FOOT AND ANKLE CENTER
of
WEST GEORGIA

PATIENT INFORMATION

First Name: _____ Middle Name: _____ Last Name: _____

Birthdate: _____Gender: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone : _____

Can we use your cell phone to text appointment reminders? _____

If not, is there an alternate (friend/ family member) number we can text? _____

Email: _____

Marital Status: (Married, Single, Divorced, Widowed, Life Partner): _____

How did you hear about us? _____

Emergency Contact: _____Phone #_____

Race: ☐American Indian ☐Asian ☐Black/African American ☐White/Caucasian ☐Other

Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic Language: _____

Pharmacy: _____ Pharmacy Location: _____

Primary Care Physician: _____ Date of last visit: _____

Shoe Size: _____ Current Weight: _____ Height: _____

Are you Diabetic? ☐YES ☐NO Do you use Insulin? ☐YES ☐NO

If you are diabetic, what was your most recent A1C Reading? _____

Do you smoke cigarettes? ☐YES ☐Never Smoked ☐Former Smoker: Quit Date _____

Do you use other tobacco/nicotine products? ☐YES ☐NO Type: _____

Alcohol Use: ☐None ☐Occasionally ☐Daily

Do you use recreational drugs? ☐YES ☐NO If so, please list: _____

Are you concerned with any of the following? ☐Food Insecurity ☐Housing Instability

☐Transportation Needs ☐Access to Utilities (Electrical, Gas, Water) ☐Personal Safety

Have you fallen in the past year? _____ If so, how many times? _____

FOOT AND ANKLE CENTER
of
WEST GEORGIA

MEDICAL INFORMATION

_____ _____

Print Patient Name Patient Date of Birth

What is your primary foot or ankle problem today? _____

When did your foot or ankle complaint begin? _____

What treatments have you tried? _____

MEDICAL HISTORY		
Have you ever had any of the following? Check the boxes that apply.		
☐ Acid Reflux/ GERD	☐ COPD	☐ Kidney Disease (Specify)
☐ ADHD	☐ Diabetes Type 1	_____
☐ AIDS/ HIV	☐ Diabetes Type 2	☐ Lung Disease (Specify)
☐ Alzheimer's/ Dementia	☐ Insulin Dependent	_____
☐ Anemia	☐ Non-Insulin Dependent	☐ Neuropathy
☐ Arthritis	☐ Drug Addiction	☐ Pacemaker
☐ Asthma	☐ Emphysema	☐ Phlebitis
☐ Atrial Fibrillation	☐ Epilepsy/ Seizure	☐ Sickle Cell
☐ Back Problems	☐ Fibromyalgia	☐ Stomach Ulcers
☐ Bleeding Disorder Specify)	☐ Gout	☐ Stroke
_____	☐ Heart Disease (Specify)	☐ Thyroid Disease (Specify)
☐ Cancer (Specify)	_____	_____
_____	☐ Hepatitis or Liver Disease	☐ Tuberculosis
☐ Cerebral Palsy	☐ High Blood Pressure	☐ Varicose Veins
☐ Circulatory Problems (Specify)	☐ History of MRSA	☐ Venous Insufficiency
_____	☐ Heart Attack	☐ Other: _____

SURGICAL HISTORY		

ALLERGIES *(Please check all that apply and list all drug allergies)* ☐ **Unknown**		
☐ Penicillin	☐ Tape/ Adhesives	☐ Iodine
☐ Codeine	☐ Latex	☐ Silver/ Silvadene

FOOT AND ANKLE CENTER
of
WEST GEORGIA

MEDICATION LIST, INSURANCE INFORMATION & PATIENT CONSENT

_____ _____

Print Patient Name Patient Date of Birth

CURRENT MEDICATIONS *(If you have a list, please allow us to make a copy)* ☐ **NONE**	

MEDICAL INSURANCE INFORMATION

Primary Insurance: _____ Policy Holder's Name: _____

Group #_____ Member ID: _____

Secondary Insurance: _____ Policy Holder's Name: _____

Group #_____Member ID: _____

PATIENT CONSENT

I certify that the above information is accurate to the best of my knowledge. I consent and authorize the physician and staff of Foot and Ankle Center of West Georgia (FACWG) to perform and administer any service, procedures, treatments, and medications that may be deemed necessary for my diagnosis and/or treatment. I authorize FACWG to receive and release my personal and medical information that may pertain to my treatment, medical history and diagnosis.

By signing this form, I expressly consent and authorize FACWG and its affiliates and agents to communicate with me for any reason, including, but not limited to, past and future medical services, collection of amounts owed for said services, and marketing. This communication may be made to any phone number, email address or mailing address that I provided to FACWG or other unique identifier or mode FACWG finds or obtains on its own which is not provided by me.

_____ _____

Print Patient Name Patient Date of Birth

_____ _____

Name of Guardian or Representative, if applicable Relationship to Patient

_____ _____

SIGNATURE of Patient, Guardian or Representative Today's Date

FOOT AND ANKLE CENTER
of
WEST GEORGIA

Patient Consent for Use and Disclosure of Protected Health Information

- I hereby give my consent for Foot and Ankle Center of West Georgia to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Foot and Ankle Center of West Georgia describes such uses and disclosures more completely.)
- I have the right to review the Notice of Privacy Practices prior to signing this consent. Foot and Ankle Center of West Georgia reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Johnna at 100 Professional Place, Suite 101, Carrollton, Ga. 30117.
- With this consent, Foot and Ankle Center of West Georgia may call or text my home or other alternative location/contact number and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.
- With this consent, Foot and Ankle Center of West Georgia may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.
- With this consent, Foot and Ankle Center of West Georgia may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Foot and Ankle Center of West Georgia restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.
- By signing this form, I am consenting to allow Foot and Ankle Center of West Georgia to use and disclose my PHI to carry out TPO.
- I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Foot and Ankle Center of West Georgia may decline to provide treatment to me.

To ensure your privacy, please answer the following questions:

Do we have permission to leave a message on the phone numbers you have provided: ☐Yes ☐No

May we discuss your medical information with any family and/or friends? ☐Yes ☐No

If yes, list the names of people we can discuss your medical information with:

Name	Relationship to Patient	Phone Number
Name	Relationship to Patient	Phone Number

PLEASE SIGN BELOW

Print Patient Name _____ Patient Date of Birth _____

Name of Guardian or Representative, if applicable _____ Relationship to Patient _____

SIGNATURE of Patient, Guardian or Representative _____ Today's Date _____

FOOT AND ANKLE CENTER
of
WEST GEORGIA

PAYMENT POLICY

Thank you for choosing Foot and Ankle Center of West Georgia as your podiatric provider. We are committed to providing you with quality healthcare. Please read the following payment policy and let us know if you have any questions, then sign at the bottom to verify that you accept our policy.

- Insurance is a contract between you and your insurance company. We will bill your primary insurance company as a courtesy to you. To do so, we require that you disclose all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. If your insurance company is not contracted with us or if we are out of network, you agree to pay any portion of the charges not covered by insurance. If your insurance changes, please notify us before your next visit, so we can make the appropriate changes.

- We participate with most insurance plans, including Medicare. It is your responsibility to verify your insurance has our practice listed as a participating provider. It is also your responsibility to be aware of coverage requirements, such as prior approval, referral by a Primary Care Provider, etc that your insurance my have in order to cover your services. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

- Certain health insurances (HMO, POS, etc.) require that you obtain a referral or prior authorization from you Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if not obtained.

- Fees for services, which include, unpaid balances, deductibles, co-payments, co-insurances, and non-covered over the counter products are due at the time of service. You understand and agree that if you fail to make payments for which you are responsible in a timely manner; such default will result in referral to a collection agency.

- The charge for a returned check is $35.00 payable by cash or credit card. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check. Unpaid returned check fees and balances will be subject to collection placement.

- Completion of Forms (e.g. Disability or Family Medical Leave) and Copies of Medical Records are not a billable reimbursement by insurance carriers. Therefore, you are responsible for the $35.00 fee related to the completion of these documents. Payment is due when forms are presented for completion.

Thank you for carefully reading our payment policy. Please let us know if you have any questions.

I have read and understand the payment policy, and I agree to abide by these guidelines.

_____	_____
Print Patient Name	Patient Date of Birth
_____	_____
Name of Guardian or Representative, if applicable	Relationship to Patient
_____	_____
SIGNATURE of Patient, Guardian or Representative	Today's Date

FOOT AND ANKLE CENTER
of
WEST GEORGIA

SELF PAY

☐ In the event a patient does not have health insurance or does not provide proof of current and active health insurance, that patient will be billed as "SELF PAY."

By signing below, I acknowledge that payment is due at the time of service.

AUTHORIZATION TO FILE PATIENT'S INSURANCE

Please check the boxes to verify you've read our policy and agree to this authorization, then sign below.

☐ I hereby certify and attest that I have sought evaluation, treatment, or medical advice from the staff at Foot and Ankle Center of West Georgia, P.C. I therefore authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration and its agents any information needed to determine these benefits or the release of medical information necessary to pay the claim.

☐ Primary Insurance: I authorize and request payment of medical insurance benefits be made on my behalf to Foot and Ankle Center of West Georgia, P.C. Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to Foot and Ankle Center of West Georgia, P.C.

☐ Secondary Insurance, if applicable: I request that payment of authorized secondary insurance benefits be made on my behalf to Foot and Ankle Center of West Georgia, P.C. if possible or otherwise to me, at which time I would forward all payments to Foot and Ankle Center of West Georgia, P.C.

_____	_____
Print Patient Name	Patient Date of Birth
_____	_____
Name of Guardian or Representative, if applicable	Relationship to Patient
_____	_____
SIGNATURE of Patient, Guardian or Representative	Today's Date