FOOT & ANKLE SPECIALISTS OF NORTHEAST GEORGIA

**Personal Information:**

First name _____ Middle _____ Last _____

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

Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widow(er)

**Contact Information:**

Cell # _____/_____/_____ Home # _____/_____/_____ Work # _____/_____/_____

Email Address: _____ ☐ No Email

Street Address: _____City: _____ State: _____ Zip: _____

(If different than street)

Mailing Address: _____City: _____ State: _____ Zip: _____

**Payment Information:** (Check those that apply) ☐ Self-Pay

Primary Ins: _____ ID# _____Grp# _____

Secondary Ins: _____ ID# _____ Grp# _____

**Guarantor:** (Financially Responsible Party) ☐ Same As Patient

Relationship to Patient: ☐ Father ☐ Mother ☐ Sibling ☐ Stepparent ☐ Grandparent ☐ Other

First Name _____ Middle _____ Last _____

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

Primary Phone _____/_____/_____ Secondary Phone _____/_____/_____

**Pharmacy:** (Please complete to ensure prescriptions are sent to correct location)

Name: _____ Phone # _____

Street Address: _____

City: _____ State: _____ Zip: _____

**Primary Care Physician:** (Name): _____

Phone # _____/_____/_____ Fax # _____/_____/_____

**Emergency Contact:** (Name): _____ Relationship: _____

Phone # _____/_____/_____

**Primary Complaint / Reason for Visit**: _____

_____

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**Surgical History:** ☐ **N/A**

_____

_____

**History of:** ☐ Blood Clots / DVT (Deep vein thrombosis) ☐ Pulmonary Embolism

**Last occurrence?**_____

**Diabetic:** ☐ NO ☐ YES Type 1 or 2 **Avg Blood Sugar:** _____ **A1C:** _____

**Ongoing Medical Problems:**

| | | |
|---|---|---|
| ☐Allergies | ☐ Depression | ☐Macular Degeneration |
| ☐Alzheimer/Dementia | ☐ Diabetes | ☐ Panic Disorder |
| ☐Anemia | ☐ Fibromyalgia | ☐ Parkinson's |
| ☐Anesthesia complications | ☐ GERD | ☐ Psoriasis |
| ☐Arthritis: Type_____ | ☐ Hammertoes | ☐ Seizures/Epilepsy |
| ☐Asthma / COPD | ☐ Heart Attack | ☐ Skin Ulcer |
| ☐Back Problems | ☐ heart disease | ☐ Sickle Cell |
| ☐Bunions | ☐ HIV | ☐ Stroke |
| ☐Cancer | ☐ Hypertension | ☐ TIA |
| ☐Cholesterol Elevated | ☐ Ingrown Toenails | ☐ Other: _____ |
| ☐Circulatory Problems | ☐ Kidney Disease | _____ |
| ☐Corn/Calluses | ☐ Liver Disease | _____ |
| ☐Drop Foot | ☐ Lyme Disease | _____ |
| | ☐ Multiple Sclerosis | |

**Current Medications:** ☐ List attached

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

**Allergies & Reactions:**

☐ Metal ☐ Contrast Dye ☐ Other _____

☐ Latex ☐ Shellfish _____

☐ Tape ☐ Iodine _____

**Social History:**

**Smoker** ☐ Yes ☐ No Packs per day? _____ Years? _____ Quit? ☐Yes ☐No When? _____

**Alcohol** ☐ Yes ☐ No What type of alcohol? _____ How many per day? _____

**Drug use** ☐ Yes ☐ No What type? _____

**Family History:**

| | | |
|---|---|---|
| ☐ Arthritis | ☐ Heart Disease | ☐ Hammertoes |
| ☐ Cancer | ☐ High Blood Pressure | ☐ Flat Feet |
| ☐ Diabetes | ☐ Sickle Cell | ☐ Other: _____ |
| | ☐ Bunions | _____ |

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**Review of Current Systems**: **Height:** _____ **Weight:** _____

Please check all that apply:

| |
|---|
| **Eyes:** ☐ Contacts ☐ Eye Pain ☐ Blurred Vision ☐ Double vision ☐ Reading Glasses ☐ Floaters ☐ Glasses ☐ Eye Disease ☐ Vision Change |
| **Head/ENT:** ☐ Headaches ☐ Vertigo ☐ Nose Bleeds ☐ Hearing Loss ☐ Ringing in Ears ☐ Sore Throat ☐ Migraines ☐ Swollen Glands ☐ Lightheadedness ☐ Hearing Aids ☐Difficulty Swallowing ☐ Nasal Congestion |
| **Cardiovascular:** ☐ Chest pain ☐ Palpitations ☐ Stents ☐ Pacemaker ☐ Cardiac Arrest ☐ Claudication Lower Extremity |
| **Respiratory:** ☐ Shortness of Breath ☐ Difficulty Breathing ☐ Cough ☐Wheezing ☐ Pain w/Breathing |
| **Gastrointestinal:** ☐ Heartburn ☐ Constipation ☐ Rectal Bleeding ☐ Vomiting ☐ Loss of Appetite ☐ Eating Disorder ☐ Nausea ☐ Abdominal Pain ☐ Diarrhea |
| **Genitourinary:** ☐ Pain Urinating ☐ Difficulty Urinating ☐ Kidney Stones ☐ Bleeding w/ Urination |
| **Endocrine:** ☐ Dry Skin ☐ Pressure Ulcers ☐ Itching ☐ Rash ☐ Nail Changes ☐ Varicose Veins ☐ Hives ☐ Heat/Cold Intolerance |
| **Neurologic:** ☐ Sciatica ☐ Tingling in Feet ☐ Burning in Feet ☐ Dizziness ☐ Poor Balance ☐ Numbness |
| **Musculoskeletal:** ☐ Joint Pain ☐ Muscle pain/cramps ☐ Weakness in joints ☐ Difficulty Walking ☐ Back Pain ☐ Joint Swelling |
| **Psychiatric:** ☐ Depression ☐ Difficulty Sleeping ☐ Anxiety |
| **Hematological:** ☐ Easy Bleeding ☐ Anemia ☐ Past Transfusions ☐ Easy Bruising |

**I was referred to this office by:**_____ ☐ Patient ☐ Doctor ☐ Other

**Privacy Policy:**

To ensure your privacy, please answer the following & notify the front office if this information changes.

1. Do we have your permission to leave a message on the phone numbers you provided? ☐ Yes ☐ No
2. 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: _____

FOOT & ANKLE SPECIALISTS OF NORTHEAST GEORGIA

**Financial Policy**

1. Insurance is a contract between you and your insurance company. We will bill your primary insurance as a courtesy. To do this, you must disclose all insurance information, including primary and secondary insurance, and keep our office updated on 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 ensure payment to us.
3. Certain insurance plans require that you obtain a referral and/or prior authorization from your Primary Care Physician 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 before your appointment, you will be considered "self-pay" with full payment due at the time of service.
4. Fee 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 rescheduled. A late fee may be applied if a patient arrives more than 15 minutes later 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 what will be provided to me at my request.

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**Disclaimer: Physician "Referrals" VS. Insurance "Authorizations"**

Primary Care Physicians 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 or a prior authorization to ensure visits to a "Specialist" will be covered by the patient's insurance plan.

The referral coordinator in our 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 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 to medically necessary treatment. Medicare Advantage Plans may differ, so it is advised to call the member number on the back of your 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 Specialists of Northeast Georgia, LLC for any fees not covered or denied by my insurance company.**

**Patient Name:** _____ **Signature:** _____ **Date:** _____

FOOT & ANKLE SPECIALISTS OF NORTHEAST GEORGIA

## PATIENT ACKNOWLEDGEMENT AND CONSENTS

**CONSENT FOR TREATMENT:** I consent to all diagnostic and treatment procedures/examinations provided at Foot and Ankle Specialists of Northeast Georgia. This will include, but not limited to injections, treatments, x-rays, and procedures considered medically necessary for the care of my foot or ankle condition. I understand that the procedures will be explained to me and that I will have the opportunity to ask questions concerning the associated risks, alternatives and prognosis before allowing the procedures to be performed. I consent to treatment and care provided by a team of health professionals

**CONSENT FOR DISPOSAL OF HUMAN TISSUE:** I agree that any tissues or specimens that are removed from my body while performing any procedures or providing my care treatment will be examined and disposed of properly.

**TELEPHONE CONSUMER PROTECTION ACT CONSENT:** I expressly consent to receive any phone calls from Foot and Ankle Specialists of Northeast Georgia, its affiliates, agents, vendors, or third parties calling or texting on their behalf at any number I provide or that may obtain for me. Such calls or texts may be made using an automated telephone dialing system and/or prerecorded or artificial voice and may be made for any non-marketing purpose, including but not limited to communications about my treatment, medication assistance, insurance benefits or account; appointment reminders; balance due and payment reminders; and debt collection attempts.

**MEDICATION CONSENT:** I provide consent to access and obtain a history of my medications.

**PRIVACY PRACTICES:** I acknowledge that I have been provided a copy of the Notice of Privacy Practices from Foot and Ankle Specialists of Northeast Georgia.

## ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENTS

**ASSIGNMENT OF BENEFITS:** If I am entitled to benefits under Medicare program or any insurance policy or other health benefit plan, in consideration for services provided to me by Foot and Ankle Specialists of Northeast Georgia, I assign, transfer, and convey the benefits payable under such program, policy, or plan for services rendered to Foot and Ankle Specialists. I authorize payment of benefits directly and such benefits applied to my bill.

**PATIENT RESPONSIBILITY:** I understand and acknowledge that the assignment of benefits does not relieve me of my financial responsibility for charges incurred by me or anyone on my behalf, and I hereby acknowledge responsibility for and agree to pay charges not paid under this assignment, including any coinsurance amounts and deductibles and any charges for services deemed to be non-covered, or not pre- authorized by my insurance plan. I agree to provide all known insurance information at the time that services are rendered. If I overpay on my account, I authorize the application of such overpayment to satisfy any outstanding charges I owe for services rendered by Foot and Ankle Specialists.

**INFORMATION RELEASE:** I authorize Foot and Ankle Specialists of Northeast Georgia to release all protected health information to my insurance, (including Medicare, if appropriate) and third-party collection agencies to secure payment for services rendered. I also authorize the release of my medical information to my Primary Care Provider for continuity of my care.

**REFERRALS:** I understand that it is my responsibility to obtain any referrals required by my insurance company from my primary care physician or insurance carrier. It is my responsibility to make sure that my referral is accurate and denial of payment because of my failure to do this will result in me being personally responsible for charges incurred.

**RETURN POLICY:** I understand that we cannot accept returns for any items purchased from the office including orthotics, topical ointments/creams. We cannot accept returns of any Durable Medical Equipment (DME) including walking boots, splints, braces, etc.

**CANCELLATION POLICY:** We will reserve the appointment time for you. Therefore, we respectfully request that you give us at least 24-hour notice if you need to cancel or reschedule. We do understand that there is an unforeseen emergency or event that may result in needing to cancel your appointment. However, a missed or canceled without notice will be a fee of $50.

| **Signature of Patient or Parent/Guardian (if a minor) or Power of Attorney**<br>**X**_____ | **Date:** |
|---|---|
| **Printed Name of Parent/Guardian or Power of Attorney (if applicable)**<br>**X**_____ | **Relationship:** |