Medication List

Name:_____ **Date:**_____

Allergies:_____

Medication	*Amount*	*Taken by mouth, inhaled or injected?*	*How often do you take it?*	*When did you last take it?*
Prescriptions for Surgery	*Amount*	*Taken by mouth, inhaled or injected?*	*How often do you take it?*	*When did you last take it?*

1) Must be completed in full by patient prior to surgery
2) Pre-Op Nurse will review with patient for accuracy, add any post-operative medications prescribed, place copy in patient chart, and give patient a copy.

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 Buckhead Office location:

Take I-75/85 South. Get off at the Mount Zion Blvd. exit, number 231. Turn right onto Mount Zion Blvd. At the third light turn right onto Spring Place and then make an immediate right into the parking lot of the surgery center.

Directions to Surgical Facility from Conyers' Office location:

Take highway 138 West toward Stockbridge. At the intersection of highways 138 and I-75, take I-75 North one exit to Mount Zion, exit 231. Turn left and go back over the interstate. At the fourth light, turn right onto Spring Place and then make an immediate right into the parking lot of the surgery center.

Directions to Surgical Facility from College Park's Office location:

Take I-285 East 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.

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.

Directions to Surgical Facility from Fayetteville Office location:

Drive East on Georgia Highway 54 towards Jonesboro until it ends at Georgia Highways 19/41/Tara Blvd. Turn left onto GA Hwy 19/41/Tara Blvd. Turn right onto Battlecreek Rd. (there will be a U-haul store on your right at the corner of GA Hwy 19/41/Tara Blvd and Battlecreek Rd.). Proceed on Battlecreek until it dead ends at Mt. Zion Blvd. Turn left onto Mt. Zion Blvd. Proceed on Mt. Zion Blvd to the first traffic light (there will be a Zaxby's on your left hand side). At the traffic light, turn left onto Spring Place. Turn right into the parking lot of 7130 Mt. Zion Blvd.

Directions to Surgical Facility from Jonesboro/Morrow Office location:

The International Center for Foot and Ankle Surgery is located in the same building as the Jonesboro/Morrow office location of Ankle and Foot Centers of Georgia. The surgical center is located in suite 14.

Directions to Surgical Facility from Newnan Office location:

Take I-85 North to I-285 East towards Macon/Augusta to I-75 South toward Macon. Take exit 231, Mount Zion Blvd. Turn right off the exit ramp. At the third traffic light, turn right onto Spring Place. The surgical center will be located immediately on the right.

Directions to Surgical Facility from Peachtree City Office location:

Drive East on Georgia Highway 54 towards Jonesboro until it ends at Georgia Highways 19/41/Tara Blvd. Turn left onto GA Hwy 19/41/Tara Blvd. Turn right onto Battlecreek Rd. (there will be a U-haul store on your right at the corner of GA Hwy 19/41/Tara Blvd and Battlecreek Rd.). Proceed on Battlecreek until it dead ends at Mt. Zion Blvd. Turn left onto Mt. Zion Blvd. Proceed on Mt. Zion Blvd to the first traffic light (there will be a Zaxby's on your left hand side). At the traffic light, turn left onto Spring Place. Turn right into the parking lot of 7130 Mt. Zion Blvd.

Directions to Surgical Facility from Stockbridge Office location:

Take I-75 N to the Mt. Zion Blvd – exit ramp #231. Turn left onto Mt. Zion Blvd to the fourth traffic light, Spring Place. Turn right onto Spring Place. The International Center for Foot and Ankle Surgery is located at the corner of Mt. Zion Blvd and Spring Place.

7130 Mt. Zion Blvd, Ste 14, Jonesboro, Georgia 30236
(770) 716-2685

Pre-Operative Appointment:

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. The surgery center will call you the day before the surgery to update your scheduled time.

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

Piedmont	404-351-5015	Fayetteville	770-460-7600
College Park	404-768-3668	Jonesboro	770-478-3668
Conyers	770-483-1100	Newnan	770-251-6100
Covington	678-342-3088	Peachtree City	770-487-6716
Decatur	404-508-4026	Stockbridge	770-474-4395
Smyrna	770-434-7078	Carrollton	770-838-4151
LaGrange	706-845-9370	Lithonia	770-981-9011

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 requested to remain at the facility during the surgical procedure of adult patients; 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. All minor patient need an adult guardian or parent present in the center at all times. Patients will normally be discharged thirty minutes after surgery; a family member will need to drive them home at this time.

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 ☐ Hollstrom ☐ Taylor ☐ Shaheed ☐ Curry ☐ Schwartz

☐ Dombek ☐ Weinstein ☐ Roman ☐ Patton ☐ Menke ☐ A. Menke ☐ Sun ☐ Lotufo

Which office location? ☐ Buckhead ☐ College Park ☐ Conyers ☐ Covington ☐ Decatur ☐ LaGrange

☐ Fayetteville ☐ Jonesboro ☐ Newnan ☐ Peachtree City ☐ Stockbridge ☐ Lithonia ☐ Smyrna ☐ Carrollton

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

L6

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 OFYOUR 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, and 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 which 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 has 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: Simone Davis
Telephone: (678) 561-9000 Fax: (678) 854-1977
E-Mail: simone@ankleandfootcenters.com
Address: 1975 Highway 54 West, Suite 205
Fayetteville, GA 30214

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: _____

_____

Original to patient – copy in surgery chart

PATIENT AUTHORIZATION FORM
FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize the International Center for Foot and Ankle Surgery and/or its staff to disclose my individually identifiable health information as described below. I understand that this authorization is voluntary. I may refuse to sign this authorization. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Patient Name: _____ Date of Birth: _____

Person(s)/Organization information shall be released to:

_____
_____
_____

For the purpose of: _____

Date(s) of Service: _____

Information to be released:

- ☐ Office Notes
- ☐ Lab Reports
- ☐ Radiology Reports
- ☐ X-ray Films
- ☐ Other (be specific) _____

_____

The following must be completed only if a health plan or a health care provider has requested the authorization:

Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? ___ Yes _x_ No

I understand that my health care and the payment for my health care will not be affected if I do not sign this form.
Initials: _____

I understand that I may see and request copies (applicable charges will apply) of the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it. Initials: _____

The patient or patient's representative must read and initial the following statements for all authorizations:

I understand that this authorization will expire on __/__/____ (DD/MM/YYYY) Initials: _____

I understand that I may revoke this authorization at any time by notifying the International Center for Foot and Ankle Surgery in writing, but if I do it won't have any affect on any actions taken before receipt of my revocation. Initials: _____

The International Center for Foot and Ankle Surgery will not condition my treatment on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. Initials: _____

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Printed name of Patient's Representative (if applicable) Relationship to the Patient (if applicable)

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 G. Clay Taylor, DPM Craig Sun, DPM
Gordon Patton, DPM Michael F. Dombek, DPM Richard Hollstrom, DPM Robert B. Weinstein, DPM Scott R. Roman, DPM
Christopher R. Menke, DPM Allison J.A Menke, DPM Nathan H. Schwartz, DPM Christopher Lotufo, DPM Craig Sun, DPM
Naim G. Shaheed, DPM Jocelyn K. Curry, DPM

Buckhead (404) 351-5015 College Park (404) 768-3668 Conyers (770) 483-1100 Covington (678) 342-3088 Decatur (404) 508-4062
Fayetteville (770) 460-7600 Jonesboro (770) 478-3668 Newnan (770) 251-6100 Peachtree City (770) 487-6716 Stockbridge (770) 474-4395
Smyrna (770) 434-7078 Carrollton (770) 838-4151 LaGrange (706) 845-9370 Lithonia (770) 981-9011

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 _____.
Date Time Location

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 me 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 Number: _____

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 Number_____

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 dystropy (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

International Center for Foot and Ankle Surgery does not honor Advanced Directives for Healthcare
I have read the above statements and all of my questions have been sufficiently answered and explained.

Patient Signature: _____ Date: _____

Billing Process

The International Center for Foot and Ankle 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 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.

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 any implants used during surgery may be billed by Access Mediquip, an implant billing company. Access Mediquip may also bill me any co-insurance fees that are due.

I understand that if I am a Medicare beneficiary my medical record is subject to review. I also understand that my physician may have a financial interest or ownership in the International Center for Foot and Ankle Surgery.

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

Printed Name of Patient or Responsible Party: _____

PATIENT RIGHTS & RESPONSIBILITIES

It's your health. It's your responsibility.

The International Center for Foot and Ankle Surgery (ICFAS) provides medical treatment without regard to race, creed, sex, nationality, gender or source of payment. As our patient, you are entitled to safe, considerate, respectful and dignified care at all times.

As a patient at ICFAS, you have the right to:

- ☞ Receive care in a safe setting, free from any form of abuse or harassment.
- ☞ Receive appropriate assessment and management of pain.
- ☞ Have a family member or representative of your choice and your personal physician promptly notified of your admission to the surgery center.
- ☞ Receive treatment free from restraints or seclusion unless clinically necessary to provide acute medical, surgical or behavioral care.
- ☞ Wear appropriate personal clothing or religious, cultural or other symbolic items that do not interfere with recommended treatment or procedures. You will receive respectful consideration of your beliefs in regard to these items.

You are entitled to personal and informational privacy as required by law. This includes your right to:

- ☞ Know the identity, professional status, role and business relationship of all those involved in your care.
- ☞ Undergo examinations in reasonably private visual and auditory surroundings.
- ☞ Request that a person of your own gender be present during physical examinations.
- ☞ Review or obtain copies of your medical records and financial records.
- ☞ Obtain a list of certain disclosures of your medical information made in accordance with state and federal laws.
- ☞ Request an amendment to your medical records if you believe information is not correct.
- ☞ Have your medical records read and discreetly discussed only by those directly involved with or related to your care, by anyone to whom you have given permission, or by those who have legal custody, or other authorized individuals.
- ☞ Experience confidentiality in all aspects of your care and payment sources. The International Center for Foot and Ankle Surgery will involve only those acting in an official capacity for the surgery center, and will exclude any individuals you choose to exclude.
- ☞ Protective privacy when necessary to provide for your personal safety or for the safety of other patients, visitors, and staff.
- ☞ Preservation of the safety and security of your personal belongings from search or seizure except for reasonable cause.

As a patient, you have the right to:

- ☞ Be involved in all aspects of your care and to participate in decisions regarding your care. This includes your right to be informed of the diagnosis and prognosis of your condition.
- ☞ Be informed of appropriate treatment options, including their risks and benefits, alternative treatment options, the consequences of no treatment, and the results of medical care provided –including any unanticipated adverse outcomes.
- ☞ Request restrictions on how your medical and financial records are used and shared. However, ICFAS may choose not to accept these restrictions if necessary to your care.
- ☞ Have access to appropriate staff for the purpose of reporting suspected child abuse or adult abuse.
- ☞ Communicate with individuals outside the surgery center.
- ☞ Have access to an interpreter, at no cost to you, if you are not fluent in English.
- ☞ Have access to auxiliary aids and assistive animals if you have an impairment which requires use of these.
- ☞ Have your instructions including Living Will, Durable Power of Attorney for Healthcare, and organ/tissue donations implemented.
- ☞ Meet with a clinical ethicist and/or Pastoral Services representative to discuss personal ethics, professional responsibilities, surgery center policies, social values and conflict resolution.
- ☞ Refuse treatment (to the extent permitted by law).
- ☞ Examine and receive an explanation of all bills regardless of the source of payment.
- ☞ Request for surgery center to communicate with you at an alternative telephone number or address.

You will not be required to undergo involuntary treatment or be subjected to research or experimental procedures without your written consent, or that of your legal representative. You will not be transferred to another facility or location without a complete explanation of the necessity for such an action.

You and your family/guardian have the right to express dissatisfaction regarding the quality of care without jeopardizing future care. You have the right to expect plans for reasonable continuity of care after discharge so that continuing health care needs may be met.

PATIENT RIGHTS & RESPONSIBILITIES

It's your health. It's your responsibility.

As a patient, you are encouraged to promote your own safety by becoming an active, involved and informed member of your health care team. This includes your right to:

- Ask questions if you are concerned about your health or safety.
- Verify the site/side of the body that will be operated on prior to the procedure.
- Remind staff to check your ID before medications are given, blood samples are obtained or prior to an invasive procedure.
- Remind the care-givers to wash their hands prior to giving care.
- Be informed about which medications you are taking and why you are taking them.
- Remember to look for identification to be worn on all surgery center employees.

As a patient at ICFAS, you are responsible for providing accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to your health.
As a patient at ICFAS, it is your responsibility to:

- Ask questions
- Follow the treatment plan recommended by your caregivers
- Accept personal responsibility if you refuse treatment
- Provide a copy of your Advance Directives, Living Will, Durable Power of Attorney for Healthcare, and organ/tissue donation authorizations
- Observe center and clinic rules
- Adhere to the surgery's center NO smoking policy
- Recognize and respect the rights of other patients, families and staff
- Report perceived risks and unexpected changes in your condition to your health care provider
- Fulfill your financial obligations

You are encouraged to ask questions about any of these rights that you do not understand. If you would like to express concerns regarding the quality of care you receive at ICFAS, or to report complaints or compliance issues please feel free to contact:

Medical Management Solutions
1975 Highway, 54 West, Suite 205
Fayetteville, GA 30214
Phone: (678) 561-9000

Georgia Department of Human Resources
Office of Regulatory Services, 2 Peachtree St. NW
Atlanta, GA 30303

Joint Commission on Accreditation of Healthcare Organizations
(630) 792-5636
complaint@jcaho.org

Medicare Beneficiary Ombudsman
Medicare Complaint Department
www.medicare.gov

Patient Name: _____

Patient Signature: _____ **Date:** _____