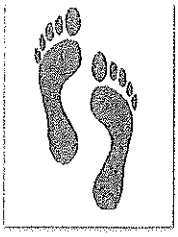

Welcome

PATIENT INFORMATION

Date_____
Social Security #_____
Patient Name_____
Address_____
City_____
State_____ **Zip**_____
Email_____
Sex □ **M** □ **F** **Age**_____ **Birthdate**_____
□ **Married** □**Widowed** □**Single** □**Minor**
□**Separated** □ **Divorced**
Occupation_____
Patient Employer/School_____
Employer/School
Address_____
Employer/School Phone_____

PHONE NUMBERS

Home(____)_____ **Cell Phone(____)**_____
Best time and place to reach you_____
EMERGENCY CONTACT:
Name_____
Relationship_____
Home Phone _____
Cell Phone_____

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (include foot, ankle, knee, thigh, and hip complaints.)_____

Have you ever seen a Podiatrist before?
□ **Yes** □ **No**
If yes, please list
Name_____
Last visit_____

Is there any personal or family history of diabetes? □ **Yes** □ **No**
Cigarette/Tobacco Use □ **Yes** □ **No** **Years Smoked**_____
Athletic activities in which you participate(indicate frequency)_____

Please indicate any foot problems you now have or have had in the past. Ankle Pain □ Yes □ No
Athlete's Foot □ Yes □ No
Bunions □ Yes □ No
Corns and Calluses □ Yes □ No
Cramps or Numbness in Feet and Legs □ Yes □ No
Flat Feet □ Yes □ No
Heel Pain □ Yes □ No
Ingrown Toenails □ Yes □ No
Plantar Warts □ Yes □ No
Swelling in Ankles or Feet □ Yes □ No
Tired Feet □ Yes □ No

INSURANCE

Insurance Company_____
Subscribers Name_____
Relationship to Patient_____ **Subscribers DOB**_____
Member ID/Insured
SSN_____
Additional Insurance □ Yes □ No
Insurance
Company_____
Subscribers Name_____
Relationship to Patient_____ **Subscribers DOB**_____
Member ID/Insured
SSN_____

INSURANCE ASSIGNMENT & RELEASE(all Insurances)
I certify that I have insurance coverage with

_____
Name of Insurance Company(ies)
and assign directly to the
Foot and Ankle Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctors may use my healthcare information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for retailed services. This consent will end when my current treatment plan is completed or one year from this date signed below.

_____
Signature of Patient or Guardian

_____
Please print name of Patient or Guardian

_____ _____
Date **Relationship to Patient**

MEDICARE AUTHORIZATION(for Medicare Insurers only)
I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits be made either by me or on my behalf to the **Foot and Ankle Center** for any services furnished to me by that provider. To extent permitted by law, I authorize any holder of medical or other information about me to release to the Center of Medicare and Medicaid Services, my Medigap Insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____
Signature of Patient or Guardian

_____
Please print name of Patient or Guardian

_____ _____
Date **Relationship to Patient**

Medical History(All information is strictly confidential)

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

GENERAL
- □ Chills
- □Depression/Nervousness
- □Dizziness/Fainting
- □Fever
- □Forgetfulness
- □Headache
- □Loss of sleep
- □Loss of weight
- □Numbness
- □Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:
- □Arms □Hips
- □Back □Legs
- □Feet □Neck
- □Hands □Shoulders

GENITO-URINARY
- □Blood in urine
- □Frequent urination
- □Lack of Bladder control
- □Painful urination

GASTROINTESTINAL
- □ Appetite poor
- □ Bloating
- □ Bowel changes
- □ Constipation
- □Diarrhea
- □Excessive thirst
- □Gas
- □Hemorrhoids
- □ Indigestion
- □Nausea
- □Rectal bleeding
- □Stomach pain
- □Vomiting
- □Vomiting blood

CARDIOVASCULAR
- □Chest pain
- □High/Low blood pressure
- □Irregular/Rapid heartbeat
- □Poor circulation
- □Swelling of ankles
- □Varicose veins

EYE, EAR, NOSE, THROAT
- □Bleeding gums
- □Blurred vision
- □Crossed eyes
- □Difficulty swallowing
- □Double vision
- □Earache/Ear discharge
- □Hay fever
- □Hoarseness
- □Loss of hearing
- □Nosebleeds
- □Persistent cough
- □ Ringing in ears
- □Sinus problems
- □Vision-Flashes/Halos

SKIN
- □Bruise easily
- □Hives
- □Itching/Rash
- □Change in moles
- □Scars
- □Sore that won't heal

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

□AIDS	□Chicken Pox	□HIV Positive	□Polio
□Appendicitis	□Diabetes	□Kidney Disease	□Prostate Problem
□Arthritis	□Emphysema	□Liver Disease	□Rheumatic Fever
□Asthma	□Epilepsy	□Measles	□Scarlet Fever
□Bleeding Disorders	□Glaucoma	□Migraine Headaches	□Stroke
□Breast Lump	□Heart Disease	□Multiple Sclerosis	□Thyroid Problems
□Cancer	□Hepatitis	□Mumps	□Tuberculosis
□Cataracts	□Herpes	□Pacemaker	□Ulcers
□Chemical Dependency	□High Cholesterol	□Pneumonia	□Venereal Disease

Describe serious illnesses or operations_____

MEDICATIONS/ALLERGIES

List medications you are currently taking_____

_____

_____

_____

Pharmacy Name_____

Phone (____)_____

List allergies to medications or substances_____

_____

HEALTH HABITS

Check (√) which you use and how much:
- □Caffeine_____
- □Street Drugs_____
- □Tobacco_____
- □Other_____

Check (√) if your work expose you to:
- □Stress_____
- □Heavy Lifting_____
- □Hazardous Substance_____
- □Other_____

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.

_____ _____ _____

Signature of Patient, Guardian, or Personal Representative **Relationship to Patient** **Date**

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	☐ Yes	☐ No
Answering Machine	☐ Yes	☐ No
Work Telephone	☐ Yes	☐ No
Voice Mail	☐ Yes	☐ No
Cell Phone and/or voicemail	☐ Yes	☐ No
Pager	☐ Yes	☐ No
Fax medical records for referrals To another provider	☐ Yes	☐ 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. Sarvepalli Jokhai and Dr. Jae Shin

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, credit/debit, or checks
Our billing service will accept credit/debit 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. 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.
3. 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.
4. **NON-INSURANCE PATIENTS:**
   All patients without insurance will be required to pay **ALL CHARGES** at the time of service.. Cash or credit/debit cards will only be accepted at the time of service.

_____ _____

Signature of patient or responsible party Date

_____

Relationship to patient

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

I assign the right to payment for all medical benefits directly to the **Foot & Ankle Center** 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, medical necessary services, I assign all my ERISA* rights to the **Foot & Ankle Center** 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 unpaid services provided and in consideration for the continued willingness of the **Foot & Ankle Center** 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 the **Foot & Ankle Center.** I give consent to the **Foot & Ankle Center** to release medical information to other healthcare providers for the purpose of treatment, when necessary for my care. I give consent to **Foot & Ankle Center** 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.

FOOT & ANKLE CENTER

Of Middle Georgia, LLC
1040 Morningside Drive
Perry, Georgia 31069

Dr. Sarvepalli D. Jokhai, DPM and Dr. Jae Y. Shin, DPM
Podiatric Physicians and Surgeons
(478) 988-4676

_____ Cancellation and Missed Appointment Policy

(pt initial)

Our goal is to provide quality individualized medical care in a timely manner. "No-Shows" and late cancellations inconvenience those individuals who need access to medical care in a timely manner. We would like to remind you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of medical care.

_____ Cancellation of an Appointment

(pt initial)

In order to be respectful of the medical needs of other patients, please be courteous and call the Foot & Ankle Center promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

_____ How to Cancel Your Appointment

(pt initial)

To cancel appointments, please call 478-988-4676. If you do not reach the receptionist you may leave a message with the answering service. Please leave your name and phone number and we will return your call.

_____ No Show Policy

(pt initial)

A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a "no-show". **A $25 fee will be billed to your account.**

_____

Patient Signature Date