FOOT & ANKLE SPECIALISTS OF NORTHEAST GEORGIA

Dr. Zachary G. Farley, DPM, FACFAS
1515 River Place Suite 390 Braselton, GA 30517
Phone: (678) 619-1270 Fax: (678) 619-1272

1. PERSONAL:

First Name _____ Middle _____ Last _____

DOB: _____/_____/_____ SS#: _____/_____/_____ SEX: Female ☐ Male ☐

Marital Status: Married Single Divorced Widow(er)

2. CONTACT INFORMATION:

Cell #: _____-_____-_____ Home #: _____-_____-_____ Work #: _____-____-_____

No Cell ☐ Email Address: _____ No Email ☐

Address: _____ City: _____ State: ____ Zip: _____

☐ Foot and Ankle Specialists of Northeast Georgia, LLC. has documented that this patient has provided prior, express consent to receive automated texts and voice messages at the number(s) provided above.

3. PAYMENT INFORMATION: (Circle those that apply) Primary Secondary Self-Pay

Primary Ins: _____ ID#: _____ Grp #: _____

Secondary Ins: _____ ID# _____ Grp #: _____

4. GUARANTOR: Relationship to Patient: _____

First Name _____ Middle _____ Last _____

DOB: _____/_____/_____ SS#: _____/_____/_____ SEX: Female ☐ Male ☐

Primary Phone #: _____-_____-_____ Ext: _____ Secondary Phone #: _____-_____-_____

5. PHARMACY: Please complete to insure prescriptions are sent to correct location.

Name: _____ Address: _____ City: _____ ZIP: _____

Phone #: _____-_____-_____ Fax #: _____-_____-_____

May we request a list of your prescription drugs from this pharmacy: Yes ☐ No ☐

6. PRIMARY CARE PHYSICIAN (Name): _____

Phone #: _____-_____-_____ Fax #: _____-_____-_____

7. EMERGENCY CONTACT: Name: _____

Relationship: _____ Address: _____

Cell #: _____-_____-_____ Home #: _____-_____-_____ Work #: _____-_____-_____

Last Name: _____ First: _____ MI: ___ DOB: _____/_____/_____

Primary complaint: _____

What treatments have you tried? _____

8. PAST MEDICAL HISTORY/SURGERIES: _____

_____

9. DIABETIC: ☐ YES Type 1 - 2 INSULIN? ☐ YES ☐ NO Avg Blood Sugar: _____

10. ONGOING MEDICAL PROBLEMS:

☐ Allergies
☐ Alzheimers/Dementia
☐ Anemia
☐ Anesthesia Complications
☐ Arthritis: Type _____
☐ Asthma / COPD
☐ Blood Clots
☐ Bunions
☐ Cancer
☐ Cholesterol Elevated
☐ Circulatory Problems
☐ Corn / Calluses
☐ Drop Foot
☐ Depression
☐ Diabetes
☐ Fibromyalgia
☐ GERD
☐ Gout
☐ Hammertoes
☐ Heart Attack
☐ Heart Disease
☐ HIV
☐ Hypertension
☐ Ingrown Toe Nails
☐ Kidney
☐ Liver Disease
☐ Lyme Disease
☐ Macular Degeneration
☐ Multiple Sclerosis
☐ Panic Disorder
☐ Parkinson's Disease
☐ Psoriasis
☐ Seizures/Epilepsy
☐ Skin Ulcer
☐ Sickle Cell
☐ Stroke
☐ TIA
☐ Other: _____
_____

11. CURRENT MEDICATIONS: _____

_____

_____

12. ALLERGIES & REACTIONS:

☐ Metal ☐ Contrast Dye
☐ Latex ☐ Shelfish
☐ Tape ☐ Iodine

Drug Allergies: _____
_____
_____

13. SOCIAL HISTORY:

Smoke ☐ Yes ☐ No How many packs per day? _____ How many years? _____
Alcohol ☐ Yes ☐ No What type of alcohol? _____ How many per day? _____
Drug Use ☐ Yes ☐ No What type? _____

14. FAMILY HISTORY: Please check conditions which have affected your family (parents/siblings)

☐ Arthritis (Type) _____ ☐ Heart Disease ☐ Bunions
☐ Cancer (Type) _____ ☐ High Blood Pressure ☐ Hammertoes
☐ Diabetes (Type) _____ ☐ Sickle Cell ☐ Flat Feet
Other: _____

Last Name: _____ First Name: _____ MI: ____

15. REVIEW OF CURRENT SYSTEMS: Please circle all that apply

EYES: Contacts Glasses Reading Glasses Blurred Vision Floaters Vision Change Double Vision Eye Pain Eye Disease
NONE APPLY

HEAD/ENT: Headaches Migraines Vertigo Light-headedness Hearing Loss Ringing in Ears Hearing Aids Nasal congestion Nose bleeds Sinus Problems Sore Throat Difficulty Swallowing Swollen Glands
NONE APPLY

CARDIOVASULAR: Chest Pain Pacemaker Cardiac Arrest Claudication Lower Extremity Palpitations Stents
NONE APPLY

RESPIRATORY: Shortness of Breath Cough Wheezing Pain w/Breathing Difficulty Breathing
NONE APPLY

GASTROINTESTINAL: Heartburn Diarrhea Constipation Nausea Vomiting Loss of Appetite Eating Disorder
NONE APPLY Abdominal Pain Rectal Bleeding

GENITOURINARY: Pain Urinating Bleeding with Urinating Difficulty Urinating Kidney Stones
NONE APPLY

ENDOCRINE: Dry Skin Nail Changes Hives Pressure Ulcers Itch Rash Varicose Veins Heat/Cold Intolerance
NONE APPLY

NEUROLOGIC: Sciatica Numbness Tingling in Feet Burning in Feet Dizziness Poor Balance
NONE APPLY

MUSCULOSKELETAL: Joint Pain Joint Swelling Muscle Pain/Cramps Difficulty Walking Back Pain
NONE APPLY Weakness in Joint/Muscles

PSYCHIATRIC: Depression Difficulty Sleeping Anxiety
NONE APPLY

HEMATOLOGICAL: Easy Bleeding Easy Bruising Anemia Past Transfusions Blood Clots
NONE APPLY

16. PRIVACY POLICY

To insure your privacy, please answer the following and notify the Front Office if this information changes.

1. Do we have your permission to leave a message on the phone numbers you provided to us? ☐ Yes ☐ No
2. May we leave test results on the number provided? ☐ Yes ☐ No
3. May we discuss your medical information with designated family and/or friends? ☐ Yes ☐ No

Please list the names of those we can discuss your medical care with:

Name: _____ Phone #: _____ Relation: _____

Name: _____ Phone #: _____ Relation: _____

Name: _____ Phone #: _____ Relation: _____

17. FINANCIAL POLICY

1. Insurance is a contract between you and your insurance company. We will bill your primary insurance as a courtesy. In order to do this, you must disclose all insurance information, including primary and secondary insurance and keep our office updated on any and all changes in your insurance coverage. Failure to provide accurate and updated information may result in you being financially responsible for the entire bill.
2. Although we may estimate what your insurance company will pay for treatment, it is your insurance company that makes the final decision regarding your benefits and eligibility. Therefore, you are financially responsible for all bills not paid by your insurance. You may be asked to sign an ABN (Advance Beneficiary Notice) to insure payment to us.
3. Certain insurance plans require that you obtain a referral and/or prior authorization from your Primary Care Physician (PCP) before seeing a Specialist such as a Podiatrist. It is your responsibility to obtain these documents, if required by your insurance plan, and provide them to our office before your scheduled appointment. If these are required and not received by our office before your appointment, you will be considered "self-pay" with full payment due at the time of service.
4. Fees for services, which include unpaid balances, deductibles, co-pays, co-insurance and non-covered fees are due at the time of service. Appointments will not be made for those with outstanding balances. Failure to pay unpaid balances in a timely manner will result in a referral to a collection agency.
5. There will be a charge of $35 for returned checks. This fee may be paid by cash or money order. If unpaid, this fee will be added to your account and may result in your account being placed on a cash basis only. Unpaid check fees and balances are subject to collection placement.
6. Completion of Forms, copies of Medical Records, X-Rays, Reports, Handicap Permits and FMLA are not billable through your insurance company. The Fee Schedule for the above is available at the Front Desk.
7. There will be a $50 fee for late or missed appointments. This must be paid before the patient is re-scheduled. A late fee is applied if a patient arrives more than 10 minutes late for their scheduled appointment. It may also result in the appointment being rescheduled for a later date.
8. I have been given the opportunity to read my HIPAA Privacy Policy and understand a copy will be provided to me at my request.

I UNDERSTAND THE ABOVE INFORMATION AND AGREE TO BE FINANCIALLY RESPONSIBLE FOR THE PATIENT BELOW:

Print Name of Patient: _____ DOB: _____/_____/_____

Print Name of Financially Responsible Party: _____ Phone #: _____

Signature of Patient or Responsible Party: _____ Date: _____

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18. I was referred to this office by: _____ Patient Doctor Other

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19. DISCLAIMER: PHYSICIAN "REFERRALS" VS. INSURANCE "AUTHORIZATIONS"

Primary Care Physicians (PCP's) often "refer" their patients to "Specialists" for further treatment. This referral does not guarantee the insurance company will pay for that treatment. Some insurance plans also require a referral and a "prior authorization" to insure visits to a Specialist" will be covered by the patient's insurance plan.

The Referral Coordinator in your PCP's office can tell you if your plan requires this authorization and can assist you in obtaining it. You can also call the Member number on the back of your insurance card for clarification. If required, Foot and Ankle Specialists of Northeast Georgia, LLC. must have this authorization prior to your appointment or you will be considered "self-pay".

Patients with Medicare as their primary insurance do not have to obtain authorization for medically necessary treatment. Medicare Advantage Plans may differ, so it is advised to call the Member number on the back of the card prior to your appointment.

I understand it is my responsibility to determine if I need a Referral and/or Insurance Authorization. I also agree to pay Foot and Ankle Specialist of Northeast Georgia, LLC. for any fees not covered or denied by my insurance company.

Patient Name: _____ Signature: _____ Date: _____

Physician "Referrals"
Vs
Insurance "Authorization"

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Patients with Medicare as their primary insurance do not have to obtain authorization for medically necessary treatment. Medicare Advantage Plans differ, and some may require prior authorization. Cigna Health Springs Plan is one that requires an authorization.

I understand it is my responsibility to contact my PCP's office to determine if I need prior authorization from my insurance company. If so, my PCP's office can FAX that authorization to: 678-619-1270.

I also agree to pay Foot and Ankle Specialists of Northeast Georgia, LLC. for any fees not covered or denied by my insurance company.

_____ _____

Patient Name (Please Print) Patient Signature

_____

Date