



New Patient Information

Patient Name: _____ Sex: M/F D.O.B: _____

What would you like to be called: _____ SS#: _____

Mailing Address: _____ City _____

Zip: _____ Marital Status: Single/Married/Divorced/Widow Height _____ Weight _____

Cell Phone: _____ Home: _____ Work: _____

Email: _____ Shoe Size/Width _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Contact Phone: _____

Relationship to Patient: _____

Primary Care Physician: _____

Practice Name/Address: _____

Phone: _____ Fax: _____ Date of last visit: _____

Pharmacy Name: _____ Pharmacy phone number: _____

Pharmacy Address: _____

PLEASE INCLUDE A COPY OF A PHOTO ID AND ALL INSURANCE CARDS

Primary Insurance Name: _____

Policy/Contract #: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder DOB: _____

Relationship to Patient: _____ Policy Holder SS#: _____

Secondary Insurance Name: _____

Policy/Contract #: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder DOB: _____

Relationship to Patient: _____ Policy Holder SS#: _____

How did you *learn* about Georgia Podiatry? (Please circle one)

- I was referred by Dr. _____
- A friend or another patient referred me _____
- Insurance Website
- Internet Search: Google Yahoo Bing Other: _____
- Brightside Newspaper
- I saw your practice sign/driving by
- Other Source: _____

www.georgiapodiatry.com

3459 Acworth Due West Rd. Suite 430 Acworth, GA 30101

Phone 678-310-0540 Fax 678-310-0538

1599 Mulkey Road SW Austell, GA 30106

Phone 678-505-8064 · Fax 678-909-5967

Patient's Name: _____

What is your chief complaint today? _____ Where? _____

When did this condition start? ____ years ____ months ____ days ago

What is the nature of your pain? (Circle one): Stabbing / Radiating / Sharp / Dull/Burning / Aching / Itching
Other _____

Is your condition getting better or worse? _____ Rate your pain: 0 1 2 3 4 5 6 7 8 9 10 (severe)

What seems to make your condition, pain worse? _____

What seems to make your condition, pain better? _____

Have you seen another physician for this problem? YES/NO If yes, doctor's name: _____

Has this condition affected your ability to work, exercise or perform other daily activities? YES/NO

If yes, how? _____

Is there a history of injury? YES/NO If yes, date of injury? _____ Is this a work-related injury? YES/NO

Women: Breastfeeding? YES / NO

Are you pregnant? YES/ NO If yes, how many weeks are you? _____ Due date: _____

<u>Past Medical History (circle all that apply)</u>	<u>NONE</u>
Cancer: lung skin breast cervical prostate	
Neurological: stroke neuropathy vertigo seizures migraines	
Skin: eczema psoriasis ulcers vitiligo dermatitis hives	
Psychiatric: bipolar depression anxiety claustrophobia dementia	
Respiratory: emphysema asthma shortness of breathe COPD	
Eyes/Ears/Noses/Mouth and Throat: cataracts glaucoma hearing loss	
Genitourinary: STD HIV UTI kidney stones kidney/bladder infections	
Hematologic/Immunologic: dialysis anemia sickle cell bleeding disorder	
Gastrointestinal: stomach ulcers hernia hepatitis reflux/GERD gallbladder disease	
Cardiovascular: heart attack coronary disease high blood pressure irregular heart rhythm	
Musculoskeletal: lupus osteoarthritis rheumatoid arthritis fibromyalgia gout back pain	
Metabolic: hypoglycemia diabetes hypothyroidism hyperthyroidism hyperlipidemia osteoporosis	
Other: _____	

<u>Past Surgeries and Hospitalizations (circle all that apply)</u>	<u>NONE</u>
Tonsils/Adenoids	Amputations
Gallbladder	Other Vascular Bypass
Coronary/Heart Bypass	Appendix
	Hysterectomy
	Hernia
	Angioplasty
	Other _____

List or attach a complete list of all CURRENT MEDICATIONS (Dose, amount taken and how often), including vitamins/supplements:

Allergies: (circle) NONE /Narcotics/NSAIDS/Penicillin / Sulfa / Aspirin / Contrast / Latex / Iodine / Shellfish / Tape
Gluten Intolerance / Food Allergies / Metal / Other: _____

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Patient HIPAA Acknowledgement and Designation Disclosure Form

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996. (HIPAA) I understand that this information explains:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.

I have been given the right to review and receive a copy of the *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request. A copy of the *Notice of Privacy Practices* can be found online, or at our office. You may contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures.

Disclosures to Friends and/or Family.

If you wish to designate a family member or other individual with whom the provider or staff may discuss your medical condition(s), provide the information below. You may revoke or modify this specific authorization, but you must do so in writing.

NAME	RELATIONSHIP	CONTACT NUMBER

Patient or Personal Representative Acknowledgement of Receipt of Notice of Privacy Practices

Signature: _____ Date: _____

Name (Print): _____ Relationship to Patient: _____

FOR OFFICE USE ONLY

We made a good faith effort to obtain an acknowledgement of _____'s receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

- ☐ Patient refused to sign (date of refusal) _____.
- ☐ An emergency situation prevents us from obtaining an acknowledgement.
- ☐ Other

Attempt was made by: _____ Date: _____



Method of Payment and Financial Policy

I, the undersigned, understand that Georgia Podiatry has agreed to accept medical and/or health insurance for payment of my medical bills. Payment is required at the time that services are rendered. Georgia Podiatry is a participating provider of Medicare, BCBS, Cigna, Aetna, United Health Care, Tri-Care, Humana and many PPO and HMO plans. Please check with the receptionist to see if we are participating with your insurance plan. Our office will file the insurance claims automatically. I understand that I am responsible for any co-pays, co-insurances or deductible amounts at the time of service. By my signature below, I acknowledge that I am fully responsible for any balances after Medicare and/or my health insurance has paid Georgia Podiatry. This may be a result of my yearly deductible, co-insurance and/or co-payment. I also understand that any benefits given to Georgia Podiatry by my insurance carrier is not a guarantee of my benefits as it may be subject to change. I also understand that it is my responsibility as the patient to get a referral if my policy requires a referral. I also understand that if I do not present a referral and it is necessary, my insurance company may deny the claim as a result of not having the referral.

It is the policy of our office that all fees are due at the time of 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 abiding with 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. We accept MasterCard, Visa, American Express, and Discover as well as cash or checks. Please note that if you write a check and it is returned, we will charge your account \$25 for a non-sufficient fund fee. If your claim is not paid within 90 days, the claim will be transferred to patient responsibility and if timely payment is not received, the account may be referred to a collection agency or attorney. In the event that your account needs to be placed with an outside collection agency or attorney, you will be assessed an additional 30% of the balance to recover the collection charges.

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 Georgia Podiatry. After all insurance payments have been paid; I fully understand that I am responsible for the remaining balance of my account.

Signature of Responsible Party

Print Name

Date

Responsible Party Mailing Address: (if different from patient)

Responsible Party Home Phone: _____ **Cell:** _____

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Acknowledgement

****Please print name even if it does not apply to you****

Please read thoroughly

(Effective 02/01/17)

An administrative fee will be charged for the completion of all documents/questionnaires presented by patients for completion by providers. (See Fee Schedule below.) These documents include but are not limited to disability insurance benefit forms, Family and Medical Leave Act (FMLA) forms, medical reports. These fees are due prior to the completion of the forms. Our priority is providing treatment to our patients, therefore, we ask that you give us a minimum of 7 business days for completion of forms. If any form is requested to be rushed a rush fee will be charged.

Payment must be made in advance for completion of the form (s).

FEES FOR DISABILITY INSURANCE BENEFIT FORMS, FMLA FORMS, OR ALL OTHER FORMS THAT NEED TO BE FILLED OUT BY STAFF OR PROVIDER:

FEES:

\$25 Processing Fee

\$5 for each additional page/side after the first page.

Name

Date

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