ankle&foot CENTERS OF GEORGIA

Save Completed Form

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 City State Zip Code

Home Ph. Work Ph. Social Security #

Email Address: Cell Ph. Cell Ph. Carrier:

May we send you appointment reminders? ☐ No ☐ Text ☐ Email

Date of Birth Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed

Race/Ethnicity Preferred Language

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.

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.

Have you been seen by a podiatrist before? ☐ YES ☐ NO

If yes, please list the name of the podiatrist: _____ Last Visit: _____

My primary foot or ankle problem today is:

_____

Name of Primary Care Physician

Doctor's Name: _____ Phone Number: _____

Address: _____

Pharmacy Information: _____

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	EMPHYSEMA	☐ YES ☐ NO	RHEUMATIC FEVER	☐ YES ☐ NO
ANEMIA	☐ YES ☐ NO	HIGH BLOOD PRESSURE	☐ YES ☐ NO	THYROID DISEASE	☐ YES ☐ NO
TUBERCULOSIS	☐ YES ☐ NO	ARTHRITIS	☐ YES ☐ NO	BRONCHITIS	☐ YES ☐ NO
CANCER/TUMOR	☐ YES ☐ NO	DIABETES	☐ YES ☐ NO	OTHER: _____	☐ YES ☐ NO
EPILEPSY/SEIZURE	☐ YES ☐ NO	KIDNEY TROUBLE	☐ YES ☐ NO		
SKIN RASH/HIVES	☐ YES ☐ NO	STOMACH ULCERS	☐ 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.		**2.**	
3.		**4.**	

Patient Name: DOB:

What is your Height? _____ Feet____Inches What is your weight? _____pounds

Have you ever tested positive for the following:

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

Social History:

Do you currently smoke cigarettes or use other types of tobacco? ☐ Yes ☐ No, I have never smoked ☐ No, but I am a former smoker.

If you quit smoking, how long ago did you quit? _____

Please check if you currently use any of these tobacco products ☐Cigars ☐Pipes ☐Chewing tobacco/snuff

Alcohol Use: ☐ Never ☐ 2-3 times per month ☐ 2-3 times per week ☐ 2-3 times per day

Do you use any recreational drugs? ☐ YES ☐ NO If YES, what type_____

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

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 **March 1, 2013**, 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.

The following is the Notice of Privacy Practices of Ankle & Foot Centers of Georgia, LLC as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated there under, commonly known as HIPAA. HIPAA requires Covered Entity by law to maintain the privacy of your protected health information and to provide you with notice of Covered Entity's legal duties and privacy policies with respect to your protected health information. We are required by law to abide by the terms of this Privacy Notice.

Uses and Disclosures of Protected Health Information

We collect protected health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your protected health information that is protected by law broadly includes any past, present and future healthcare information. Your protected health information includes any information that is created or received through oral, written or electronic communications by certain health care entities, including health care providers, such as physicians and hospitals, as well as, health insurance companies or plans. The law specifically protects health information that contains data consisting of eighteen (18) identifiers described in the HIPAA Privacy Rule including but not limited to your name, address, social security number, date of birth and others that could be used to identify you as the individual patient who is associated with that health information.

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. We may use and disclose your protected health information to manage and coordinate your healthcare and inform you of treatment alternatives that may be of interest of you. This may include telling you about treatments, services, products and/or other healthcare providers. There are some services provided at Ankle & Foot Centers of Georgia, LLC through contracts with business associates. When these companies are contracted to perform services for Ankle & Foot Centers of Georgia, LLC, we may disclose your protected health information to these companies so that they can perform the job we have asked them to do. However, to protect your protected health information, we require the business associate to appropriately safeguard your protected health information.

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: Without your consent, we may use or disclose your protected health information in order to provide you with services and the treatment you require or request, or to collect payment for those services, and to conduct other related health care operations otherwise permitted or required by law. In addition, we are permitted to disclose your protected health information within and among our workforce in order to accomplish these same purposes. However, even with your permission, we are still required to limit such uses or disclosures to the minimal amount of protected health information that is reasonably required to provide those services or complete those activities.
Examples of treatment activities include: (a) the provision, coordination, or management of health care and related services by health care providers; (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another.
Examples of payment activities include: (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.
Examples of health care operations include: (a) development of clinical guidelines; (b) contacting patients with information about treatment alternatives or communications in connection with case management or care coordination; (c) reviewing the qualifications of and training health care professionals; (d) underwriting and premium rating; (e) medical review, legal services, and auditing functions; and (f) general administrative activities such as customer service and data analysis.

Generally, we may not use or disclose your protected health information without your permission. Further, once your permission has been obtained, we must use or disclose your protected health information in accordance with the specific terms that permission. The following uses and disclosures require an authorization:

(1) Most uses and disclosures of psychotherapy notes;
(2) Uses and Disclosures of protected health information for marketing purposes unless (i) the communication occurs face-to-face; (ii) consists of marketing gifts of nominal value; (iii) is regarding a prescription refill reminder that is for a prescription currently prescribed or a generic equivalent; (iv) is for treatment pertaining to existing condition(s) and Ankle & Foot Centers of Georgia, LLC does

not receive any financial remuneration in either case or cash equivalent; and/or (v) communication from a healthcare provider to recommend or direct alternative treatments, therapies, healthcare providers, or settings of care when the company does not receive any financial remuneration for making the communication; and (3) Disclosures that constitute a sale of protected health information

The following are the circumstances under which Ankle & Foot Centers of Georgia, LLC is permitted by law to use or disclose your protected health information.

We may use and disclose your protected health information to provide a reminder to you about an appointment you have for treatment or medical care at Ankle & Foot Centers of Georgia, LLC.

We may release protected health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine cause of death. We may also release protected health information to funeral directors as necessary for them to carry out their duties.

Inmates

If you are an inmate of a correctional institution or under the custody of law enforcement official, we may release your protected health information to the correctional institution or law enforcement official. The release of protected health information is required: (1) for the institution to provide you with health care; (2) to protect your health and safety of others; and (3) for the safety and security of the correctional institution.

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.

Right to Request Restriction on Disclosures to Health Plans for Services Paid for In Full at Time of Service: You have the right under the American Recovery and Reinvestment Act, Section 13405(a) to request Ankle & Foot Centers of Georgia, LLC to restrict disclosures of protected health information to a health plan for purposes of carrying out payment or healthcare operations if the protected health information pertains solely to a healthcare item or service for which Ankle & Foot Centers of Georgia, LLC has been paid out of pocket in full at time of service.

Right to Receive Confidential Communications: You have the right to receive confidential communications of your protected health information. We may require written requests. We may condition the provision of confidential communications on you providing us with information as to how payment will be handled and specification of an alternative address or other method of contact. We may require that a request contain a statement that disclosure of all or a part of the information to which the request pertains could endanger you. We may not require you to provide an explanation of the basis for your request as a condition of providing communications to you on a confidential basis. We must permit you to request and must accommodate reasonable requests by you to receive communications of protected health information from us by alternative means or at alternative locations.

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 to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. *Examples of instances in which we are required to disclose your protected health information include*: (a) public health activities including, preventing or controlling disease or other injury, public health surveillance or investigations, reporting adverse events with respect to food or dietary supplements or product defects or problems to the Food and Drug Administration, medical surveillance of the workplace or to evaluate whether the individual has a work-related illness or injury in order to comply with Federal or state law; (b) disclosures regarding victims of abuse, neglect, or domestic violence including, reporting to social service or protective services agencies; (c) health oversight activities including, audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs; (d) judicial and administrative proceedings in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or other lawful process; (e) law enforcement purposes for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or reporting crimes in emergencies, or reporting a death; (f) disclosures about decedents for purposes of cadaveric donation of organs, eyes or tissue; (g) for research purposes under certain conditions; (h) to avert a serious threat to health or safety; (i) military and veterans activities; (j) national security and intelligence activities, protective services of the President and others; (k) medical suitability determinations by entities that are components of the Department of State; (l) correctional institutions and other law enforcement custodial situations; (m) covered entities that are government programs providing public benefits, and for workers' compensation. We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Right to Inspect and Copy Your Protected Health Information: Your designated record set is a group of records we maintain that includes Medical

records and billing records about you, or enrollment, payment, claims adjudication, and case or medical management records systems, as applicable. You have the right of access in order to inspect and obtain a copy your protected health information contained in your designated record set, *except for* (a) psychotherapy notes, (b) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and (c) health information maintained by us to the extent to which the provision of access to you would be prohibited by law. We may require written requests. We must provide you with access to your protected health information in the form or format requested by you, if it is readily producible in such form or format, or, if not, in a readable hard copy form or such other form or format. We may provide you with a summary of the protected health information requested, in lieu of providing access to the protected health information or may provide an explanation of the protected health information to which access has been provided, if you agree in advance to such a summary or explanation and agree to the fees imposed for such summary or explanation. We will provide you with access as requested in a timely manner, including arranging with you a convenient time and place to inspect or obtain copies of your protected health information or mailing a copy to you at your request. We will discuss the scope, format, and other aspects of your request for access as necessary to facilitate timely access. If you request a copy of your protected health information or agree to a summary or explanation of such information, we may charge a reasonable cost-based fee for copying, postage, if you request a mailing, and the costs of preparing an explanation or summary as agreed upon in advance. We reserve the right to deny you access to and copies of certain protected health information as permitted or required by law. We will reasonably attempt to accommodate any request for protected health information by, to the extent possible, giving you access to other protected health information after excluding the information as to which we have a ground to deny access. Upon denial of a request for access or request for information, we will provide you with a written denial specifying the legal basis for denial, a statement of your rights, and a description of how you may file a complaint with us. If we do not maintain the information that is the subject of your request for access but we know where the requested information is maintained, we will inform you of where to direct your request for access.

Right to Amend Your Protected Health Information: You have the right to request that we amend your protected health information or a record about you contained in your designated record set, for as long as the designated record set is maintained by us. We have the right to deny your request for amendment, if: (a) we determine that the information or record that is the subject of the request was not created by us, unless you provide a reasonable basis to believe that the originator of the information is no longer available to act on the requested amendment, (b) the information is not part of your designated record set maintained by us, (c) the information is prohibited from inspection by law, or (d) the information is accurate and complete. We may require that you submit written requests and provide a reason to support the requested amendment. If we deny your request, we will provide you with a written denial stating the basis of the denial, your right to submit a written statement disagreeing with the denial, and a description of how you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services ("DHHS"). This denial will also include a notice that if you do not submit a statement of disagreement, you may request that we include your request for amendment and the denial with any future disclosures of your protected health information that is the subject of the requested amendment. Copies of all requests, denials, and statements of disagreement will be included in your designated record set. If we accept your request for amendment, we will make reasonable efforts to inform and provide the amendment within a reasonable time to persons identified by you as having received protected health information of yours prior to amendment and persons that we know have the protected health information that is the subject of the amendment and that may have relied, or could foreseeably rely, on such information to your detriment. All requests for amendment shall be sent to Ankle & Foot Center of Georgia, LLC's Privacy Officer.

Right to Receive an Accounting of Disclosures of Your Protected Health Information: You have the right to receive a written accounting of all disclosures of your protected health information that we have made within the six (6) year period immediately preceding the date on which the accounting is requested. You may request an accounting of disclosures for a period of time less than six (6) years from the date of the request. Such disclosures will include the date of each disclosure, the name and, if known, the address of the entity or person who received the information, a brief description of the information disclosed, and a brief statement of the purpose and basis of the disclosure or, in lieu of such statement, a copy of your written authorization or written request for disclosure pertaining to such information. *We are not required to provide accountings of disclosures for the following purposes*: (a) treatment, payment, and healthcare operations, (b) disclosures pursuant to your authorization, (c) disclosures to you, (d) for a facility directory or to persons involved in your care, (e) for national security or intelligence purposes, (f) to correctional institutions, and (g) with respect to disclosures occurring prior to 4/14/03. We reserve our right to temporarily suspend your right to receive an accounting of disclosures to health oversight agencies or law enforcement officials, as required by law. We will provide the first accounting to you in any twelve (12) month period without charge, but will impose a reasonable cost-based fee for responding to each subsequent request for accounting within that same twelve (12) month period. All requests for an accounting shall be sent to Ankle & Foot Center of Georgia, LLC's Privacy Officer.

Questions or Complaints: If you have questions regarding this Notice or if you believe your privacy rights have been violated or you wish to file a complaint about our privacy practices, you may contact the Ankle & Foot Centers of Georgia, LLC's Privacy Officer by phone or submission of your complaint in writing by mail to the Ankle & Foot Centers of Georgia, LLC's Privacy Officer. You also have the right to file your complaint with the Secretary of DHHS. A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this Privacy Policy. A complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you knew or should have known that the act or omission complained of occurred. You will not be penalized for filing any complaint. As required by law, Ankle & Foot Centers of Georgia, LLC will notify you in the event that a breach of your protected health information occurs.

Amendments to this Privacy Policy: We reserve the right to revise or amend this Privacy Policy at any time. These revisions or amendments may be made effective for all protected health information we maintain even if created or received prior to the effective date of the revision or amendment. We will provide you with notice of any revisions or amendments to this Privacy Policy, or changes in the law affecting this Privacy Notice, within 60 days of the effective date of such revision, amendment, or change.

On-going Access to Privacy Policy: We will provide you with a copy of the most recent version of this Privacy Policy at any time upon your written request sent to Ankle & Foot Centers of Georgia, LLC's Privacy Officer. For any other requests or for further information regarding the privacy of your protected health information, and for information regarding the filing of a complaint with us, please contact Ankle & Foot Centers of Georgia, LLC's Privacy Officer.

All Other Situations, With Your Specific Authorization: Except as otherwise permitted or required, as described above, we may not use or disclose your protected health information without your written authorization. Further, we are required to use or disclose your protected health information consistent with the terms of your authorization. You may revoke your authorization, in writing, to use or disclose any protected health information at any time, except to the extent that we have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

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: Todd Domangue
Telephone: (678) 561-9000 Fax: (678) 854-1977
E-Mail: tdomangue@ankleandfootcenters.com
Address: 1975 Hwy 54 West, Suite 205
Peachtree City, GA 30269

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: _____

_____

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

Patients:

To ensure your privacy, please answer the following questions and notify the Front Office Staff whenever this information change.

1. Do we have permission to leave a message on the phone number(s) you have provided to us?

   YES ☐ OR NO ☐

2. May we discuss your Medical Information with family and friends?

   YES ☐ OR NO ☐

   OR:

   Please list names of people we can discuss your medical care with:

   Name: _____ Phone #: _____

   Pt's Relationship to contact: ☐ Spouse ☐ Parent ☐ Child ☐ Friend

   Name: _____ Phone #: _____

   Pt's Relationship to contact: ☐ Spouse ☐ Parent ☐ Child ☐ Friend

   Name: _____ Phone #: _____

   Pt's Relationship to contact: ☐ Spouse ☐ Parent ☐ Child ☐ Friend

3. If someone calls for you or asks for you while you are in our office, do we have permission to tell them you are here?

   YES ☐ OR NO ☒

_____ _____

Patient Signature Original Date

_____

Patient Name (Printed)

Save Completed Form

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN
APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Ankle and Foot Centers of Georgia, LLC, Ankle and Foot Centers of Georgia PC, Decatur Center for Foot and Ankle Surgery, International Center for Foot and Ankle Surgery, Newnan Center for Foot and Ankle Surgery, Windy Hill Associates PC, The Foot Surgery Center as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan.

This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 ____.

X_____(SEAL)
(patient signature)

_____
(please print patient name)

X_____(SEAL)
(signature of Guardian if applicable)

ankle&foot CENTERS OF GEORGIA

Payment Authorization Form

We are committed to meeting your healthcare needs and keeping your insurance and other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner for all our patients, we ask that you adhere to our practice's financial policy. By signing below, you are agreeing to its terms for the following companies: Ankle and Foot Centers of Georgia, LLC, Ankle and Foot Centers of Georgia PC, DeKalb Center for Foot and Ankle Surgery, International Center for Foot and Ankle Surgery, Newnan Center for Foot and Ankle Surgery, Windy Hill Associates PC, The Foot Surgery Center.

1. I am ultimately responsible for payment of charges for services I receive from this practice including those covered by my insurance. As a convenience, this practice will submit claims for reimbursement with my insurance provider; however, all payment responsibility is ultimately mine.
2. Some immediate payment may be expected at the time of service. This may include a co-pay and additional payment if this practice determines that the cost of my visit today will not be reimbursed by my insurance provider. This often happens if my deductible is not yet satisfied.
3. This practice may deny service or charge a service fee for failure to pay a co-pay at the time of service.
4. It is my responsibility to provide my current address, telephone number, email address, and insurance information at each visit.
5. I agree to provide the above practice and/or its designated payment agent with my debit/credit card or ACH information.
6. I understand that my signature and payment information will be maintained on file digitally for future use by the practice. The applicable payment card or ACH information will be truncated and "tokenized" by the payment agent in order to help maintain the security of my payment information. Card or ACH information will be obtained through a card swipe, manual entry from card, void check, or orally in person or over the phone.
7. If warranted, this practice may offer the option of paying my share of costs via an automated payment plan. I understand that I may incur some interest expense beyond my balance in exchange for this convenience. I can avoid interest charges by paying my bill immediately if required or by its due date.
8. I authorize the above practice and/or its designated payment agent to apply charges to my payment card and/or ACH account for all amounts owed to the practice for medical visits, procedures or supplies, including (i) amounts agreed as part of a payment plan, (ii) copayments, (iii) coinsurance (after application of insurance proceeds), (iv) amounts not covered by insurance and/or (v) fees (if applicable) charged by the practice for failure to keep a scheduled appointment or provide timely notice of appointment cancellation.
9. In the case of a patient balance that is not satisfied by a charge to my payment method or a payment plan, I may receive a monthly statement for any outstanding balance. I am responsible for paying this balance by its due date in order to avoid paying possible interest on the balance.
10. Transaction receipts will be maintained in the patient file or will be emailed to me if I provide and maintain a valid email address.
11. I authorize the above practice and/or its designated provider to send electronic account statements and invoices to my email address on file. I understand that it is my responsibility to maintain a current email address on file and that I will not receive a mailed copy of any electronic statement.

This authorization will remain in effect until I provide written notice of cancellation to the practice. Authorization for services already rendered cannot be cancelled or refunded. I agree to notify the practice in writing of any changes in my payment or other information.

Name as it Appears on Card/ACH Account

Email Address

Billing Address City State Zip Code

Phone Number

SIGNATURE DATE

Revised: 06-20-2016