totally feet pc
podiatry and laser center

Patient Information

Patient Information

Name_____ Date of Birth_____
Address_____City_____Zip_____
Home Phone_____ Cell _____
SS#_____ Sex ❒M ❒F Who referred you?_____
Email _____

Emergency Contact Information

Name_____Phone_____
Address_____City_____State___Zip_____

Primary Care Doctor

Name_____ Phone_____
Address_____City_____State_____Zip_____
Date of last visit_____Fax_____

Insurance Information

Primary Insurance Company_____
Name of Insured_____ Policy #_____
Insured Employer_____
Relationship to Insured: ❒Self ❒Spouse ❒Child ❒Other_____

Secondary Insurance Company_____
Name of Insured_____ Policy #_____
Insured Employer_____
Relationship to Insured: ❒Self ❒Spouse ❒Child ❒Other_____

Current Foot Problem

Explain your foot problem:_____
When did it start? _____
Anything make it better or worse? _____
Has it changed over time? ❒Better ❒No Change ❒Worse Time?_____
Type of pain? (all that apply) ❒Burning ❒ Tingling ❒ Sharp ❒ Shooting ❒ Dull ❒ Achy
Shoe Size_____ Weight_____ Height_____

Medical History

Smoke? ❒Yes how much? _____ ❒ No Drink? ❒Yes how much? _____ ❒ No
Allergies_____
Medications_____
What do you take Medication for? _____
_____
Other health problems? _____
Surgery on hips, knees, ankle, or feet? _____

8753 Yates Drive, Suite 110, Westminster, CO 80031, Phone: 7209.980.3668
Website: totallyfeet.net Email: drterry@totallyfeet.net

Payment Agreement

Due to the administrative costs of billing and in the interest of keeping our fees as low as possible, it is necessary for our patients to make payment for all services at the time services are rendered. If the billing service has to send a bill for any reason, a $5.00 billing charge will be added to your account. If you are insured with one of the insurance carriers we are contracted with, and the services rendered are covered, we will first bill your insurance(s) and then you for any uncovered amount, in this instance a billing charge will not be added. In the instance a service (i.e. routine care) is not covered and the patient is made aware yet the patient insist his or her insurance be billed a $5.00 billing charge will be added.

The patient or guardian of the patient is fully responsible for the charges incurred at Totally Feet Inc. or any of the other locations we service. If we are contracted with your insurance, we will file with your insurance for you. It is your responsibility to provide us with a proper identification card and information about your podiatric coverage (ie. Specialist co-pay, x-ray co-pay, deductibles). It is in your best interest to verify and be aware of your podiatric benefits. Please keep us informed of any changes in your insurance coverage. Co-pays are due at the time of service. If your claim is denied, you are responsible for all amounts not covered by your insurance.

If a balance with our clinic persists greater than 60 days 10% will be added to the bill monthly. We accept cash, check, MasterCard, and Visa as forms of payment. There is a $35.00 fee for any returned checks.

I authorize the release of any medical information necessary to process insurance claims.
Thank you for taking the time to read Totally Feet Inc. financial policies. Please sign and date below verifying you have read our payment agreement and agree to cooperate with our policies.

Permission to treat and Information Verification

I hereby give permission for Terry Oehler D.P.M. to administer treatment as may be deemed necessary in the diagnosis of my foot and/or ankle condition, after such treatment has been reviewed with the patient and or guardian of the patient. I have read the entire form front and back and given information that is accurate to the best of my knowledge. I understand that this information may be utilized in my evaluation and treatment making accuracy critical.

Patient signature_____Date_____

Guardian signature for minor_____Date_____