Medicine and Reconstructive Surgery of the Foot and Ankle
Board Certified in Foot and Ankle Surgery

PATIENT INFORMATION

Title **First Name** **MI** **Last Name**

Address **Apt#** **City** **State** **Zip Code** **County**

Home Ph. ( ) **Work 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 #

How did you learn about the Ankle and Foot Center? ☐ I saw your sign. ☐ I was referred by Dr. _____

☐ A friend or another patient referred me. ☐ Yellow Pages ☐ Promotional Coupon ☐ Other: _____

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 at the time of treatment in order to avoid any misunderstandings.

We are happy to file your insurance for you, however, regardless of insurance coverage; you are responsible for payment of your account within the credit policy of this office. 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/medical equipment benefits to be made directly to Ankle and Foot Centers of Georgia and/or 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:** _____

Personal Medical History

Patient Name: DOB:

The following information is important for your maximum safety and optimum care.
This office will hold this information in utmost confidence.

My primary foot or ankle problem today is: _____

_____

Name of Primary Care Physician

Doctor's Name: _____ Phone Number: ( ) -

Address: _____

Are you under the care of this physician now? ☐ YES ☐ NO

When was the date of your last medical examination? ____/____/____

Are you being treated for or have you ever been treated for any of the following:

ASTHMA	☐ YES ☐ NO	ARTHRITIS	☐ YES ☐ NO
ANEMIA	☐ YES ☐ NO	DIABETES	☐ YES ☐ NO
TUBERCULOSIS	☐ YES ☐ NO	KIDNEY TROUBLE	☐ YES ☐ NO
CANCER/TUMOR	☐ YES ☐ NO	STOMACH ULCERS	☐ YES ☐ NO
EPILEPSY/SEISURE	☐ YES ☐ NO	RHEUMATIC FEVER	☐ YES ☐ NO
SKIN RASH/HIVES	☐ YES ☐ NO	THYROID DISEASE	☐ YES ☐ NO
EMPHYSEMA	☐ YES ☐ NO	BRONCHITIS	☐ YES ☐ NO
HIGH BLOOD PRESSURE	☐ YES ☐ NO	OTHER: _____	☐ YES ☐ NO

Please explain any YES answer(s) below:

Medical Condition	Date(s) of Treatment	Outcome	Hospital Name & Address	Primary Doctor Name & Address

Please list all surgeries that you have had and the date performed:

Surgery	Date	Surgery	Date
1.		**3.**	
2.		**4.**	

Patient Name: DOB:

Have you ever tested positive for the following:

HIV/AIDS ☐ YES ☐ NO Sickle Cell Disease ☐ YES ☐ NO Hepatitis ☐ YES ☐ NO

Social History:

Do you smoke? ☐ YES ☐ NO If Yes, How much? _____ How many years? _____

Do you drink? ☐ YES ☐ NO If Yes, How much? _____ How many years? _____

Are you pregnant: ☐ YES _____ weeks ☐ NO Date of last menstrual cycle: _____ / _____ / _____

Are you breastfeeding: ☐ YES ☐ NO

Please list any medications you are currently taking on a regular basis:

Medication Name	For Medical Condition	Start Date	Dosage	Reaction/Side Effects
1.				
2.				
3.				
4.				

Are you allergic or have you had an adverse reaction to any of the following:

PENICILLIN	☐ YES ☐ NO	OTHER ANTIBIOTICS	☐ YES ☐ NO
LOCAL ANESTHESIA	☐ YES ☐ NO	GENERAL ANESTHESIA	☐ YES ☐ NO
CODEINE	☐ YES ☐ NO	ASPIRIN	☐ YES ☐ NO
SULFA DRUGS	☐ YES ☐ NO	TAPE OR BAND-AIDS	☐ YES ☐ NO
IODINE	☐ YES ☐ NO	LATEX	☐ YES ☐ NO
SEDATIVES	☐ YES ☐ NO	SHELLFISH	☐ YES ☐ NO
OTHER _____		OTHER _____	

I hereby authorize the physicians and their assistants of the Ankle & Foot Centers of Georgia to administer treatment as deemed necessary.

_____ _____

Signature of Patient or Responsible Party Date

ankle&foot centers of georgia

Office Policy Regarding Insurance

Every individual's group insurance policy is different. We sometimes see patients for tests, procedures, and even visits that their insurance company will not cover. To help prevent these situations, please refer to your insurance handbook before you make your appointment. We suggest you confirm the following:

1. Does my policy require a co-payment and/or what is my deductible?
2. Do you need a referral to see a specialist? **We are considered specialists.**
3. Does my policy cover routine foot care and to what extent and maximum per year? The trimming of nails and/or removal of corns and calluses may be considered routine foot care.
4. Over the counter products are not usually covered by your insurance company.
5. What lab procedures can be done in our office or where do you need to be referred for laboratory procedures?

It is our desire to help you as much as possible with claims that are submitted to your insurance company. If procedures are done in the office that are deemed non-covered by your insurance company, you will be responsible for payment. We make every effort to verify podiatry benefits as a courtesy to our patients. If we are given incomplete or inaccurate information from you or your insurance company, we will not accept responsibility for this erroneous data. We encourage you to take the time to become familiar with your individual insurance plan.

It is important that you know your coverage and check it annually or whenever your insurance changes.

We are always here to help in any way we can and will be glad to work with you and your insurance company to clear any matters that may arise.

If you have any questions, please do not hesitate to give us a call. Thank you for your cooperation in this matter.

Sincerely,

The Staff and Physicians of the Ankle and Foot Centers of Georgia

_____ _____

Patient Signature Date

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 compliant 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: Consuelo Dodson
Telephone: (678) 854-1976 Fax: (678) 854-1977
E-Mail: cdodson@ankleandfootcenters.com
Address: 2326 Highway 34 E.
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 Date

_____

Patient Name (please print)

_____

Parent or Authorized Representative (if applicable)

-- OR --

FOR OFFICE USE ONLY:

I hereby certify that, as an employee or agent of Ankle & Foot Centers of Georgia, I have made a good faith effort to obtain from the patient or the patient's authorized representative a written acknowledgment of the Ankle & Foot Centers of Georgia "Notice of Privacy Practices" in accordance with the policy of the Notice of Privacy Practices (Section E; Sub-section 1.2).

_____ _____

Employee or Agent's Signature Date

_____

Employee or Agent's Name (please print)

Reason(s) for not obtaining acknowledgment: _____

_____