Southeast Podiatry

Patient Information

Last Name:	First Name:				M.I.
Address:		City:		State:	Zip:
SSN:	DOB:	Sex: M/F	Shoe size:	Height:	Weight:
Race:	Home:	Work:		Cell:	
Employer:					
Emergency Contact Name:		Emergency Contact Number:			
Primary Care Physician:		Primary Care Phone Number:			
Date of last visit with Primary Care Physician?					
Cell Phone Carrier (ex: Verizon, Sprint):					

Medical Insurance/Policy Holder

Primary Insurance Company:			
Policy/ID Number:		Group Number:	
Policy Holder Last Name:	First Name:	SSN:	
Relationship to Patient:		Policy Holder Date of Birth:	
Street Address:			
City:	State:	Zip:	
Home:	Work:	Cell:	
Secondary Insurance Company:			
Policy/ID Number:		Group Number:	
Policy Holder Last Name:	First Name:	SSN:	
Relationship to Patient:		Policy Holder Date of Birth:	
Street Address:			
City:	State:	Zip:	
Home:	Work:	Cell:	

Responsible Party/Guarantor (__ check if same as patient)

Last Name:	First Name:	
SSN:	DOB:	
Street Address:		
City:	State:	Zip:
Home:	Work:	Cell:

How did you hear about Southeast Podiatry?

o Primary Care Physician o Other Physician _____ o Internet

o Patient/Family/Friend o Newspaper o Other

Assignments of Medical Benefits/Authorization to Release Medical Information

Initial
_____

I hereby authorize payments of medical benefits directly to physician for Medical Services provided. ***I understand I will be responsible for co-payments, Durable Medical Equipment out of pocket expenses, office visit deductibles, non-covered services, office visit /procedures cost if referral is not obtained, denied services due to incorrect insurance information given, and any portion of my bill not covered by my insurance company. I understand that such above mentioned responsibilities, if applicable, will be collected at the time of my visit with no exceptions.*** I authorize the Physician to release any information acquired in the course of any treatment necessary to process insurance claims. I understand that the physician will forward record of my office visit and treatment plan to my Primary Care Physician.

Privacy Practice agreement has been given to me to read. I fully understand all the information. If I have any questions I understand I can contact the Privacy officer at 770-675-7904. This notice discusses how my medical information may be used and disclosed as well as my rights as a patient. If any changes are made to this Privacy Practice agreement , I understand the information will be posted in the waiting area and copies will be available to me upon request.

Do you have Advance Directives? ( ) Yes ( ) No

Email Address: _____ ( ) check if okay to receive email reminder of appointments and email giving you access to Electronic Medical Records to view your medical records from Southeast Podiatry and any correspondence emails with the exception of lab results.

Pharmacy Name: _____ Telephone Number: _____
Location/Address: _____

Patient Signature: _____ **Date:** _____

Parent/Guardian Signature (if patient is a minor): _____Date:_____

Name: _____ Height: _____ Weight: _____

1. Brief description for the reason of your visit today? Please circle (Right or Left Foot)(Right or Left Toe 1,2,3,4,5)

_____

2. Any Trauma (injury) that you are aware of that may have caused problem? _____

3. How long have you had this problem? _____

4. Please check all that applies regarding pain:

o Sharp o Aching o Radiating o Burning o Stabbing o Dull o Other

5. Pain Level is: 0 1 2 3 4 5 6 7 8 9 10 (circle one)

6. Pain/Condition seems to get worse: (circle all that applies)

Walking Sitting Standing Lying down Elevating Other _____

7. Pain/Condition seems to get better:

Walking Sitting Standing Lying down Elevating Other _____

8. Have you tried any conservative treatment for your condition ? (ex. Soaking, OTC medications, icing)

_____

_____

Medical History

o Asthma	*o Anemia*	*o Arthritis*	*o COPD*
o Diabetes	*o High Blood Pressure*	*o High Cholesterol*	*o Stroke/TIA*
o Heart rhythm disorder	*o Heart Failure*	*o Heart Attack/Angina*	*o Blood clot in veins*
o Bronchitis	*o Reynaud's*	*o Gout*	*o Glaucoma/Eye Conditions*
o Cerebral Palsy	*o Multiple Sclerosis*	*o Parkinson's Disease*	*o Sarcoidosis*
o Blood Transfusion	*o Neuropathy*	*o Thyroid Disorder*	*o GERD/Reflux*
o Rheumatic Fever	*o Sickle Cell*	*o Colitis*	*o Crohn's Disease*
o Ulcerative Colitis	*o Lyme Disease*	*o HIV/Aids*	*o Sexual Transmitted Disease*
o Hepatitis B or C	*o Back/Neck Trouble*	*o Tuberculosis*	*o Lung Disease*
o Seizures/Epilepsy	*o Depression*	*o Rheumatoid*	*o Bi-Polar/Schizophrenic*
o Polio	*o Osteoarthritis*	*o Lupus*	*o Anxiety*
o Kidney Failure	*o Kidney Stones*	*o Kidney Dialysis*	*o Alzheimer's/Dementia*
o Cancer : *Type:* *Chemotherapy: yes /no*	*o Other medical problems:* _____		

Family History medical condition(s) that were checked as your medical condition(s). (List relation and condition)

_____

_____

Surgical History

Please list any past surgeries:

_____

_____

_____

Current Medications & Dosage

Patients 65 and over: Hospital Admission in last 6 months o Yes o No and/or Falls in last 6 months o Yes o No
Updated Vaccinations: Flu Vaccine o Yes o No, if yes when_____
Pneumonia o Yes o No, if yes when _____

Allergies

o None o Codeine o Sulfa o Aspirin o Penicillin o Latex

o Adhesive Tape o Food Allergies o Other Allergies: _____

List Reaction to allergies checked: _____

Social History

o Single o Married o Divorced o Widowed o Significant Other/Partnered

Do you smoke? o Yes o No If yes, how many packs a day? _____ Have you ever smoked? _____ How long ago did you quit? _____

Do you drink alcohol? o Yes o No If yes, how often? _____ How much? _____

Have you ever used recreational drugs? o Yes o No

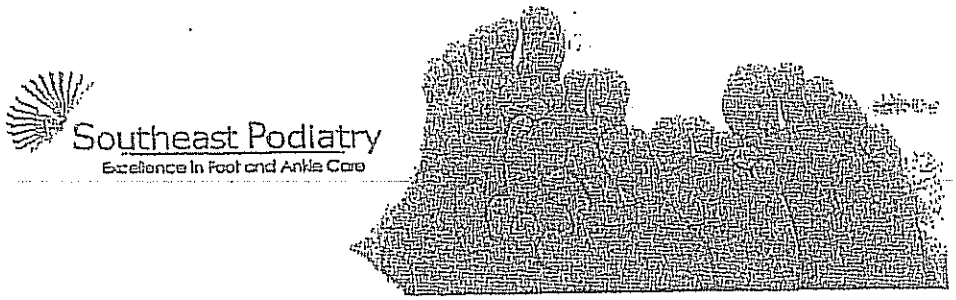
What is your current occupation? _____ Disabled? o Yes o No

<u>Women only</u>: Hormones or Oral Contraceptive? o Yes o No Breastfeeding? o Yes o No Pregnant? oYes oNo

I believe I have answered all the questions on this form to be best of my knowledge. It is my responsibility to advise the physician and office staff of any changes in my medical history. I understand if I have answered any of the questions incorrectly it could affect my treatment by the physician. I hereby authorize the physician and his or her assistants of Southeast Podiatry to administer treatment as deemed necessary.

Patient's Signature _____ Date: _____

Parent/Guardian Signature (if patient is a minor):_____ Date:_____



Financial Policy

1. If your plan requires a referral you must obtain this referral prior to being seen otherwise you will be responsible for all charges for visit. It is your responsibility to make sure that the physician is covered under your insurance network. You will not be seen if referral is needed and you refuse to pay for office visit.

2. All deductibles, co-pays, co-insurances and all out of pocket expenses will be collected at the time of service. Any Durable Medical Equipment dispensed a deposit may be collected.

3. We will file your claim for you if we are a participating provider of your plan. You will be responsible for any and all services in excess of your insurance limits as well as all non-covered services, Durable Medical Equipment, and any supplies.

4. We will mail you a statement for any outstanding balances not covered by your insurance for any reason.

5. Unpaid previous balances must be paid prior to seeing the physician for any appointments unless payment arrangements have been made with our billing department.

6. It is your responsibility to provide correct insurance information, present an insurance card, and current driver's license or state issued identification at the time of your appointment.

7. There is a $30.00 return check fee charge for any unpaid checks.

8. To receive copies of your medical records, signed medical release must be received and records will be dispensed within 48-72 hours. There may be a charge for release of medical records. Fees will be due prior to dispensing these records.

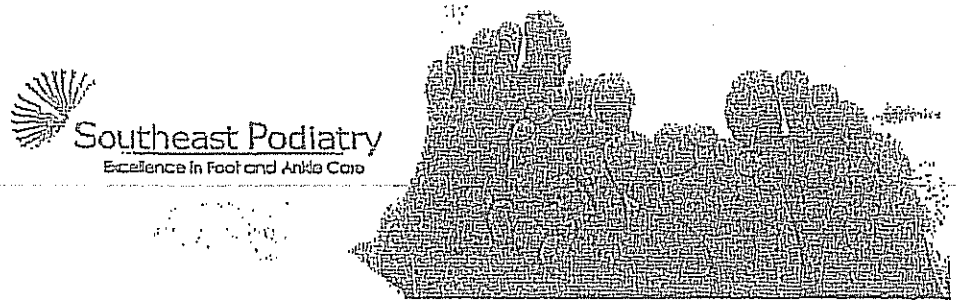
9. There is a $25.00 charge for any disability forms, family medical leave and disability papers, and any other forms for administrative purposes. This fee is charged each time forms have to be completed.

10. Our office reserves the right to charge a $25.00 No Show/ No Cancellation Fee to patients who fail to cancel appointments at least 24 hours in advance. This fee will be billed directly to you and is not reimbursable by insurance.

By signing below, you acknowledge that you understand and accept this financial policy.

_____ _____

Signature Date



Release Medical Information to Designated Person(s)

HIPAA laws do not allow us to release medical information to anyone other than the patient unless a written authorization is on file. If you wish to have your medical information released to Designated person(s) please complete information below. You have a right to revoke this consent at any time with a written request.

I authorize Southeast Podiatry to release medical information to the following Designated person(s)

Name: _____ Relationship to Patient: _____

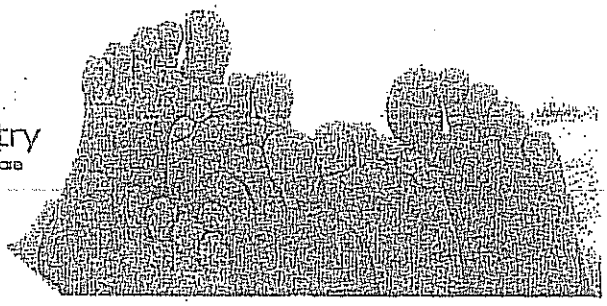
Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Patient Signature: _____ Date: _____

Parent Signature (if patient is minor): _____ Date: _____

Southeast Podiatry
Excellence In Foot and Ankle Care



CONSENT TO CONTACT DEBTORS ON THEIR CELL PHONES

Express Prior Consent to Contact Patients by cell Phone:

You agree, in order for us to service your account or to collect monies you may owe, Southeast Podiatry and/or agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide us. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing devices, as applicable.

I/we have read this disclosure and agree that Southeast Podiatry, its employees and/or agents may contact me/us as described above.

_____ _____

Patients Signature Date