THE FOOT & ANKLE CENTER, P.C.

Surgical & Medical Treatment of the Foot, Ankle & Leg
1000 Towne Center Blvd, Ste 505 •Pooler, GA 31322 • 912.330.8885 • fax 912.330.8858

(all patient information is kept strictly confidential)

Patient: ____ **SS#:**_____-____-_____ **Date of Birth** ___________
(full name)

Mailing Address: ______________________________________ **City:** ________________ **State:** ___ **Zip:** _________

Home Phone: (______) ______________________ **Cell Phone: (______)** ________________________________

Male / Female **Marital Status: S - M - D - W** **Age:** ______________________

E-mail address: ____

Occupation: ____

Employer: ____ **Work Phone: (_____)**______________________

Spouse's Full Name:____________________________________ **Occupation:**_____________________________

Emergency Contact - Name: ___________________________________ **Phone: (_____)** ____________________

May we disclose confidential health information to your contact in the case of an emergency: Yes / No

Primary Ins. Co.: ____**Policy #:** _________________________

Name of Insured: ____**Group #:**_________________________

Secondary Ins. Co.: ____**Policy #:** _________________________

Name of Insured: ____**Group #:**_________________________

How did you hear about our office?____

Name of Pharmacy: _____________________________ **Town:** ________________ **Phone #:** ________________

I hereby give my permission to The Foot & Ankle Center, P.C. to perform diagnostic, therapeutic and/or operative procedures as may be deemed necessary in diagnosis and/or treatment of my feet and/or ankles. In addition, I will assume full responsibility for the payment of such treatment.

PATIENT SIGNATURE: ____ **DATE:**______________________

HEALTH HISTORY QUESTIONAIRRE

NAME: ____ DATE: __________________

- ***IN DETAIL,* DESCRIBE YOUR FOOT/ANKLE PROBLEM: __________________________**

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- **YOUR MEDICAL HISTORY: *(CIRCLE ALL THAT APPLY):***

  - ☐ **Diabetes, low blood sugar Morning Blood Sugar _________HgA1c________**
  - ☐ **High blood pressure**
  - ☐ **Heart disease: heart attack, stroke, chest pain (angina), mitral valve prolapse**
  - ☐ **Heart murmur, irregular heartbeat, congestive heart failure**
  - ☐ **Peripheral vascular disease**
  - ☐ **Peripheral neuropathy**
  - ☐ **Lung Disease: bronchitis, emphysema, pneumonia, shortness of breath, asthma**
  - ☐ **Sinus infection, ear infection**
  - ☐ **Seizures, mental illness, depression, epilepsy**
  - ☐ **Liver disease: hepatitis, cirrhosis**
  - ☐ **Kidney disease: infection, UTI, kidney stones, water retention**
  - ☐ **Stomach ulcers, gastric reflux, heartburn, intestinal problems**
  - ☐ **AIDS/HIV positive**
  - ☐ **Bleeding disorders: anemia, sickle cell disease, clotting abnormalities, cramping in legs**
  - ☐ **Thyroid or goiter problems**
  - ☐ **Arthritis (OA / RA), fibromyalgia, gout**
  - ☐ **Artificial joints (hip, knee, ankle, toe, other)**
  - ☐ **Cancer: Yes / No type ____**
  - ☐ **Do you take Cortisone or have you had steroid treatment: Yes / No**
  - ☐ **Dentures, hearing aids, glasses, contact lenses**
  - ☐ **Skin lesions, rash, psoriasis**
  - ☐ **If you are female, is there any chance that you could be pregnant: Yes / No**
  - ☐ **Other illnesses not listed ____**

- **YOUR SURGICAL HISTORY: ____**

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- **FAMILY HISTORY:** *do any blood relatives have a history of any of the following* (***circle***)*:*

Diabetes	**Heart disease**	**Neurological disorders**	**Cancer**
Arthritis	**HTN / Stroke**	**Bleeding disorders**	**Circulatory problems**

Other ____

- **SOCIAL:**
  - □ **Do you smoke:** **Yes / No** **How much?** ____________________
  - □ **Do you use alcohol:** **Yes / No** **# drinks / week** ____________________
  - □ **Do you use recreational drugs:** **Yes / No**
  - □ **Occupation** ______________________________________

- **LIST ALL MEDICATIONS: (*include aspirin, vitamin supplements and birth control pills)***

________________	________________	________________
________________	________________	________________
________________	________________	________________
________________	________________	________________

- **ALLERGIES:** ***(include food and drug allergies)***

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- **FAMILY PHYSICIAN:** ____________________ **LAST VISIT**____________________

I understand that honest and complete answers to each question stated above are important to the provision of my medical care and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on the form I should ask the doctor or a member of the staff for assistance.

Patient Signature: ______________________________ **Date:** ________________

Witness Signature: ______________________________**Date:** ________________

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B/P ____________ **R** ____________ **T** ____________

P ____________ **PO2** ____________ **Wt** ____________

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FINANCIAL POLICY

As a part of our desire to offer excellent medical care to you and your family and in order to minimize any misunderstandings regarding our fees, we would like to outline our office payment policy.

DEDUCTIBLES

- For those of you who have not met your deductible with your medical insurance company or those of you who have no medical insurance – ***Full payment is expected at the time services are rendered.***
- For those who have already met their annual deductible – ***you are responsible for your pre-determined co-payment at the time services are rendered*** (i.e. insurance: 80% / patient: 20%).

As a courtesy to you, we will file all claims to your insurance company. However, all office charges are ultimately your responsibility from the date the services were rendered. While we realize that temporary financial problems do occasionally arise, we ask that if you find yourself in financial difficulty please contact our office for assistance in the management of your account.

ACCOUNTS PAYABLE

If no payment has been made on your account within 90 days and you have not contacted our office to establish a payment schedule, your account will be turned over to our collection agency. In such instances, additional charges may then be added to your account to cover the costs of the collection agency. In the event that you default on your payments, the remainder of the balance due may be reported to the IRS as a cancellation of debt. A 1099-C will be filed with the Internal Revenue Service indicating that we have cancelled debt on your behalf. You will be responsible for reporting this cancelled debt as income on your tax return.

MISSED APPOINTMENTS

Our office tries to make every effort to schedule office visits at your convenience. If you know that you are not going to be able to keep your scheduled appointment time, please call our office (if possible, 24 hours prior to the scheduled time) to reschedule or cancel the appointment. This enables us to open that time slot for another person who may need to be seen that day. For repeated missed appointments without cancellation, a $65.00 fee will be assessed for the missed visit. We also reserve the right to deny future service.

This policy is offered as a means to establish and maintain a long-term, professional and pleasant relationship. We are always willing to answer any questions that you may have and we hope that you will bring any problems that may arise to our attention.

I acknowledge that should I fail to pay for any balance due on office visits or surgeries rendered at The Foot & Ankle Center, PC and my account is referred to a collection agency and/or attorney for collection, I will be responsible for paying all collection expenses, including, but not limited to, any collection agency fees and/or attorney fees. In addition, I agree to pay 18% interest per year on all amounts owed after 30 days of treatment. I also acknowledge that in the event that my check is returned for insufficient funds I agree to pay the balance plus an Insufficient-Fund-Fee of $35.

Patient's Signature____ Date___________________

Witness's Signature____ Date___________________

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HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

NOTICE OF PRIVACY PRACTICES

SUMMARY

This notice contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with your health information. For further information, there is a copy of Patient Rights & Responsibilities posted in the reception area.

DISCLOSURE OF HEALTH INFORMATION

Your health information will be disclosed in order to treat you or to assist other health care providers in treating you. We will also disclose your health information in order to obtain payment for our services or to allow insurance companies to process claims for services rendered by our office or other health care providers. Lastly, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students. Except as stated in more detail we will not use or disclose your health information without your written authorization.

In the following circumstances we may disclose your health information *without your written authorization*:

1. for certain limited research purposes.
2. for purposes of public health safety
3. to government agencies for purposes of audits, investigations and other oversight activities.
4. to government authorities to prevent child abuse or domestic violence.
5. to the FDA to report product defects or incidents.
6. to law enforcement authorities to protect public safety or to assist in apprehending criminal offenders.
7. when required by court order, search warrant, subpoena or otherwise required by the law.

PATIENT RIGHTS

As a patient of The Foot & Ankle Center, P.C., you have the following rights:

1. to have access to and / or a copy of your health information.
2. to receive an accounting of certain disclosures we have made of your health information.
3. to request restrictions as to how your health information is used or disclosed.
4. to request that we amend your health information.
5. to receive notice of our privacy practices.

If you would like to submit a comment or complaint about our privacy practices or if you believe that your rights have been violated, please send a letter outlining your concerns to:

Privacy Officer
The Foot & Ankle Center, P.C.
1000 Towne Center Boulevard, Suite 505
Pooler, GA 31322

Patient's Name: ____ Date____________________

Patient / Guardian Signature: ____

Witness's Signature____ Date____________________