Georgia Foot & Ankle

PLEASE PRINT CLEARLY **Today's Date _____/_____/____**

Name _____ Date of birth _____/_____/____
First MI Last

SSN_____Marital Status M S D W Age____Weight_____Height_____Male___Female___

Address_____ City _____State _____ Zip_____

Phone (Home)_____(Work)_____(Cell)_____(Alternate)_____

Email: _____

Name and address of employer_____

Occupation:_____

Spouse's Name_____DOB_____If Minor, Name of parent_____

How did you find out about our office? _____

Responsible Party or Insured's Information (If different than above)

Name: _____ Date of Birth_____ SSN_____

Address: _____ City_____ State_____ Zip_____

Phone# (H)_____ Phone# (W)_____(Cell)_____

Nearest Relative (Not Living With You) or Emergency contact information

Contact: Name _____ Phone #_____

Insurance Information

Name of Insurance Company_____

Policy Holder if other than the Patient _____Date of Birth_____

Policy # _____ Group # _____

Is this Workman's Compensation? _____ Date of Incident: _____

Workman's Comp Insurance Information:_____

Secondary Insurance Information

Name of Company _____

Policy Holder if other than the Patient _____Date of Birth_____

Policy # _____ Group #_____

AS A COURTESY, OUR OFFICE CALLS TO CONFIRM APPOINTMENTS. PLEASE PROVIDE THE BEST NUMBER TO CONTACT YOU REGARDING YOUR APPOINTMENT. _____

I authorize Georgia Foot and Ankle, PC. To obtain my prescription history from external sources

X_____

Georgia Foot & Ankle

Steven R. Carter, D.P.M.
770-786-0070

Date:_____

Name: _____ Age:_____

Primary Care Physician:_____ Last PCP Office Visit _____

Pharmacy: _____

What is your main concern today? _____

_____

_____

When did this problem begin?_____

Is this problem the result of an injury? _____

If so, describe the circumstances of the injury_____

_____

What types of things aggravate or worsen your condition? _____

_____

Have you been seen by another doctor for this condition? _____

Please describe any treatment by you or recommended by another doctor for this condition _____

_____

Name:_____ Date: _____

Please list all of your current prescription and over the counter medicines:

Medication Name	**Dosage(Strength)**	**How many times per day?**

Name: _____- **Date**: _____

Please check any of the following that you currently have or have ever had in the past:

Eyes

__ Use of glasses or contacts

__ Glaucoma

General Medical Problems

__ Cancer

__ Diabetes

__ Hepatitis

__ Anemia

__ HIV

__ Sickle Cell Anemia

__ Liver Problems

__ Thyroid Problems

__ Cholesterol Problems

Skin

__ Foot Ulcers

__ Psoriasis

__ Slow to heal wounds

__ Tendency for thick scar formation

Heart

__ Artificial Heart Valve

__ Chest Pain

__ Heart attack/Heart disease

__ Heart murmur

__ Heart rhythm problems

Breathing

__ Asthma

__ Emphysema

Circulation

__ High blood pressure

__ Poor Circulation

__ History of blood clots

__ Color changes in fingers/toes if exposed to cold

Bone/Joint

__ Gout

__ Arthritis; What type?: _____

Neurologic

__ Neuropathy (Numbness in feet/legs)

__ Stroke

Emotional

__ Depression / Anxiety

__ Bipolar Disorder

__ History of substance abuse

__ Inpatient treatment of psychiatric disorder

Urinary / Kidneys

__ Kidney failure / insufficiency

__ Loss of a kidney

__ Dialysis

Stomach

__ Stomach Ulcers

__ Problems with taking anti-inflammatories

__ Blood noted in stools

Allergies: _____

_____

Even if you are not allergic to them, are there any medicines that you have been told not to take: _____

Please provide details of any **operations**, **serious injuries**, or **hospitalizations**:

Operation	Date	Physician	Hospital

Indicate which of your immediate blood relatives have had any of the following diseases:

Cancer _____ Diabetes _____

Heart Trouble _____ High Blood Pressure _____

Stroke _____ Arthritis _____

Do you **smoke**? _____ How many packs per day? _____

How many years have you smoked? _____

Do you drink **alcohol**? _____ How often? _____

Have you used any drugs not prescribed by a doctor for you

in the past 12 months? _____

If yes, please, indicate what drugs have been used? _____

Have you ever used narcotic pain medication for an extended period of time (anything more than 4 weeks)?_____

Please describe the circumstances?_____

Have you ever received or has it been recommended that you receive treatment for any substance abuse issue? _____

Review of Symptoms:

Do you currently have:	NO?	YES?	DETAILS (if answered "YES")
Fever			
Chills			
Weight changes			
Cough			
Rash			
Decreased Hearing			
Dizziness			
Weakness			
Shortness of breath			
Wheezing			
Pain in legs with walking			
Palpitations (heart flutters)			
Nausea			
Vomiting			
Easy bruising			
Difficulty urinating			
Muscle aches			
Cramping in legs			
Itching			
Fainting			
Headache			
Anxiety			
Depressed Mood			

Georgia Foot & Ankle, P.C.

Payment Policy

1. As a courtesy to our patients, we will file your insurance. **However, all copays, deductibles, and patient-due portions are due at the time of service based on the information provided to us by your insurance company.**
2. If, after 90 days, your primary insurance company has not paid the claim, it is your responsibility to pay the balance and seek payment from your insurance carrier.
3. Secondary insurance will be filed only once as a courtesy. If after 90 days it has not been paid, it will then be your responsibility to pay the balance and seek payment from your insurance carrier.
4. It is your responsibility to notify our office of any insurance or address changes.
5. Past due accounts are subject to being turned over to an outside collection agency and/or attorney. If collected through an attorney, attorney fees of 15% of the principal and interest owed and all court costs will be charged.
6. There is a $25 service charge for all returned checks, $25 for each out of work document set; $15 for each clean-claim resubmission and $50 for all “no- show” missed appointments.
7. All past due accounts will be assessed a finance charge of 1.5% monthly (18% annual rate).
8. Due to restrictions outlined by individual insurance carriers (including Medicare, HMO’s, PPO’s, and standard indemnity) certain supplies and/or services may be considered non-covered. However, due to the many plans with which we participate and the extreme variances among policies, our office does not always know in advance which supplies and/or services will or will not be covered.
9. During your visit there may be a consultation component as well as a procedure during the encounter. If a claim is submitted for both, it is because the work involved during the examination, formulating the diagnosis and recommending a treatment plan is separate from the work in doing an actual procedure. Some insurances combine the two and deny or reduce payment of one or the other. We find this unacceptable and therefore, if you choose to have both an office visit/consultation on the same day of service as a procedure, and your insurance company denies or reduces payment for either or both, you agree to be responsible for the allowable amount of both minus what the insurance carrier pays for those services. Please ask is you have any questions about this.
10. Payment may be made by Cash, Check, VISA, Mastercard, and American Express.
11. Office charts and x-rays are the permanent property of Georgia Foot and Ankle, P.C. Be aware that the original documents will not be released. Copies can be made, but there is a charge for this.
12. I authorize the release of any medical or other information necessary to process any insurance claims on my behalf by this office.

13. Patient understands and agrees that if he/she disputes any service, charge, or amount shown on an invoice, he/she will present that dispute to Georgia Foot & Ankle, P.C. in writing within ten (10) days of receipt of the invoice or he/she waives any dispute.
14. Patient agrees that in the event of any claims, issues, causes of action or lawsuits arising out of or related to services provided by Georgia Foot & Ankle, P.C., venue shall lie exclusively in the Courts of Newton County, Georgia. The choice of forum set forth in this section shall not be deemed to preclude the bringing of any action by Georgia Foot & Ankle, P.C. to collect on any judgment obtained in such forum in any other appropriate jurisdiction. Patient waives the right to assert the defense of forum non-convenience and the right to challenge the venue of any court proceeding.

14. This payment policy constitutes the entire agreement between the parties on the specific matters contained herein and supersedes any and all prior contracts, agreements, or understandings between the parties on the same specific matters. This agreement may not be amended or modified in any manner except by an instrument in writing signed by the patient and an authorized representative of Georgia Foot & Ankle, P.C. The failure of Georgia Foot & Ankle, P.C. to enforce at any time any of the provisions of this payment policy shall in no way be construed to be a waiver of any such provision or the right of Georgia Foot & Ankle, P.C. thereafter to enforce each and every such provision.

Thank you for your cooperation in this matter.

I have read and understand the above policies of this practice and any questions have been answered to my satisfaction.

_____ _____

Patient's Signature Date

Georgia Foot & Ankle

Steven R. Carter, DPM
3160 Elm Street
Covington, GA 30014

Medicare Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to Georgia Foot and Ankle, P.C. for any services provided by the physicians of this group. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand that my signature requests that payment be made and authorizes release of medical information to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, Georgia Foot & Ankle agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon charge determination of the Medicare carrier.

_____

Patient's Name (Please Print)

_____

Patient's Signature

_____

Patient's Medicare Number

_____

Date

GEORGIA FOOT & ANKLE, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (FEDERAL HIPPA POLICY)

I acknowledge that I was given the opportunity to review and/or read a copy of the Notice of Privacy Practices (HIPPA Policy) and understood the notice.

I give my consent for the following persons to have access to my medical information at Georgia Foot & Ankle with regards to my appointments and/or care:

_____ _____
Name Relation

_____ _____
Name Relation

_____ _____
Name Relation

_____ _____
Patient Name (Please print)

_____
Parent or Authorized Agent

_____
Signature