Keith Rouse, DPM, FACFAS, FAENS   Samuel Hall, DPM   David Valbuena, DPM, FACFAS

You are scheduled for an appointment at our office on:

_________________________________ @ _________________________

Welcome to Our Practice

We welcome you to our office and appreciate the opportunity to provide you with medical services. We strive to provide the highest quality of podiatry care to our patients with compassion and integrity.
If you are being seen for treatment of your toenails – it is required that you arrive without any polish on your toe nails. If you arrive at your appointment with polish will applied you will be asked to remove the polish before the provider sees you, or you may have to reschedule.

Fees and Payments

We made every effort to keep down the cost of your medical care. It is our policy to ask for payment at the time of your visit. For your convenience we accept Visa, MasterCard, American Express, Discover and personal checks.

Insurance

Your insurance contract is an agreement between you and your insurance carrier. We participate with most major insurance carriers. As required by most insurance carriers, you are responsible for the payment of deductibles, co-payments, and any non-covered services at the time of your visit. It is your responsibility to get an authorization or referral from your insurance company or primary care physician if one is required, or you will be charged the full amount on the day of your visit.

HMO Insurance	You must have a current HMO card and a referral sheet from your primary care Physician/insurance carrier. Be prepared to pay your applicable co-payments or deductible. If you do not have a referral, your visit may be rescheduled or you may be held financially responsible for the entire amount of your visit.
PPO Insurance	You must have a current PPO card. Your applicable co-payment and/or Deductible is due at the time of service.
Medicare	You must have a current Medicare card and be prepared to pay your deductible and/or 20% co-insurance of allowed charges.
No Insurance/Self Pay	Payment in full is due at the time of service.

310 Eisenhower Dr., Bldg 7A   (P) 912-355-6503
Savannah, GA 31406   (F) 912-355-9837

Savannah   Statesboro   Pooler   Richmond Hill   Springfield

georgia foot & ankle
institute p.c.

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PATIENT REGISTRATION

Name: ____________________________ DOB ___/___/_____ SSN:_______________________
Please circle all that apply: (these questions are required by the Federal Government. You may decline to answer by circling DECLINE in each column)

Marital Status	**Race**	**Ethnicity**	**Sex**
Married	American Indian	Hispanic/Latino	Male
Single	Asian	Not Hispanic/Latino	Female
Divorced	African American	Declined	
Separated	Hawaiian/Pacific Islander		
Widowed	White		
Domestic Partner	Other__________		
Decline	Declined		

Mailing Address______________________________ Apt:______________

City:___________________________ State: _____ Zip:________________

Home #:_________________________ Cell #________________________ Okay to leave a message?

YES NO

Email:____

Employer:____

If Patient is a minor or dependent, please complete the following information

Responsible Party:______________________________ DOB: ___/___/_____

SSN: _______________________ Relationship to Patient: ________________

Home #:________________________ Cell #:_________________________

Emergency Contact (Other than responsible party)

Name:________________________________ Relationship to Patient: ________________________

Home #: ______________________________ Cell #: _____________________________

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Patient Acknowledgment

I consent to treatment necessary for the care of the above named patient.
I authorize the release of all medical records to the referring and primary care physicians and to my insurance company if applicable.
I allow fax transmission of my medical records, if necessary.
I acknowledge full financial responsibility for services rendered by Georgia Foot and Ankle Institute.
I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
I further authorize and request that insurance payments be made directly to Georgia Foot and Ankle Institute should they elect to receive such payment.

Patient/Responsible Party Signature________________________________ Date_____________

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Insurance and Injury Questionnaire

All patients are required to answer the following questions

Patient Name____ Date of birth ___________________

Primary Insurance

Insurance Carrier____

ID#___________________________________ Group #___________________________

Policy Holder Information (if other than patient)

Name____ Date of birth _____________________

SSN ______________________________ Relationship to Patient______________________________

Secondary Insurance

Insurance Carrier____

ID#___________________________________ Group #___________________________

Policy Holder Information (if other than patient)

Name____ Date of birth ________________

SSN _____________________________ Relationship to Patient____________________________

Are you receiving Black Lung Benefits? YES NO

Are you receiving Worker's Compensation Benefits? YES NO

Are you receiving treatment for an injury or illness which another party could be held liable or could be cover under no-fault auto insurance? YES NO

Will this claim be filed with any other insurance such as homeowners or business liability, etc?

YES NO

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Acknowledgement of the Privacy Act of 2007
Patient Record of Disclosure

In the general HIPAA privacy rules give individuals the right to request a restriction on uses and disclosures of protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of their home via mail or fax.

I have agreed to let certain individuals participate in discussions and decisions related to my medical care, including but not limited to prescription pick-up and the release of medical records. Therefore, I hereby give permission for Georgia Foot and Ankle Institute to disclose my personal medical information to the following individual(s). I understand that Georgia Foot and Ankle Institute will refuse to discuss my information with anyone not listed below, except in an emergency. I also understand that this consent does not apply to medical providers in the treatment of my care. This form can be amended at any time.

Name:____________________________ Relationship to Patient:________________

Name:____________________________ Relationship to Patient:________________

Name:____________________________ Relationship to Patient:________________

Name:____________________________ Relationship to Patient:________________

In addition to granting permission to the above named individuals, I have received a copy of the Georgia Foot and Ankle Institutes "Notice of Privacy Practices" which details how my personal health information may be used and disclosed as permitted under Federal and State law. I have read and understand the contents of the notice.

__________________________   _______________
Patients Name   Date

__________________________   ______________________________
Signature of Patient/Responsible Party   Witness

STAFF ONLY:
If a patient/responsible party refuses to sign this acknowledgment of Receipt, please document why including the date and time.

____
Presented and Refused Reason   Name/Date/Time

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History and Physical

Patient Name: ________________________________ **DOB**: ___/___/_____

Primary Care Physician: ____
Referring Physician:____

Physical Characteristics
Height: _______________________ Weight: ____________________ Shoe size _________________

Chief Complaint?
How would you describe your problem/reason for your visit?

____

____

History of Present Illness
When did your problem start? ___________________ Is it getting Better / Worse / Same
Have you seen another doctor for this problem YES NO

If yes, which Doctor and when? ____
Have you had any testing for this problem? YES NO

If yes, where? ___________________________ When? ______________________

Do you currently wear or have you ever worn orthotics (shoe inserts)? YES NO

If yes, were they prescribed by a physician or health care provider? YES NO

If yes, did they help you to any significant degree? YES NO

Diabetes and Circulation
Are you under active care for diabetes and/or circulation problems? YES / NO
if yes, Doctors Name: _________________________ Phone #: ____________________
Date you were last seen by the above doctor: ___/___/______

Insulin dependent diabetic? YES / NO Diet Controlled? YES / NO

Number of years Diabetic? _____________ Average blood sugar range: _______________

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Drug Allergies: Please include the name of the medication and the reaction

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Preferred Pharmacy: ______________________________**Location:**______________

Medications: Please list all prescriptions / vitamins/ birth control / over the counter / herbal supplements, their dosage and how many times you take them per day.

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________

Past Medical History

Have you ever been diagnosed or treated for any of the following conditions? Please circle all that apply.

Asthma	Emphysema	Skin Condition	Lung Disease
Allergies	Seizures	Thyroid Disease	Kidney Disease
Alzheimer's	Fibromyalgia	Swelling of Arms/Legs	
Aneurysm	Glaucoma	Ear Infections	
Arthritis	Headaches	Drug Abuse	
Anemia	Heart Disease	Stroke	
ADD/ADHD	Hepatitis	Dementia	
Anxiety	High Cholesterol	Muscle Conditions	
Balance Trouble	High/Low Blood Pressure	Mental Illness	
Cancer	HIV Positive	Diabetes	

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Family History

Please mark any major medical conditions that run in your immediate family (Mother, Father, Maternal/Paternal Grandparents, Aunts, Uncles, Brother, Sistres) and indicate your relationship to that person.

Condition	Relative	Condition	Relative
Asthma		Heart Disease	
Arthritis		High/Low Blood Pressure	
Cancer		Mental Illness	
Dementia/Alzheimer's		Muscle Disease	
Diabetes		Stroke	
Epilepsy/Seizures			

Social History

Do you smoke? YES / NO

If yes, amount? ______________________________ How often? ____________________________

Have you smoked/used tobacco products in the past? YES / NO

If yes, amount? ______________________________ How often? ____________________________

Do you drink alcoholic beverages? YES / NO

If yes, amount? ______________________________ How often? ____________________________

Do you use recreational/illegal drugs?

If yes, what type? ___________________________ How often? ____________________________

Do you drink caffeinated beverages?

If yes, what type? ___________________________ How often? ____________________________

Do you exercise regularly? YES / NO

Do you currently practice any diet restrictions? YES / NO

If yes, what type? ____

Previous Hospitalizations/Surgeries

Reason: Date: Location:

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

Review of Systems: Circle any symptoms you have experienced in the last month

General:
Altered Taste/Smell
Change in Appetite
Weight Loss/Gain

Cardiac:
Chest discomfort
Cold hands/feet
Swelling of Extremities
Heart murmurs
High/low blood pressure

Gastrointestinal
Abdominal Pain
Constipation
Diarrhea
Hemorrhoids
Heartburn
Nausea
Vomiting

Endocrine:
Changes in hair
Excessive hunger/thirst
Change in body odor

Respiratory:
Asthma
Shortness of breath
Cough
Pneumonia
Upper respiratory infections
Tuberculosis

Eyes:
Cataracts
Glaucoma
Changes in vision
Vision correction(glasses, etc)

Ears/Nose/Throat
Changes in hearing
Recent sinus infection
Snoring
Nose bleeds
Mouth Sores

Genital/Urinary
Prostate problems
Sexual Dysfunction
Changes in urinary habits
Kidney stones
Incontinence

Hematologic/Lymphatic
Anemia
Easy bleeding/bruising
Swollen lymph nodes

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Review of Systems: (cont.) Circle any symptoms you have experienced in the last month

Psychiatric:
Personality changes
Depression
Anxiety
Nervousness
Mood swings
Hallucinations
Sleep disturbances

Neurological:
Balance problems
Numbness
Tingling
Burning sensation
Seizures
Falls/Lack of Coordination
Muscle weakness
Headaches

__________________________________ __________________

Patient/Responsible Party Signature Date

Financial Policy

We are dedicated to providing you with the best possible care and to maintain this relationship we find it necessary to implement the following financial policy. Your insurance company requires that you use in-network physicians, labs, hospitals and services in order to receive your maximum benefits. In effort to help you stay compliant with your insurance requirements:

- **Your insurance cards and picture id will need to be presented each time you visit our practice** to assure we have the most recent information. If insurance card is not provided, appointment will be handled as self-pay and payment for services will be collected prior to being seen.

- Co-payments must be paid **prior** to seeing the physician on the date service is rendered. Patients are responsible for their deductibles or charges not reimbursed by insurance. As a courtesy to you we file your insurance claims, therefore it is **your responsibility** to provide our office with up to date billing information.

- Please understand that your insurance is a contract between you and your insurance company and you are ultimately responsible for the bill. If you have not received an explanation of benefits **within 30 days** of seeing your physician you are expected to contact your insurance company for an explanation as to why payment has been delayed.

- Self-pay patients are required to pay for services prior to being seen for their visit and will be balance billed for the remainder of the fees at the time of charge posting.

- It is understood that returned checks made payable to this office for insufficient funds, stop payments or other reason for non-payment will be assessed a **$30.00 NSF fee** for which the patient will be held responsible.

- Patients with no financial ability to pay SJ/C's charges will be screened for eligibility under Medicaid and other state programs and/or evaluated against established guidelines for financial assistance. Please notify the Front Desk staff if you would like more information about how to apply for financial assistance.

- If you do not show up or if you do not cancel your follow up appointment within 24 hours of your scheduled appointment a $**50.00 No Show fee** will be added to your account balance. This includes procedure appointments, new patient exams and office visits. (Effective September 1, 2017)

I have read and understand the financial policy of the practice and agree to be bound by its terms and conditions. I also understand and agree that such terms may be amended occasionally by the practice. I authorize the release of any medical information necessary to process my insurance claim.

_______________________________________ _________________________________

Patient Signature or Responsible Party Date