Lorry A. Melnick, D.P.M. **Richard Charles, D.P.M.**
Diplomates, American Board of Podiatric Surgery

Thank you for choosing Cherry Creek Foot Clinic!

We would like to congratulate you on becoming a member of our family! We are very excited to give you the quality care you deserve. *Our goal at Cherry Creek Foot Clinic is to get you back on your feet, pain free, as soon as possible.*

At Cherry Creek Foot Clinic we pride ourselves on the quality of our services. We understand that choosing a health care provider can be stressful decision. By choosing Cherry Creek Foot Clinic you have taken the first step to healthy feet.

Lorry Melnick, D.P.M. has been in the Podiatry practice for over 30 years and treats patients from pediatrics to geriatrics. We are also very happy to announce that Richard Charles, D.P. M. has joined our practice. Dr. Charles has over 28 years of experience in Podiatry and sees a wide range of patients as well. So, please invite all your friends and family members to come and join us, too.

In order for us to treat you quickly and get you back on healthy feet we will need your assistance. Enclosed are some forms we request for you to fill out prior to your appointment. If you have any questions regarding the forms please feel free to contact our office at **303-355-1695** and anyone here will be more than happy to assist you.

Once again, thank you for choosing Cherry Creek Foot Clinic. We look forward to seeing you soon!

Sincerely,

Lorry Melnick, D.P.M.
Richard Charles, D.P.M.

201 University Boulevard • Suite 204 • Denver, Colorado 80206 • (303) 355-1695

Lorry A. Melnick, D.P.M.
Diplomate, American Board of Podiatric Surgery

Patient Name:______________________ Birth Date:__________ M______ F______

Best number to call during business hours: ______________________ cell home work

Are you in Pain? 1 2 3 4 5 6 7 8 9 10

What is the reason for this visit?______________________

Is the injury related to Work or Auto? __________ injury date or onset of symptoms__________

Whom may we thank for referring you to our office?______________________

Mailing Address:______________________ Apt #:__________

City:______________ State:__________ Zip code:__________

Home Phone:______________ Cell Phone:______________

Work Phone:______________ Marital Status:______________

Social Security #:______________ Spouse/Partner/Parent:______________

Primary Care Dr. ______________ Date of last visit:______________

Whom may we contact in case of emergency?:______________ Phone:__________

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INSURANCE INFORMATION

Insurance Company______________________ Insured Date of Birth__________
Insured Person______________________ Your Relationship__________
Insurance ID# ______________________ Group #__________

SECONDARY INSURANCE?

Insurance Company______________________ Insured Date of Birth__________
Insured Person______________________ Your Relationship__________
Insurance ID# ______________________ Group #__________

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ASSIGNMENT AND RELEASE

- I am aware that my account and referrals are ultimately my responsibility. Your office cannot guarantee payment, coverage or benefits from my insurance company.
- I authorize my insurance benefits to be paid directly to *Lorry A. Melnick, DPM.*
- I authorize the facility to release medical information for treatment, payment or daily operations.
- I voluntarily consent to examination and treatment for myself and/or dependent.
- Unpaid personal balances over 30 days are charged a minimum $5 fee or 1.5% interest per month.
- Patients who do not show or do not cancel within 24 hours an appointment will be charged $25.00.
- I hereby accept responsibility for treatment costs incurred that are not covered by my insurance.
- I have read all the above information. I understand my obligations as outlined by this release.

Signature:______________________ Date:______________

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MEDICAL HISTORY AND INITIAL EXAM

Name:____________________________Date__________Age_____________
D.O.B_____________Height________Weight_______Sex: M F Shoe Size:_____
Occupation:__________________________
Chief Complaint:

____
____
____
____
____

When did the problem begin?____
How many hours do you spend on your feet?____________________________________
What kind of activities do participate in? _____________________________________
Are you able to find comfortable shoes?____
What type of shoes do you normally wear? Athletic Slip Ons Ties Dress High Heels
Do you ever experience pain or stiffness in your feet upon arising? Y N
Do you ever have numbness, burning or shooting pains in your feet? Y N
Do you ever experience leg cramps? Y N

Medical History:

Diabetes	Y N	Arthritis	Y N
Heart Condition	Y N	Asthma	Y N
Hypertension	Y N	Hepatitis	Y N
Ulcers	Y N	Liver Disease	Y N
Gout	Y N	Kidney	Y N

Medication:_____________ Surgical History:_____________________________
________________________ ____
________________________ ____

Drug Allergy: Penicillin Sulfa Anti-biotics Local Anesthetics
Other:____

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Notice of Privacy Practices and HIPAA Contact Sheet

I acknowledge that I was provided a copy of or access to the Notice of Privacy Practices. I have read or had the opportunity to read and understand the HIPAA Notice of Privacy Practices.

Your signature:_______________________________________Date:________________

Your provider and/or staff will at times need to contact you. By filling out the information below we will be better able to serve you.

PATIENT NAME (please print) ________________________________

PERSON COMPLETING THIS FORM ________________________________

RESPONSIBLE PARTY ________________________________

Cherry Creek Foot Clinic
WRITTEN, PHONE & PHONE MESSAGE CONSENT

In an effort to protect you privacy, we have developed a policy on leaving medical care information:

- We will ***NOT*** leave messages with anyone except the patient, legal guardian or responsible party.
- We will ***NOT*** leave any confidential information on an answering machine.
- We will ***NOT*** leave any messages on a voice mail.
- We will ***NOT*** release medical treatment information or medical records without written consent.

UNLESS WE HAVE YOUR WRITTEN PERMISSION TO DO SO.

Please read below and consider carefully whom you authorize to have access to protected information regarding your care.

I, ______________________________ give *Cherry Creek Foot Clinic* my permission to speak with and/or leave phone messages regarding medical care and/or billing information with the following. I fully understand that this consent will remain valid until revoked in writing. Written documents include release of medical records and mailing of billing statements.

My Home/Cell answering machine: ( ) Yes ( ) No Your Initials:________

My Office/Work voice mail: ( ) Yes ( ) No Your Initials:________

Fax billing statements ( ) Yes ( ) No Your Initials:________

Person(s) we are allowed to communicate with and share medical and billing information to:

________________________ relationship______________ Your Initials:________

________________________ relationship______________ Your Initials:________