

MEDICAL HISTORY All information is strictly confidential

Check (✓) symptoms you currently have or have had in the past year.

<p>GENERAL</p> <input type="checkbox"/> Chills <input type="checkbox"/> Depression/Nervousness <input type="checkbox"/> Dizziness/Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats	<p>GASTROINTESTINAL</p> <input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood	<p>EYE, EAR, NOSE, THROAT</p> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Earache/Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision - Flashes/Halos	<p>MEN only</p> <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Penis discharge <input type="checkbox"/> Sore on penis <input type="checkbox"/> Other
<p>MUSCLE/JOINT/BONE Pain, weakness, numbness in:</p> <input type="checkbox"/> Arms <input type="checkbox"/> Hips <input type="checkbox"/> Back <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Hands <input type="checkbox"/> Shoulders	<p>CARDIOVASCULAR</p> <input type="checkbox"/> Chest pain <input type="checkbox"/> High/Low blood pressure <input type="checkbox"/> Irregular/Rapid heart beat <input type="checkbox"/> Poor circulation <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins	<p>SKIN</p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching/Rash <input type="checkbox"/> Change in moles <input type="checkbox"/> Scars <input type="checkbox"/> Sore that won't heal	<p>WOMEN only</p> <input type="checkbox"/> Abnormal Pap Smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast lump <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Hot flashes <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Other
<p>GENITO-URINARY</p> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination			<p>Date of last menstrual period _____</p> <p>Date of last Pap Smear _____</p> <p>Have you had a mammogram? _____</p> <p>Are you pregnant? _____</p> <p>Number of children _____</p>

Check (✓) conditions you have or have had in the past.

<input type="checkbox"/> AIDS <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Breast Lump <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts <input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Chicken Pox <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Herpes <input type="checkbox"/> High Cholesterol	<input type="checkbox"/> HIV Positive <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pneumonia	<input type="checkbox"/> Polio <input type="checkbox"/> Prostate Problem <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Stroke <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Ulcers <input type="checkbox"/> Venereal Disease
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Describe serious illnesses or operations _____

MEDICATIONS/ALLERGIES

List medications you are currently taking _____

Pharmacy Name _____

Phone (____) _____

List allergies to medications or substances _____

HEALTH HABITS

<p>Check (✓) which you use and how much:</p> <input type="checkbox"/> Caffeine _____ <input type="checkbox"/> Street Drugs _____ <input type="checkbox"/> Tobacco _____ <input type="checkbox"/> Other _____ <p>Your occupation _____</p>	<p>Check (✓) if your work exposes you to:</p> <input type="checkbox"/> Stress <input type="checkbox"/> Heavy Lifting <input type="checkbox"/> Hazardous Substances <input type="checkbox"/> Other _____
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SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

<p>_____ Signature of Patient, Parent, Guardian or Personal Representative</p>	<p>_____ Date</p>
<p>_____ Please print name of Patient, Parent, Guardian or Personal Representative</p>	<p>_____ Relationship to Patient</p>
<p>_____ Reviewed By</p>	<p>_____ Date</p>

Foot & Ankle Center of Middle Georgia, LLC & Peach State Surgery Center, LLC

HIPAA

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996 (a federal law). Of significant concern to healthcare organizations is the Administrative Simplification section of the Act, which requires healthcare organizations to comply with specific rules including the following:

- Privacy Regulations over disclosure and use of health information.
- Security Regulations over protections of electronic health information.

It is the office policy of **Foot & Ankle Center of Middle Georgia, LLC & Peach State Surgery Center, LLC** and staff to not release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Whenever returning telephone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone.

If you would like to have information released to someone other than yourself please complete the following:

I **authorize Foot & Ankle Center of Middle Georgia, LLC & Peach State Surgery Center, LLC** staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

Home Telephone	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Answering Machine	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Work Telephone	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Voice Mail	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cell Phone and/or voicemail	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pager	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fax medical records for referrals To another provider	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please list names of authorized people:

Spouse: _____ Yes No

Parent: _____ Yes No

Other Names (please list relationship such as boyfriend, fiancé, girlfriend, sister, etc.) Yes No

Patient/Guardian Signature _____ Date _____

FOOT & ANKLE CENTER
Of Middle Georgia, LLC

Dr. Savepalli D. Jokhai

PAYMENT POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Payment Policy, which we require you to read and sign prior to any treatment. In addition, all patients must complete our information and insurance forms before seeing the doctor.

We accept cash or checks

Our billing service will accept credit card payments as well !

1. We participate and file insurance claims with a variety of Physician Reimbursement plans. You will be responsible for any deductibles, co-payments or non-covered services at the time of service.
2. For all other insurance companies, we provide detailed itemized receipts for you to file your claims . Assistance in filling your insurance is available upon request.
3. You are responsible for any balances remaining after your insurance pays and for any non-covered services. Your payment of this balance must be received within 30 days of the date you are billed. If your account has to be turned over for collection, you will have to pay any and all collection fees, court costs, and expenses.
4. Shoe inserts, medical supplies and medical equipment may or may not be covered by your insurance company. These charges are separate and are not included in your office visit charge. If you wish to purchase these items from our office, please keep in mind you will be responsible for the charges.

5. NON- INSURANCE PATIENTS:

All patients without insurance will be required to pay at least 50% of the charges at the time of service. The remaining balance can be paid in monthly payments to the discretion of the practice. Cash and checks will be accepted by our billing service as well as credit card payments .

Signature of patient or responsible party

Date

Relationship to patient

Foot & Ankle Center
Of Middle Georgia, LLC
Dr. Sarvepalli D. Jokhai

I assign the right to payment for all medical benefits directly to **Dr. Sarvepalli D. Jokhai** in consideration for medical services and supplies provided pursuant to my health insurance plan.

In the event my health insurance plan refuses to pay for provided, medically necessary services, I assign all my ERISA* rights to **Dr. Sarvepalli D. Jokhai** for a full and fair review of any and all denied claims, including any penalties that may be assessed against the insurance company for faulty claims processing. This ERISA assignment is in consideration for the unpaid services provided and in consideration for the continued willingness of **Dr. Sarvepalli D. Jokhai** to see patients, including myself, on an insurance assignment basis, I understand that if my treating doctor prevails in any such payment of dispute, I may be liable for the co-payments for the contested services.

I give consent to release medical information to **Dr. Sarvepalli D. Jokhai**. I give consent to **Dr. Sarvepalli D. Jokhai** to release medical information to other healthcare providers for the purpose of treatment, when necessary for my care. I give consent to **Dr. Sarvepalli D. Jokhai** to send medical information, as necessary, to my insurance plan.

Patient's Name (Printed)

Patient's Signature

Date

*ERISA is an acronym for the Employee Retirement Income Security Act. The Employee Retirement Income Security Act includes federal laws requiring insurance companies to process submitted insurance claims and appealed (denied) insurance claims according to ERISA regulations. The failure to process submitted insurance claims and appealed (denied) insurance claims according to ERISA regulations may result in fines charged to the insurance company in amounts up to \$110.00 a day for each infraction.