New Patient Information

Patient Name: ______________________________________ Date of Birth:_____/_____/_____ Age:____ Sex: ☐ M ☐ F
Last First MI MM DD YYYY

Home Address:____ SS#:_____________________
Street City State Zip

Home: (______) _________-_________ Cell: (________) _________-_________ Work: (________) _________-________

E- Mail: ____

Primary Care Doctor:_______________________________________ Phone: (_________) _________-___________

Pharmacy: ________________________ Location: ___________________ Phone #:(________)-__________-___________

How did you hear about the practice? ☐ Internet/Google ☐ Friend/Family ☐ Insurance Company ☐ Facebook
☐ Doctor Referral (Who?)__________________________ ☐ Other __________________________________

Emergency Contact Information

Emergency Contact: ______________________Relationship:_______________________Phone#: (______) ______-_____

Is there a Family Member or Other Person You Would Like For Us To Share YOUR Medical Information?
☐ Yes ☐ No If Yes, Name: __________________ Relationship:__________________ Phone #: (_____) ______-_____

Insurance Information

Primary Insurance Company Name: ____

Address:____ Phone #: (________) _______-________
Street City State Zip

Insured Name:___________________DOB_________________ Relationship to Patient___________________
Policy #____________________ Group #___________________

Secondary Insurance Company Name: ____

Address:____ Phone #: (______) _______-_________
Street City State Zip
Insured Name:____________________ DOB_____________ Relationship to Patient__________________
Policy #_________________ Group #____________________

Allergies

☐ Tape ☐ Latex ☐ Sulfa ☐ Iodine ☐ Anesthesia __________________ ☐ Other_______________ ☐ None Known

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Medications

Please List All Medications You Are Currently Taking (Include Prescriptions, Over-the-Counter and Herbal Supplements):

____________________________ __________________________ ______________________
____________________________ __________________________ ______________________

_____________________________ ___________________________ ________________________

Surgical History

Please List All Prior Surgeries:

TYPE OF SURGERY Date Type of Surgery Date

_______________________________________ _______________________________________
_______________________________________ _______________________________________
_______________________________________ _______________________________________

Social History

Use of Alcohol: Never Socially Daily Rare

Use of Tobacco: Nonsmoker Current Smoker Former Smoker ________Packs/Day for ___________Years
Occasional

Use of Recreational Drugs: Never Occasional Daily Quit

Employer: ____ Occupation: ____

Medical History

Please check the box if YOU currently or in the past have had the following symptoms:

Arthritis:	Rheumatoid Osteo Gout Other ________________________________
EENT:	Tonsillitis Glaucoma Cataracts Migraines Hearing Aid/Deficit
Gastrointestinal:	Ulcers Acid Reflux Hernia Irritable Bowel Syndrome Hemorrhoids
Genito-Urinary:	Kidney/Bladder Infections Kidney Stones STD Prostate Disorders
Major illnesses:	Diabetes Type I/ Type II High Cholesterol Cancer HTN Stroke Pacemaker Mitral Valve Prolapse Heart Disease Heart Murmur Other ______________________
Psychological:	Anxiety Depression Drug/Alcohol Dependency Other __________________________
Respiratory:	Asthma TB COPD Sinus Problems Emphysema Lung Disease SOB
Skin Disorders:	Psoriasis Skin Cancer
Vascular Disease/ Blood Disorders:	Poor Circulation Vein Problems Blood Clot Leg Ulcers Anemia Transfusions Other _______________________________________
Other Illnesses:	Epilepsy/ Seizures Thyroid Disease HIV/ Aids Hepatitis Other __________________

Others: Are you pregnant? ☐Yes ☐No Are you nursing? ☐Yes ☐No
HEIGHT: _____________ WEIGHT:____________ SHOE SIZE:__________

Family History

Do you Have A Family History of:

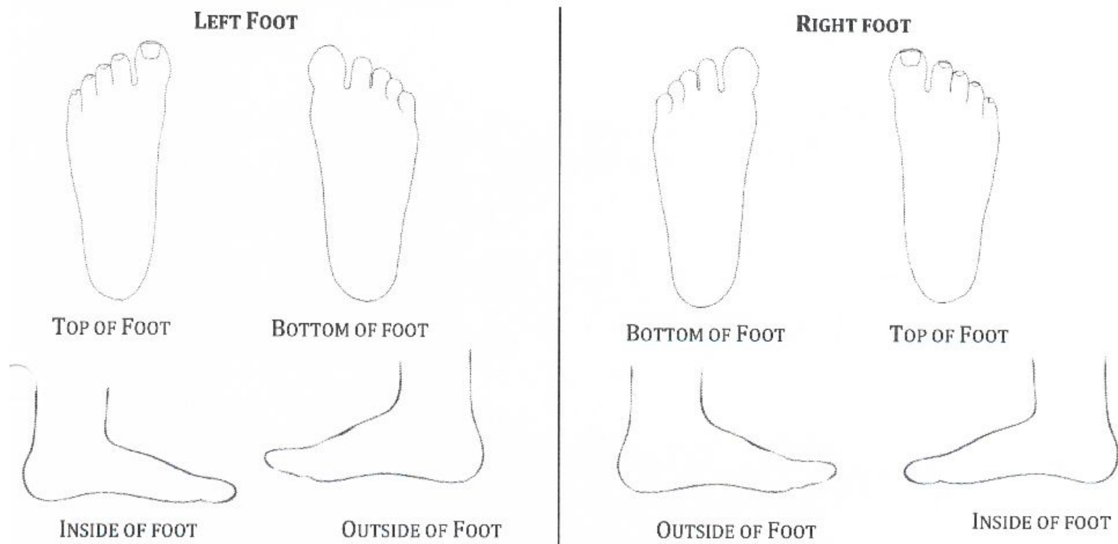
☐Thyroid Disease ☐Diabetes: Type I or Type II ☐Cancer
☐High Blood Pressure ☐Stroke ☐Other: ____________________________________

Current Problem

What specific problems bring you to our office today?____

Are you interested in Regenerative medicine for pain relief? (Circle One) Yes / No

Where is the pain/problem located? Please mark on the pictures below.



PLEASE READ THE ACKNOWLEDGEMENT ON THE NEXT PAGE AND SIGN IT. THANK YOU.
To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

_________________________________ _________________________
Print name of patient , parent, or guardian Signature

_________________________________ _________________________
If other than patient, Relationship to patient Date

PATIENT HIPAA ACKNOWLEDGMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgment of Practice's *Notice of Privacy Practices*:
By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:
I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name:_____________________________ Last four digits SSN (required):______________________

Print Name:_____________________________ Last four digits SSN (required):______________________

III. Request to receive Confidential Communications by Alternative Means:
As provided by the Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications To me by the alternative means that I have listed below.

Home Telephone Number:

____

___OK to leave message with detailed information
___Leave message with call back numbers only

Written Communication Address:

____

___OK to mail to address listed above
___E-mail me at:______________________________

Work Telephone Number:

____

___OK to leave message with detailed information
___Leave message with call back numbers only

Fax Number:

____

___OK to Fax at the number listed above
___E-mail me at:______________________________

Other:____

____________________________ ____________________ ___________________________________
Name of Patient DOB Signature of Patient/Parent/Guardian

FINANCIAL POLICY

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE: We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However; that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any convenience, which is usually 20% of the allowed amount for an item or service.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

COPAYMENTS AND DEDUCTIBLES: All copayments and deductibles must be paid at the time of service. This arrangement is part of your contract with the insurance company. Failure on our part to collect copayments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your copayment at each visit.

SELF PAY: Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment of these services.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Obtaining referrals from your primary physician and keeping track of your visits is your responsibility. If you do not have a valid referral at the time of your visit, your appointment will be rescheduled.

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility. Your insurance benefit is a contract between you and your insurance company.

PATIENT BILLING: You will be sent up to three notices for your financial responsibility (co-insurance, deductible) after payment and-or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account may be forwarded to collections with interest accruing on the balance. It is also your responsibility to pay for the interest accrued if sent to collections. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Credit/Debit Cards, Checks. An additional $25.00 will be added to your statement if the check is returned for insufficient funds. In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance.

I have read the above policy regarding my financial responsibility to Atlanta Total Foot and Ankle Care for medical services provided. I agree to pay Atlanta Total Foot and Ankle Care any balance unpaid by my insurance carrier for myself or the below named person.

Assignment of Benefits

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Atlanta Total Foot and Ankle Care all insurance benefits, payable to me for the services rendered. I understand that I am responsible for payment of deductibles, copayments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

Print Name: ____ Signature: ______________________________________

Atlanta Total Foot and Ankle Care

Relationship to Patient: ________________________________ Date: ____

E - PRESCRIBING CONSENT

E- PRESCRIBING IS DEFINED BY A PHYSICIAN'S ABILITY TO ELECTRONICALLY SEND AN ACCURATE, ERROR FREE, AND UNDERSTANDABLE PRESCRIPTION DIRECTLY TO YOUR PHARMACY. CONGRESS HAS DETERMINED THAT THE ABILITY TO ELECTRONICALLY SEND PRESCRIPTIONS IS AN IMPORTANT ELEMENT IN IMPROVING THE QUALITY CARE OF PATIENT CARE. E-PRESCRIBING GREATLY REDUCES PATIENT ERRORS AND ENHANCES PATIENT SAFETY. THE MEDICARE MODERNIZATION ACT 2003, LISTED STANDARDS THAT HAVE TO BE INCLUDED IN AN E -PRESCRIBING PROGRAM. THESE INCLUDE: (1) FORMULARY AND BENEFIT TRANSACTIONS WHICH GIVES THE PRESCRIBER INFORMATION ABOUT WHICH DRUGS ARE COVERED BY A DRUG BENEFIT PLAN; (2) MEDICATION HISTORY TRANSACTIONS, WHICH PROVIDES THE PHYSICIAN INFORMATION ABOUT MEDICATIONS THE PATIENT IS ALREADY TAKING TO MINIMIZE ADVERSE DRUG EVENTS. I AUTHORIZE **ATLANTA TOTAL FOOT AND ANKLE CARE** TO VIEW MY EXTERNAL PRESCRIPTION HISTORY VIA ELECTRONIC E- PRESCRIBING SERVICES. I UNDERSTAND THAT PRESCRIPTION HISTORY FROM MULTIPLE, OTHER UNAFFILIATED, PROVIDERS, INSURANCE COMPANIES, PHARMACIES AND PHARMACY BENEFIT MANAGERS MAY BE VIEWABLE BY THE PROVIDERS AND STAFF OF **ATLANTA TOTAL FOOT AND ANKLE CARE** AND IT MAY INCLUDE PRESCRIPTIONS BACK IN TIME FOR SEVERAL YEARS AND MAY INCLUDE PRESCRIPTIONS TO TREAT: HIV, SUBSTANCE ABUSE AND PSYCHIATRIC CONDITIONS. IF APPLICABLE, I UNDERSTAND THAT MY PRESCRIPTION HISTORY WILL BECOME PART OF MY RECORD AT THIS PRACTICE. UNDERSTANDING ALL THE ABOVE, I HEREBY PROVIDE INFORMED CONSENT TO **ATLANTA TOTAL FOOT AND ANKLE CARE** TO ENROLL ME IN THE E-PRESCRIBING PROGRAM. THIS CONSENT WILL REMAIN ENFORCED UNTIL REVOKED OR CHANGED.

I CERTIFY, TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

I GIVE PERMISSION TO THE DOCTORS AT **ATLANTA TOTAL FOOT AND ANKLE CARE** TO ADMINISTER AND PERFORM ANY DIAGNOSTIC, THERAPEUTIC AND/OR OPERATIVE PROCEDURES AS MAY BE DEEMED MEDICALLY NECESSARY IN DIAGNOSIS AND/OR TREATMENT OF MY CONDITION.

PATIENT/MINORS UNDER THE AGE OF 18, WILL NOT BE TREATED WITHOUT A PARENT OR LEGAL GUARDIAN PRESENT. IF ANOTHER FAMILY MEMBER, CARETAKER OR FRIEND, OVER THE AGE OF 18 WILL BE PRESENT' WRITTEN CONSENT FROM THE PARENT/LEGAL GUARDIAN STATING AS SUCH MUST BE PRESENTED AT THE TIME OF THE APPOINTMENT. THANK YOU.

________________________________	________________________________
NAME OF PATIENT	PATIENT SIGNATURE
________________________________	________________________________
NAME OF PARENT/LEGAL GUARDIAN	PARENT/LEGAL GUARDIAN SIGNATURE

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Date