ Broken Ankle ☐ Ankle Sprain
☐ Cramps in legs/toes ☐ Bunions ☐ Flat Feet
☐ Lower Back Pain ☐ Arch Pain ☐ High Arch Feet
☐ Gait (walking) problems ☐ Knee Pain ☐ Heel Pain
☐ Childhood foot problems ☐ In-Toeing ☐ Toe Walking
☐ Rash ☐ **None of These**

Do you previously/Do you now wear:
☐ Shoe Inserts: ☐ Still Use them ☐ They Still Help
☐ Orthotics: ☐ Still Use them ☐ They Still Help
The orthotics were obtained from: ☐ Another podiatrist
☐ An Orthopedist ☐ Physical Therapist
☐ Chiropractor ☐ Other
Are your first steps out of bed painful ☐ Yes ☐ No
then subside? ☐ Yes ☐ No
Does foot pain limit your desired activities? ☐ Yes ☐ No

Medical History

☐ **No past or active medical conditions reported**.
☐ Anemia ☐ Anxiety ☐ Arthritis
☐ Asthma ☐ Bleeding Disorder ☐ Cancer
☐ COPD: ☐ Emphysema ☐ Chronic Bronchitis
☐ Stroke: Affected: _____
☐ Dementia ☐ Depression ☐ Osteoporosis/Osteopenia
☐ Diabetes with ☐ kidney probs ☐ neuropathy ☐ eye probs
☐ Fibromyalgia ☐ Gout ☐ Heart Disease
☐ Hyperlipidemia ☐ Hyperthyroid ☐ Hypothyroid
☐ Liver problems ☐ Neuropathy ☐ Hep C ☐ Obesity
☐ Parkinson's ☐ Renal probs ☐ Vascular Disease
☐ High blood pressure ☐ Macular degeneration

Social History

Tobacco use ☐ none ☐ occasional ☐ daily ☐ Quit
_____packs per day for _____ years
Alcohol use ☐ none ☐ occasional ☐ daily
Caffeine use ☐ none ☐ occasional ☐ daily
Recreational Drugs ☐ none ☐ occasional ☐ daily
Living arrangement ☐ alone ☐ w/spouse ☐ w/children
☐ w/pets ☐ w/significant other ☐ w/roommate
☐ at assisted living facility
Current Occupation _____
Amount of Time per day on feet at work
Recreational Activities ☐ running ☐ walking ☐ hiking ☐ golf
☐ lifting weights ☐ cycling ☐ dance ☐ swimming
☐ Other _____
Activity Level ☐ low ☐ moderate ☐ strenuous

Surgical History

Surgery	Year

Medications

Or attach a list of ALL your medications

Medication	Dosage	Frequency

Family History

List the relationship to you, of family who have had…

Diabetes _____ Foot Problems _____
Arthritis _____ Heart Attack _____
Stroke _____ High Blood Pressure _____
Cancer _____ Birth Defects _____

Allergies / Drug Reactions

☐ **No Known Drug Allergies**
☐ Sulfa ☐ Iodine ☐ Aspirin
☐ Other Antibiotics ☐ Morphine ☐ Codeine ☐ Latex
☐ NSAIDs (Advil/Aleve/Motrin) ☐ Penicillin
☐ Local Anesthetic (Lidocaine/Novocaine) ☐ Adhesives
☐ Other: _____

Sierra Foot & Ankle

To Our Valued Patients,

As you might be aware, Nevada law (AB 474) is now in full effect. This law governs controlled substance including prescribing use, addiction, abuse and treatment of addiction. As a medical provider we have been directed, by the State of Nevada and more specifically, the Governor to adopt and follow certain guidelines. These guidelines include procedures and protocols when it comes to prescribing medications that are considered to be controlled substances. An example of this would be opioids; these are drugs whose base pain-relieving formula is derived from opium. Common examples include medications such as Tylenol #3, Norco, Percocet and Dilaudid. While these medications can be very effective in both postoperative and perioperative pain control, they can have addictive and abusive potential.

The State of Nevada has asked and challenged its medical providers to help in the prevention of the rapidly growing epidemic of opioid addiction, overdose and abuse. Here at Sierra Foot & Ankle, we have embraced the states call to action and have adopted methods to both remain in compliance with the state law as well as assist in decreasing opioid abuse and addiction.

In the Packet attached you will find an opioid risk assessment survey and an opioid prescription consent form.

These forms must be filled out by all of our patients. **BY LAW WE CANNOT SEE YOU IF THESE ARE NOT FILLED OUT.**

We appreciate your understanding and cooperation with the Nevada State law. We do believe with this state law along with your help we can make a positive impact towards containing and preventing the epidemic of opioid addiction and abuse in our state.

Warm Regards,

Sierra Foot & Ankle
Dr. Victoria Melhuish

Sierra Foot & Ankle

This risk assessment tool is required by the state of Nevada for all patients that are seen in our office. We are required by law, to administer this assessment questionnaire to every patient upon initial visit and again prior to beginning opioid therapy for pain management.

The objective of this assessment tool is to determine a patient's risk for opioid addiction and/ or abuse and to use that in the consideration when prescribing narcotics. **This assessment screening tool is required by law and we cannot see you unless it is filled out.**

Summary of opioid assessment tool:

A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

Mark each box that applies to you below:

	Female	**Male**
Family History of substance Abuse		
Alcohol	1	3
Prescription Drugs	2	3
Illegal Drugs	4	4
Personal History of Substance Abuse		
Alcohol	3	3
Prescription Drugs	4	4
Illegal Drugs	5	5
Patient Age		
Age less than16	0	0
Age 16-45	1	1
Age>45	0	0
Psychological and Social History		
History of sexual abuse < 12 yo	3	0
ADO, OCD, Bipolar, Schizophrenia	2	2
Depression	1	1
Total Score:		

Patients Name:_____ Date:_____

Patients Signature: _____

2350 S. Carson Street #3
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Office: 775-783-8037
Fax: 775-782-3787

Narcotic Prescribing Policy

Agreement for prescription request and use of controlled substances:

Part of your treatment program may involve the prescription of analgesic medications (pain medications). These medications have both beneficial effects as well as possible side effects. Analgesic medications often produce substantial relief of even the most severe pain and can improve a patient's quality of life (QOL). Side effects are usually mild and manageable but may include sedation, fatigue, euphoria, stimulation, confusion, and/or somnolence. Other side effects involve the stomach and intestines and include nausea or vomiting, constipation, dry mouth and changes in appetite.

Although the majority of patients control their medications well and follow their provider's orders strictly, there are some patients that are prone to medication dependency or addiction. Because of this, the state and federal regulatory bodies have placed strict guidelines for controlled substances. This means that the use of these medications involves special responsibilities on the part of the **patient** and the **health care provider**. This is especially true when opioid medications (narcotic medications such as codeine, hydrocodone, and oxycodone among others) are prescribed.

It is important that you read and understand the following policies and procedures as well as the rights and responsibilities of both the patient and providers.

1. Adhere to your providers orders on how to take your pain medication. Never take more than the prescribed dose without first consulting your provider. Do not abruptly stop your pain medications since withdrawa1 symptoms may occur and some of these symptoms are dangerous.
2. Do not take your narcotic medications in any altered form or other than prescribed or intended. It can be life threatening to chew or crush long acting medications such as Avinza, Oxycontin, MS Contin, and Kadian.
3. When asking another provider to refill medications, you are required to inform them of the medications that you are receiving from this office.
4. If your provider agrees to prescribe medications for you, then no other provider should prescribe any medication with pain relieving or sedative properties without the provider's knowledge and permission.
5. No emergency room visits expressly for the purpose of receiving opioid medications (including Demerol), especially by injection, will be permitted.
6. It is imperative that all requests for pain medication be submitted at least 7 days before you might run out of your medication. Certain narcotics require a hand-written prescription and these will only be written when providers are not with patients. Covering or on call providers will not refill prescriptions.
7. Every time a prescription is written, we document the medication, quantity, and expected refill date.
8. Many insurance policies restrict the type and quantity of medication prescribed. It is your responsibility to work with your insurance company for any variance beyond their policy coverage.
9. It is important to understand the side effects of all pain relieving medications such as drowsiness, poor coordination, and impaired reflexes, Therefore, it is your responsibility to exercise caution when attempting to operate a motor vehicle.

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10. You must keep follow up appointments as outlined and recommended. Our practice is busy caring for patients and our schedule always fills up. It is essential to plan in advance on order to make sure that all patients are seen in a timely manner and have full opportunity to address their individual needs.
11. If you run out of medication, either because of poor planning or because of taking the medication on excess of what was prescribed, you are responsible for the consequences, including poor pain control or any withdrawal symptoms.
12. It is a felony in the state of Nevada to obtain controlled substances from multiple providers (NRS4S3.391t). We will periodically run pharmacy checks and will discontinue writing prescriptions for pain medications if you are found in violation of the law.
13. Lost, stolen or misplaced prescriptions or medications will not be replaced. Selling medication or sharing medication with family, friends or any other person is i1legal and will not be tolerated.
14. If we have recommended a procedure that would eliminate your pain and you choose not to proceed, your pain and the consequences associated with it are your responsibilities. We will not continue to write prescriptions for narcotics when there is a procedure that would eliminate your pain.
15. If you are or may become pregnant, you must inform your provider immediately. Narcotic medications can seriously and adversely affect unborn or breast- feeding children.
16. It has been explained to me that there are other treatments that do not involve use of narcotic/opioid medications. Having been informed of these risks and potential benefits both of such medications and possible alternative treatment, I have freely consented to taking the narcotic/opioid medication.

Patient Signature: _____

We expect you to take the above patient responsibilities seriously. We will attempt to care for you in the best possib1e manner and take that responsibility seriously as well. Failure to comply with our policies may result in immediate dismissal from our practice or termination of all or part of your medical regimen, regardless of any withdrawal effects or other consequences.

Bring all medications prescribes by this clinic in the original bottles to your appointments. If new medication is to be prescribed, the remaining tablets will need to be given to the healthcare provider.

I have read and understand all of the above policies and all of my questions have been answered. I agree to comply with all of the conditions for prescriptions of pain medications set forth by my provider(s). I understand that failure to comply may result in the termination of the prescribing of my pain medication and/or my immediate dismissal from my provider's care.

Patients Name: _____

Patients Signature: _____

Date of Birth: _____

Date: _____

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NOTIFICATION OF FINANCIAL POLICIES AND PROCEDURES

_____**1. It is your responsibility to understand the following policies and procedures. Reading this document annually will keep you informed about our office practices.**

_____2. **Patient treatment:** It is our primary goal to restore and maintain the health of your feet, ankles and wellness. We strive to provide with the highest quality podiatric care. If you have any questions regarding your treatment, please feel free to consult with your physician who is providing your care. We highly value your confidence in our practice and we will make a sincere effort to satisfy all your podiatric needs. Your initials and signature of 1 through 20 will act as an authorization and consent for treatment.

_____3. **Appointments**: Physicians are available by appointment during posted hours. During a medical emergency, patients should seek care at the nearest emergency room or call 911. **Missed Appointments**: We make appointment confirmation calls through an automated system as a courtesy; it is your responsibility to keep track of your appointments. A missed appointment or a late cancellation (without 24 hours advanced notice) will result in a fifty dollar ($50.00) service fee. A missed office procedure will result in a seventy-five dollar ($75.00) service fee. These fees are not covered by your insurance.

_____4. **Refills and Medication**: Refills are completed via a pharmacy request. Contact your pharmacist for refill requests. For medication coverage contact your insurance plan regarding your drug coverage.

_____5. **Messages**: Phone messages received before 3pm are usually returned that day. Messages received after 3pm will be returned the next business day.

_____6. **Benefits**: SFA will reiterate the benefits that were disclosed to us by your insurance plan. We will then collect based on the benefit level all applicable copays, deductibles, coinsurances and balances that apply at the time of service or at the pre-operative appointment.

_____7. **Payment**: Payment for your visit is due ***in full*** at the time of service. SFA accepts VISA, MasterCard, Discover, AMX, Cash or Checks, and Care Credit. All checks are immediately scanned for processing. Our office does not accept temporary checks and we will contact the bank directly to verify checks over $500. SFA does not offer payment plans. For those patients needing financial assistance, we offer Care Credit. Depending on your Care Credit Plan, additional fees may apply.

_____8. **Insurance Claims**: SFA files claims electronically for the patient's primary contracted plan and accepts payment via the patient's assignment. SFA only files secondary claims for Medicare patients; non-Medicare patients may request itemized statements to file to multiple carriers. To ensure correct claims submission, we require a current copy of your insurance card at each visit or we consider your visit to be self-pay. We bill your primary insurance *only*. You are responsible for submitting claims to any secondary insurance for reimbursement. ***Any inaccurate information provided by the patient that causes your insurance billing to be rejected will incur a twenty-five dollar ($25.00) service fee if the patient requests a resubmission to the primary insurance carrier. This fee is not covered by your insurance.***

_____9. **Multiple Policies**: When multiple policies exist, it is the policy holder's responsibility to inform SFA of their primary plan. Delayed filing to the primary plan can result in violating timely filing limits, resulting in a denial of service and full patient financial responsibility.

_____10. **Non-Covered Services:** SFA will not submit claims for non-covered items including, but not limited to cosmetic services and in-office-dispensing convenience items (OTC eg. Biofreeze, Coban, Sole, Mycomist, etc…). Often, these items and services can be purchased with your medical savings account.

_____11. **Referrals**: SFA may refer patients to other providers, facilities, and labs. SFA is not responsible for these entities. The patient should contact these non-SFA providers, facilities or labs directly regarding any billing questions. For those patients referred to SFA by other providers, it is the policy holder's responsibility to obtain insurance authorizations and/or managed care referrals that are necessary for payment to SFA.

_____12. **Appointment Hold**: Repetitive broken appointments, non-compliance, hostile behavior, and/or financially deficient accounts will result in appointment hold and/or the termination of the SFA Doctor-Patient relationship. 30 days' advance notice will be given should the situation result in a transfer of the patient's care.

_____13. **Patient Balance Statements**: We file your insurance claim as a courtesy to you. You are responsible for co-pays, deductibles and any charges not covered by your insurance. SFA will send a monthly balance statement to the patient for any monies due. Upon receiving your patient statement, the ***patient responsibility balance*** is due in full at that time. Re-billing for non-payment of the ***patient responsibility***

balance will be assessed a ten dollar ($10.00) billing fee for the ***patient responsibility balance*** carried each month. Should your insurance company payment take longer than sixty (60) days, you are responsible for total charges.

_____14. **Delinquent Accounts**: Past due accounts are subject to collection proceedings and are reported to the credit bureau. All collection fees, attorney fees and court fees shall become the patient/guarantor's responsibility in addition to the balance due the office.

_____15. **Returned Checks**: A forty dollar ($40.00) fee will be assessed on all returned checks. Any NSF or Closed Account will result in future services on a pre-pay cash or credit basis. The District Attorney's Office will prosecute unresolved checks.

_____16. **Refunds**: SFA issues patient refunds by check within 30 days of a completed investigation of the potential overpayment, as long as other outstanding accounts have been resolved.

_____17. **Returns**: Only unworn and non-custom items are returnable within 14 days of receipt, if no visible signs of wear, tear, or odor. Custom items are tailored to meet individual needs; custom items are non-returnable, non-refundable. Appropriate returns are will be issued immediately if paid by credit card only if that credit card is in possession at time of return. Otherwise, a check will be mailed within 7 business days.

_____18. **Medical Records**: The cost for copied medical records and completion of disability forms will be charged to the patient. We require a twenty dollar ($20.00) retainer prior to replicating; the balance for this service will be due prior to release of records. The fees for these services are regulated by HIPAA and Nevada Health and Safety Code.

_____19. **Release of Records:** If you request your records released to another physician or facility you must sign a Release of Information form indicating who we are releasing records to, as well as, which relevant information you would like us to release. If you request to receive a copy of your records for your personal files, we must receive a written request. Allow 7-10 business days to have your records to be available. SFA charges twenty dollars ($20.00) for the first 20 pages and $0.20 for each additional page. There is a thirty-five dollar ($35.00) per hour handling fee in order to copy your protected health information, and a postage fee if you want the copies mailed. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Fees also apply for all FMLA and other disability forms that we are requested to complete. Contact us using the information listed at the end of this notice for full explanation of our fee structure. HIPAA states that the covered entity must act on a request for access no later than 30 days after receipt of the request. Digital records and/or x-rays are available for a fee. Hard-copy X-rays taken within our office are our personal property which we are legally responsible to maintain with your records. Therefore we DO NOT release these original films, but can make replicates for a fee. Copies of digital X-rays are available upon request for a fee of thirty dollar ($30.00) per CD.

The undersigned certifies that he/she has read and understands the foregoing 1-20 statements, and is either the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accepts its terms.

_____ _____ _____ _____

Print Name of Patient or Legal Authorized Representative | Signature | Relationship to Patient | Date

Name of Contact Persons: Office Manager

Telephone: 775-783-8037

Fax: 775-782-3787

Physical Address: 2350 S. Carson Street, Suite #3, Carson City, NV 89701

Website: www.SierraFootAnkle.com

Patient Communications Authorization

HIPAA rules prohibit healthcare providers from communicating with patients via regular email or text. However, HIPAA provides avenues for these communications to happen, as long as the patient is aware of it and authorizes such communications.

At SFA, we offer helpful administrative information by regular text messaging and email like appointment reminders. We can also provide treatment information, but there is a low risk that information in a regular text message or email could be read by someone besides you. Being aware of this risk, please indicate below if you would like us to communicate with you by text message or email.

Patient Name:_____ Date:_____

E-Mail Communications

☐ **Yes** – Please communicate with me by regular email. My email address is:

I will let you know right away if my e-mail address changes.

☐ **No** – Please do not communicate with me by regular email.

Text Messaging Communications (SMS)

☐ **Yes** – Please communicate with me by regular texting or SMS. My mobile number is:

I will let you know right away if my mobile number changes.

☐ **No** – Please do not communicate with me by regular text messaging (SMS).

_____

Patient Name (Please Print)

_____ _____

Signature Date

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