



Fax Cover Sheet

| | |
|----------------------------|--------------------------|
| To: Yvonne, Nancy or Tracy | From: |
| Fax: (770) 716-1384 | Pages: (including cover) |
| Phone: (770) 716-2685 | Date: |
| Re: | CC: |

Urgent For Review Please Comment Please Reply Please Recycle

This transmission contains personal health information that you are required by law to maintain in a secure and confidential manner. Re-disclosure is prohibited. Failure to maintain confidentiality or re-disclosure without authorization could result in penalties as described in State and Federal law.

● Comments:

Patient Name:

The following checked information is contained in this fax:

- Labs (if required)
- Pre-Anesthetic Evaluation Form (If previously faxed, check here)
- Surgery Benefits Sheet
- Surgery Worksheet

Employee Signature: _____

This message is intended only for the person listed above. The attached information is confidential and considered privileged by law. If the reader of this fax is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you are not the intended recipient, please notify us and shred this information. Thank you for your cooperation.

Pre-Anesthetic Evaluation Form

Patient Name: _____ DOB: _____ Surgery Date: _____ Current Date: _____

Occupation: _____ Current Address: _____

Home Telephone: _____ Work Phone: _____ Cell Phone: _____

Family Doctor: _____ Family Doctor's Phone: _____

Age: _____ Height: _____ Weight: _____ Surgeon: _____

Emergency Contact: _____ Relationship: _____ Their Number: _____

Will someone be with you the first 24 hours after surgery? YES NO Their Name: _____

Are you allergic to anything (Medications, Latex, Betadine, Alcohol, Foods, Tape, etc)? _____

What medications do you take regularly? _____

What medications do you take occasionally? _____

List any previous surgeries you have had: _____

What is your primary foot problem? _____

| | | | | | |
|--|------------------------------|-----------------------------|-------------------|------------------------------|-----------------------------|
| Do you have a history of cancer? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Does your family? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do you have a history of heart problems? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Does your family? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do you have a history of circulation problems? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Does your family? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do you have a history of skin problems? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Does your family? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do you have a history of severe injuries? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | | | |
| Do you have a history of any other illnesses? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Does your family? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Do you smoke? YES NO If yes, how many packs/day? _____ For how many years? _____

Do you drink? YES NO If yes, how many times/week? _____ How much? _____

Do you take cortisone or steroids? YES NO Is there any chance you may be pregnant? YES NO

Do you have any of the following?

| | | | | | | | | |
|----------------------|------------------------------|-----------------------------|--------------------|------------------------------|-----------------------------|------------------------------|------------------------------|-----------------------------|
| Acid Reflux? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Herpes? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | AIDS/HIV? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| High Blood Pressure? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Hepatitis? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Tuberculosis? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Sleep Apnea? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Hiatal Hernia? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Thyroid/Goiter? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Epilepsy? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Stroke? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Unconsciousness? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Bronchitis/Asthma? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Emphysema? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Shortness of Breath? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Kidney Disease? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Neck Trouble? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | False/Capped Teeth? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Bleeding Problems? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Clotting Problems? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Sickle Cell Disease? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Diabetes? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Sickle Cell Trait | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Are you pregnant or nursing? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Do you treat your diabetes with Medicine? Diet? Insulin?

If you answered yes to any of the above, please explain: _____

Do you have any problems with walking? YES NO hearing? YES NO seeing? YES NO communicating? YES NO

Do you have any disease or symptom that can be transmitted? YES NO

Is this your first anesthetic? YES NO Date of last anesthetic? _____

Have you ever had any problems with any type of anesthesia? YES NO, If yes, please explain: _____

Has any of your family members ever had a problem with any type of anesthesia? YES NO

Patient Signature: _____ RN _____

Anesthetist: _____



7130 Mt. Zion Blvd, Ste 14, Jonesboro, Georgia 30236

Pre-Operative Appointment at the Decatur office:

Date and Time: _____

Surgical Appointment at the Surgical Facility

Date and Time: _____

**Time is subject to change, please check time notated on the pre-operative instructions given at pre-op visit.

Location of surgical facility

The International Center for Foot and Ankle Surgery is located at 7130 Mt. Zion Blvd, Suite 14, Jonesboro, Georgia.

Directions to surgical facility from Decatur office location:

Take I-285 to I-75 South to Exit 231 (Mount Zion Blvd). Turn right off of the ramp. At the third light, make a right onto Spring Place and then an immediate right into the parking lot of 7130 Mount Zion Blvd.

Cancellation Policy

Large blocks of the Surgeon's operating time are scheduled for each surgical patient. If cancellation or rescheduling is necessary please provide at least 7 working days prior notice. Please call the office and speak with the nursing staff or the front office coordinator.

**Ankle and Foot Centers of Georgia
Office Telephone Numbers**

College Park 404-768-3668
Conyers 770-483-1100
Fayetteville 770-460-7600
Buckhead 770-474-4395
Decatur 404-508-4026

Morrow 770-478-3668
Newnan 770-251-6100
Peachtree City 770-487-6716
Stockbridge 770-474-4395

Please note:

Surgical times may vary; therefore assigned appointment times are only an estimate. Surgical patients should arrive approximately one hour prior to their scheduled surgical time so that all necessary preparations can be made prior to surgery. Late arrivals, unexpected surgical procedures, emergencies and other factors may delay the start time of your surgical procedure. It is not uncommon for a delay period of one hour or more to develop in the surgical area. The surgical staff is always concerned with timeliness and we do apologize for any and all delays.

Family members are not request to remain at the facility during the surgical procedure; however, if you call to check on the status of a patient please ask for a member of the surgical staff, as the receptionist does not know the status of the patient and cannot tell you when to arrive to pick-up your family member.

Thank you for choosing the International Center for Foot and Ankle Surgery. It is our pleasure to serve you.

Disability Questionnaire

There is a \$15.00 per form charge for FMLA forms and \$10.00 charge per form for Disability forms that are to be completed by our physician staff. Please allow 7-10 days for completion of such forms.

To assist us in completing your disability form, please answer the following questions to the best of your ability. Your detailed responses will assist us in determining the amount of time that is necessary for you to be out of work. **This form must be completed in its entirety!**

Patient Name: _____ Chart No. _____

Social Security Number: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Which doctor do you see? Giovinco Alvarez Pearson Patel Gabbay Dombek Weinstein Roman Patton

Which office location? College Park Conyers Fayetteville Morrow Newnan Peachtree City Stockbridge Buckhead

Please describe medical problem: _____

Date of Accident: _____ Date of First Visit: _____

Date of Last Visit: _____ Date of Next Visit: _____

What kind of work do you do? _____

How much standing, walking, sitting do you do in a day (hours per day)? _____

Date first out of work: _____

Date(s) you plan to return to work: Limited Duty _____ Full Duty _____

How long did the doctor tell you that you would be out of work? _____

How long do you plan to be out of your current position and full duties? _____

Do you plan to return part-time? _____ When? _____

Do you plan to return limited duty with restrictions? _____ When? _____

What restrictions do you need when you return? _____

DO NOT WRITE BELOW THIS LINE – FOR OFFICE USE ONLY

Type of Form: _____ Date received: _____ Date returned: _____

Payment Received: \$ _____ Payment Type: Cash Check Credit Debit Other: _____

Employee Signature: _____

original in patient's office chart



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect **April 14, 2003**, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes. You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

We will use and disclose your protected health information about you for treatment, payment, and health care operations. Following are examples of the types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist, anesthesia or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact us to request that these materials not be sent to you.

Uses and Disclosures Based On Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

Marketing: We may use your protected health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further such information by telling us using the contact information listed at the end of this notice.

Research; Death; Organ Donation: We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Required by Law: We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

Process and Proceedings: We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

Law Enforcement: We may disclose limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Patient Rights

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you \$0.25 for each page, \$3.00 per x-ray film, and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities after April 14, 2003. After April 14, 2009, the accounting will be provided for the past six (6) years. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below. If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Name of Contact Person: Danny Barnett, Practice Administrator
Telephone: (770) 251-6100 Fax: (678) 854-1977
E-Mail: adminafc@bellsouth.net
Address: 2326 Highway 34 East
Newnan, GA 30265

OCR – Georgia
Telephone: (404) 347-3125

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have read or had the opportunity to read, if I so chose, and understood the Notice of Privacy Practices.

Signature of Patient or Guardian

Date

Patient Name (Please Print)

I here by certify that, as an employee or agent of the International Center for Foot and Ankle Surgery, I have made a good faith effort to obtain from the patient or the patient's authorized representative a written acknowledgment of the "Notice of Privacy Practices" in accordance with the policy of the Notice of Privacy Practices (Section E; sub-section 1.2).

Signature of Employee or Agent

Date

Employee or Agent's Name (Please Print)

Reason(s) for not obtaining acknowledgment: _____



Pre-Operative Instructions and Information

Patient Name: _____ Date: _____

Surgery Date: _____ Surgery Time: _____ ARRIVE AT: _____

Please Read and Follow These Instructions Carefully

1. Do not cut your toenails and do not shave your legs three days prior to surgery. **Make sure your feet are clean, especially the nails.** Do not apply any powder or lotion. Remove all nail polish on toes prior to surgery. Also the left index finger must be free of nail polish for proper monitoring by the anesthetist. Do not wear any jewelry or metal on your skin or in your hair. Leave all valuables at home. Bring only your insurance card and a form of identification.
2. Notify your doctor of any cuts, scrapes, or infected bites that develop on your foot or leg the week prior to surgery.
3. Should you develop any signs or symptoms of illness before your surgery, please notify your doctor. The doctor should be aware of any sore throat, earache, abdominal illness or fever that may occur in the week before surgery.
4. **Do not eat or drink ANYTHING after midnight the night before surgery.** Do not drink coffee the morning of surgery; not even a piece of toast is permissible. You may be instructed to take certain medications. Drink fluids as late as possible before midnight to ensure better hydration.
 - a. If you are on medication(s) for diabetes, **DO NOT** take your medication(s) unless directed to do so. **Please bring your diabetic medication(s) to surgery.**
 - b. If you are on any inhalers please use as directed and **bring your inhaler to surgery.**
 - c. If you are on medication for acid reflux or hiatal hernia, please **take your medication as usual.**
 - d. If you take medication for high blood pressure, please take your medications as usual.
5. **You may take these medications with a sip of water (less than ¼ cup) the morning of surgery:**
_____ **You must have an empty stomach unless otherwise directed.**
6. Make arrangements to have a responsible adult to drive you to and from surgery. We ask that this person remain at the Surgery Center during your surgery. You may not drive yourself home from surgery. **Your surgery time may change.** The Surgery Center will call you the day before surgery to review instructions and to verify your surgery time. Please plan to be at the Surgery Center for a minimum of 3 hours.
7. Make arrangements for a responsible adult to be with you the first 24 hours after surgery.
8. If you need a wheelchair, make arrangements for this prior to surgery so you will have it at home when you arrive.
9. Discuss with your doctor any anticipated plans with regards to special activities, events or travel following surgery.
10. Wear loose fitting clothes, nothing restrictive. This is very important as you will have a bulky dressing on your foot and be drowsy after surgery. Baggy sweat pants and a thick short sleeve shirt are usually best because it tends to be cool in the operating room. Also, the sweats are easy to get off over your dressings. Avoid long sleeve shirts because this makes it difficult to monitor your blood pressure. If you know that you will be having a cast after surgery, it is very important to wear very loose pants or you will have to cut the pant leg to get them off over the cast. Avoid any clothes that have metal on them like zippers, metal clasps (often found on most bras) or metal buttons.

If you have any questions or concerns, do not hesitate to contact our nurse, at (770) 716-2685.

I have read the above pre-surgical instructions and they have been reviewed with me. I understand them completely and have no questions at this time.

Patient Signature: _____ Reviewer: _____



Post-Operative Instructions

Joseph D. Giovinco, DPM Gregory Alvarez, DPM W. Kevin Pearson, DPM Ketan Patel, DPM Gordon Patton, DPM
 Michael F. Dombek, DPM Nick Gabbay, DPM Robert B. Weinstein, DPM Scott R. Roman, DPM

College Park (404) 768-3668 Conyers (770) 483-1100 Fayetteville (770) 460-7600 Buckhead (770) 474-4395
 Morrow (770) 478-3668 Newnan (770) 251-6100 Peachtree City (770) 487-6716 Stockbridge (770) 474-4395

Proper care during the post-operative period is an integral part of your surgical treatment program. It is imperative that these instructions are followed to ensure proper healing and to obtain the best results.

1. Go directly home. Keep your foot elevated in the car.
2. Elevate your feet above your heart keeping your knees bent slightly.
3. If necessary, bedding may be kept from irritating the surgical site by use of a cardboard box to cradle the covers over the feet. Apply a waterproof ice bag covered with a towel over the ankle or behind the knee for 30 minutes on and 10 minutes off for the first three days. Do not apply during sleep. If you have a cast or splint, you may apply the ice pack to the back of the knee.
4. Limited swelling is expected. Occasionally, the skin may take on a bruised appearance. This is normal. The ends of your toes should be a healthy pink color that blanches when you touch them. The healthy pink color should return within 3 to 4 seconds after touching them.
5. **Keep your bandages/cast clean and dry. DO NOT** remove the bandages or inspect the wound. A small amount of blood on the bandage is normal. If you see excessive bleeding, **call your doctor.**
6. **NO SHOWERS.** Cover the bandages with a plastic bag and hang your leg outside the tub while bathing. If you have been instructed to sponge bathe, do so. You must keep this area completely dry. If you get your dressings wet, **CALL YOUR DOCTOR IMMEDIATELY.**
7. Exercise your leg frequently by bending your knees and ankles to stimulate circulation and speed healing. Lay on your back with your foot in the air. Bend and straighten your knee and ankle.
8. Have your prescriptions filled and take your medications as directed. If medications cause stomach upset, headache, rash, or other abnormal reactions, discontinue their use and **CALL THE DOCTOR.**
9. Curtail or discontinue the use of tobacco products and alcoholic beverages.
10. Do not operate machinery, drive a car, or make any important decisions for at least 24 hours after your surgery.
11. If you have a surgical shoe, cast shoe, crutches, walker, or wheelchair, use them as directed and instructed.
12. Limit your activities to bathroom privileges only the first three days following surgery.
 - You may place your weight on your foot only while wearing the surgical boot/shoe
 - You may only put weight on your heel while wearing the surgical boot/shoe
 - You may not put any weight on your foot until otherwise instructed by your doctor
 - You may not put any weight on your cast and should walk only with the crutches/walker
 - You may put weight on the cast while using crutches/walker to stabilize you
 - Use crutches/walker as directed
13. You should get plenty of rest with the foot elevated. Drink plenty of fluids. Start off eating light with some fluids, soup, etc. Slowly progress to a normal, well-balanced diet.
14. Take your temperature three times each day until your follow-up visit. Do not drink or eat anything hot or cold within thirty minutes of taking your temperature. **Call your doctor immediately if your temperature is 100 degrees or greater.**
15. Do not stay alone for the first 24 hours following surgery. A responsible adult should be with you.
16. If you have any problems, concerns, or questions, call your doctor anytime. He is available 24 hours a day. Also, contact the doctor immediately if: You should bump or injure the surgical site Your medications do not stop your discomfort

Your follow-up appointment is _____ with Dr. _____ at _____.

I have read and understand the above instructions. I agree to fully comply with these instructions.

I have read the post-operative instructions and completely understand them. I have received a copy of my post-operative instructions to take home.

I understand that the outcome of my surgical procedure is dependent upon strict compliance with these instructions. I further understand that failure to follow these post-operative instructions jeopardizes the success of the surgical procedure. I also understand that my surgeon cannot be held accountable for a failure on my to comply with these instructions.

Patient's Signature _____ Date _____ Reviewer's Signature _____

copy to patient

PATIENT INFORMATION

Title _____ First Name _____ MI _____ Last Name _____
Address _____ City _____ State _____ Zip Code _____
Home Ph. (_____) _____ Work Ph. (_____) _____ Cell Ph. (_____) _____
Social Security # _____
Date of Birth _____ Age _____ Sex: Male Female Marital Status: Single Married Widowed _____
Spouse's Name _____ Home Ph. (_____) _____ Work Ph. (_____) _____
Patient's Employer _____ Patient's Occupation _____
Employer Address _____ City _____ State _____ Zip Code _____
Emergency Contact not living with you _____ Home Ph. (_____) _____ Work Ph. (_____) _____
Emergency Contact Address _____ City _____ State _____ Zip Code _____

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

First Name _____ MI _____ Last Name _____
Address _____ City _____ State _____ Zip Code _____
Work Ph. (_____) _____ Date of Birth _____ Social Security # _____
Employer _____ Address _____ City _____ State _____ Zip Code _____

INSURANCE INFORMATION

Primary Insurance Company _____ Phone (_____) _____ Effective Date _____
Address _____ City _____ State _____ Zip Code _____
Policy Holder's Name _____ DOB _____ SSN _____
ID # _____ Group # _____
Secondary Insurance Company _____ Phone (_____) _____ Effective Date _____
Address _____ City _____ State _____ Zip Code _____
Policy Holder's Name _____ DOB _____ SSN _____
ID # _____ Group # _____

ASSIGNMENT OF BENEFITS

It is the policy of our office that all fees are due at the time services are rendered whether by check, cash or credit card unless prior arrangements have been made. We welcome frank discussion of services and fees prior to the time of treatment in order to avoid any misunderstandings.

We are happy to file your insurance for you, however, regardless of insurance coverage or policies set by your insurance company, you are responsible for payment of your account within the credit policy of this office. You agree to make payment in full upon notification of any of the following:

- Non Payment by Insurance Company
- Any Portion of Claim Applied to your Deductible
- Receipt of Payment from Insurance Company to Policy Holder
- Any Amount Not Paid by Your Insurance Company

If fees are incurred in order to collect delinquent accounts, those fees will be the responsibility of the patient.

I authorize the release of any medical/surgical information necessary to process this claim and authorize payment of medical/surgical benefits to be made directly to the International Center for Foot and Ankle Surgery. After all insurance payments have been paid I fully understand that I am responsible for the remaining balance of my account.

Signature of Patient or Responsible Party: _____ Date: _____

Consent for Anesthesia

Do not sign this form until you have read it and fully understand its contents.

Patients Name _____

Date _____

Possible risk of Anesthesia include: Aspiration (breathing in of blood, mucus or stomach contents), pneumonia, loose or broken teeth, cardiac arrhythmias (irregular heartbeat), hoarseness, phlebitis, corneal abrasion if contacts are left in place during surgery, hyperthermia (abnormally high body temperature), or reaction to medications. Please discuss these with your anesthetist.

I CONSENT to the administration of anesthesia by the anesthetist (CRNA) and agree to the use of such anesthetics as the anesthetist deems advisable for this procedure except _____.

I understand that the physician, CRNA, medical personnel and other assistants will rely on statements about the patient, the patient's medical history, and other information in determining whether to perform the procedure or the course of treatment for the patient's condition and in recommending the procedure which has been explained. I understand that anesthesia is not an exact science and that no guarantees or assurances have been made to me concerning this anesthetic.

I understand that during the course of the procedure described above it may be necessary or appropriate to perform additional procedures which are unforeseen or not known to be needed at the time of this consent is given. I consent to and authorize the persons described herein to make the decisions concerning such procedures. I also consent to and authorize the performance of such additional procedures as they deem necessary or appropriate.

By signing this form, I acknowledge that I have read or had the form read and/or explained to me, that I fully understand its contents, and that I have been given ample opportunity to ask questions and that any questions have been answered satisfactorily. All blanks or statements requiring completion were filled in and all statements I do not approve of were stricken before I signed this form. I also have received additional information including but not limited to the materials listed relating to the procedures described herein.

I voluntarily consent to the administration of anesthesia by a CRNA, and agree to the use of such agents, drugs, and techniques as the anesthetist deems necessary for this procedure except as listed above.

Signature of Patient or Patient's Representative

Witness

Printed Name of Patient's Representative (if applicable)

Relationship to Patient (if applicable)

Patient unable to sign because of: _____

Surgical Information and Alternatives

Patient Name: _____ Date: _____

Alternative Methods of Treatment - Surgery is typically offered as a last resort to help our patients. Before surgery is recommended, certain conservative alternatives may be tried which include some of the following. If you have any questions concerning any other conservative alternatives, please ask your doctor.

1. Wider shoes or changes in shoe gear
2. Periodic care by doctor or other health care provider
3. Antibiotics
4. Padding and strapping
5. Orthotic shoe inserts
6. Changes in occupation
7. Physical therapy
8. No other treatment options

Indications For Procedures - The following are some of the indications for podiatric surgery:

1. Pain and inflammation of operated areas
2. Conservative treatment not sufficient to resolve symptoms
3. Unable to wear normal shoe gear or walk with comfort

As a result of this procedure being performed, there may be material risk. The risks associated with having these procedures done may include but are not limited to the following:

1. Infection and/or inflammation of the surgical area
2. Delayed or non-healing of the incision and/or operated bones
3. Excessive bleeding/severe blood loss
4. Excessive swelling/poor or delayed healing
5. Allergic reaction to suture or other implanted material
6. Peripheral neurovascular complications (i.e. phlebitis)
7. Adverse reactions to anesthesia such as allergic reaction
8. Loss of or loss of function of a toe or foot
9. Failure of procedure or reoccurrence or worsening of condition/disability
10. Flail toe/stiff toe/shorter toe/elevated toe/stiffness of joint/jamming of joints with pain
11. Transfer lesions/callous/problems with other bones and/or joints
12. Damage to nerves or vascular structures/numbness/nerve entrapment
13. Significant chronic pain/altered sensation(i.e. burning, tingling, stinging)
14. Reflex sympathetic dystrophy (painful nerve condition of the foot)
15. Need for additional surgery
16. Painful or disfiguring scars
17. Implants, pins, or screws that need to be taken out because they loosen, break, or migrate
18. Fracture or dislocation
19. Permanent swelling or enlargement of toe, foot, or limb
20. Paralysis/Paraplegia/Quadraplegia
21. Brain damage, cardiac arrest, stroke, or death
22. Difficulty in walking or wearing shoes or playing sports

I have read the above statements and all of my questions have been sufficiently answered and explained.

Patient Signature: _____ Date: _____

Billing Process

The Center for Reconstructive Surgery is an ambulatory surgical facility. As such, when a procedure is performed here, insurance companies and patients will receive two (2) bills from our office. One bill is for the services provided by the physician and the other bill is for the use of the facility, equipment and supplies associated with the procedures performed. The billing process is the same as if you were having the procedure at the hospital. Similarly, we do not bill for your anesthesia services.

Per verification of your insurance benefits you will have a \$_____ out patient surgical co-pay. This amount is due on the date of your History & Physical appointment scheduled on _____.

Assignment of Benefits

It is the policy of our office that all fees are due at the time services are rendered whether by check, cash, or credit card unless prior arrangements have been made. We welcome frank discussion of services and fees prior to the time of treatment in order to avoid any misunderstandings.

We are happy to file your insurance for you, however, regardless of insurance coverage or policies set by your insurance company, you are responsible for payment of your account within the policy of this office. You agree to make payment in full upon notification of any of the following:

- Non Payment by Insurance Company
- Any Portion of Claim Applied to your Deductible
- Receipt of Payment from Insurance Company to Policy Holder
- Any Amount Not Paid by Your Insurance Company

If fees are incurred in order to collect delinquent accounts, those fees will be the responsibility of the patient.

I authorize the release of any medical/surgical information necessary to process this claim and authorize payment of medical/surgical benefits to be made directly to Ankle and Foot Centers of Georgia and/or Center for Reconstructive Surgery. After all insurance payments have been paid, I fully understand that I am responsible for the remaining balance of my account.

Authorization for Billing Anesthesia Services

Please understand the fee for anesthesia service is a separate charge from the physician office charge for surgery. Your anesthesia fee usually is covered by your insurance provider. Consult with your provider before surgery if you have any questions about coverage.

I certify that the information given by me is correct. I authorize Henry C. Balance & Associates to release to all medical information requested by third party payers, Social Security Administration, or its intermediaries or carriers related to this illness. I further authorize payers, including worker's compensation medical benefits to make payment directly to Henry C. Balance & Associates for anesthesia services rendered on the date listed below.

I understand that I am responsible to Henry C. Balance & Associates for their regular charges and agree to pay for such charges not covered or paid under this authorization. I agree to pay any unpaid balance in full 30 days after notification of insurance payment.

I understand that if I am a Medicare beneficiary my medical record is subject to review.

Signature of Patient or Responsible Party: _____ **Date:** _____

Printed Name of Patient or Responsible Party: _____