WELCOME

Foot and Ankle Center of Middle Georgia, LLC
Phone: 478-988-4676 Fax: 478-988-7907
Locations in Ft. Valley, Perry & Warner Robins

1 PATIENT INFORMATION

How did you hear about us? _____

Patient Name: _____
Last First MI

SSN: ___-___-___ Today's Date: _____

Birth Date: ___/___/___ Age: _____ Sex: ☐M ☐F

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Email: _____

May we send you an occasional email? ☐Yes ☐No

Occupation: _____

Employer/School: _____

Work/School Address: _____

City: _____ State: _____ Zip: _____

Marital Status: ☐ Single ☐Married ☐Partnered
☐ Separated ☐ Divorced ☐ Widowed

Spouse Name (if applicable): _____

2 PHONE NUMBERS

Home Phone: (_____) _____-_____

Cell Phone: (_____) _____-_____

Work/School: (_____) _____-_____

Preferred Contact Number: ☐ Home ☐ Cell ☐ Work

May we leave a message regarding your care? ☐ Yes ☐ No

May we send Text Messages/Emails? Yes No

IN CASE OF AN EMERGENCY:

Contact: _____ Relationship: _____

☎1:☎ _____ #2: _____

3 RESPONSIBLE PARTY

Who is financially responsible for this account?

☐ Self ☐Parent/Guardian ☐ Other: _____

GUARANTOR INFORMATION (IF OTHER THAN SELF):

Name: _____ DOB: ___/___/___

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Relationship: _____

4 INSURANCE INFORMATION

Does patient have health insurance? ☐Yes ☐No

If yes, present insurance card & complete the following:

Insurance Company: _____

Member ID: _____

Group Number: _____

Policy Holder's Name: _____

SSN: _____ DOB: _____ Sex: ☐M ☐F

Relationship to Patient: _____

Employer: _____

SECONDARY INSURANCE:

Insurance Company: _____

Policy Number: _____

Group Number: _____

Policy Holder's Name: _____

SSN: _____ DOB: _____ Sex: ☐M ☐F

Relationship to Patient: _____

Employer: _____

5 MEANINGFUL USE (please read)

Meaningful Use is new federal initiative to improve our nation's healthcare system by identifying inequalities based on race and ethnicity. We are <u>required</u> to collect this information on every patient. **NOTE: We <u>DO NOT</u> define the options under each category. They are pre-defined by the Federal Government. <u>YOU MUST PROVIDE A RESPONSE UNDER EACH SECTION</u>.**

Race

☐ **I DECLINE**
☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Hawaiian Native or Pacific Islander
☐ White

Ethnicity

☐ **I DECLINE**
☐ Non-Hispanic or Latino
☐ Hispanic or Latino
☐ Other: _____

Preferred Language

☐ **I DECLINE**
☐ English
☐ Spanish
☐ Other: _____

Is a translator required:
☐ Yes ☐ No

Do you have a Living Will or Surrogate Decision maker if you are unable make decisions about your health care.
Name _____ Phone: _____

6 PAST MEDICAL HISTORY

Fill in the bubble next to **ALL** conditions that you currently have or that you have had in the past.

☐ **NONE**

☐ Acne	☐ Cysts (ovarian)	☐ HIV/AIDS	☐ Pneumonia
☐ Allergies	☐ Dentures	☐ Irregular Heartbeat	☐ Poor Circulation
☐ Anemia	☐ Depression	☐ Indigestion (acid reflux)	☐ Pregnancy
☐ Anxiety	☐ Diabetes	☐ Impetigo	☐ Psoriasis
☐ Arthritis	☐ Dialysis	☐ Kidney Disease	☐ Rashes
☐ Asbestosis	☐ Diarrhea	☐ Kidney Infections	☐ Rheumatoid Arthritis
☐ Asthma	☐ Dizziness	☐ Kidney Stones	☐ Ringworm
☐ Athletes Foot	☐ Drug/Alcohol Abuse	☐ Leukemia	☐ Scarlet Fever
☐ Back Pain	☐ Eczema	☐ Lymphoma	☐ Scoliosis
☐ Bladder Infections	☐ Epilepsy	☐ Lupus	☐ Seizures
☐ Blood Clots	☐ Fainting/Lightheadedness	☐ Melanoma	☐ Sexually Transmitted Disease
☐ Boils/Abscess	☐ Fever Blisters (cold sores)	☐ Meningitis	☐ Shingles
☐ Broken Bones	☐ Fungal Infections	☐ Menstrual Problems	☐ Staph Infection (MRSA)
☐ Bronchitis	☐ Gallbladder Disease	☐ Mitral Valve Prolapse	☐ Stress
☐ Cancer/tumors	☐ Gout	☐ Moles / Skin Tags	☐ Stroke/TIA
☐ Canker Sores	☐ Headaches/Migraines	☐ Mononucleosis	☐ Swelling / Fluid Retention
☐ Chicken Pox	☐ Heart Attack	☐ Muscle spasms	☐ TMJ (jaw pain)
☐ Chronic Fatigue	☐ Hemophilia	☐ Neck pain	☐ Thyroid Disease
☐ Congestive Heart Failure	☐ Herniated Disk(s)	☐ Neuropathy	☐ Tuberculosis
☐ Constipation	☐ Herpes Simplex	☐ Numbness & Tingling	☐ Urinary Tract Infection
☐ Contact Lenses	☐ Hepatitis	☐ Osteoporosis	☐ Varicose Veins
☐ COPD	☐ High Blood Pressure	☐ Paralysis	☐ Warts

FEMALES ONLY

When was the first day of your last period? ____/____/____ ☐ I'm unsure of the date of my last period.

Are you currently pregnant or nursing? ☐ No ☐ Yes ☐ Unsure Method of birth control: _____

7 SURGICAL HISTORY

☐ **NONE, I'VE NEVER HAD SURGERY**

☐ Appendectomy	☐ Stent Placement
☐ Cesarean Section	☐ Tonsillectomy/Adnoidectomy
☐ Gallbladder Removed	☐ Tubal Ligation
☐ Hernia Repair	☐ Vasectomy
☐ Hysterectomy	☐ _____
☐ Orthopedic surgery	☐ _____
☐ Pacemaker	☐ _____
☐ Spine surgery	☐ _____

Give dates, reason(s), location, complications, etc: _____

8 FAMILY HISTORY

List any significant family medical history for each of the following:

Mother: _____

Father: _____

Grandmother(s)_____

Grandfather(s): _____

Siblings:_____

Children: _____

9 SOCIAL HISTORY

Tobacco: ☐ **Never** ☐Quit ☐_____ packs/day for ____ yrs

Alcohol: ☐ **Never** ☐ Quit ☐_____ drinks per day / mo / yr

Drugs: ☐ **Never** ☐ Quit ☐Type:_____

10 ALLERGIES

Medication	Food	Environmental
☐ **NONE**	☐ **NONE**	☐ **NONE**
☐ Aspirin	☐ Peanuts	☐ Ragweed
☐ Ibuprofen	☐ Tree Nuts	☐ Pollen
☐ Sulfa	☐ Shellfish	☐ Dust
☐ Penicillin	☐ Eggs	☐ Mold
☐ Codeine	☐ Soy	☐ Pet Dander
☐ Cephalosporins	☐ Mangos	☐ Bee/Wasp Stings
☐ Iodine	☐ Milk	☐ Latex
☐ _____	☐ _____	☐ _____

11 MEDICATIONS

Drug Name/Strength	Dosage	Frequency	Reason
☐ **NONE, I DO NOT TAKE ANY MEDICATIONS.**			

12 DOCTOR & PHARMACY PREFERENCES

Primary Doctor: _____
Name Phone

Pharmacy: _____
Name Location

13 ACKNOWLEDGEMENT, CONSENT, & RELEASE

I acknowledge that the information provided in the foregoing Patient Registration & Health History is true and correct to the best of my knowledge. I agree to provide updates and/or changes to this information at any future visits. My initials below indicate I have read, understand, and agree to each section.

Consent to Treat	**Initial**
I consent to medical evaluation and treatment, including procedures, medications, or other interventions as deemed necessary by my treating provider. I understand that services rendered to me at Foot and Ankle Center of Middle Georgia LLC will be performed by licensed podiatrists or licensed midlevel providers. I authorize the podiatrists and staff to render services as deemed medical necessity without any additional consent. Lastly, I certify that no guarantee has been, or will be, made to me regarding the result of my treatment.	

Notice of Privacy Practices	**Initial**
Your privacy is very important to us. Foot and Ankle Center of Middle Georgia's HIPAA Privacy Policy & Notice of Privacy Practices is available for patients to review during registration. However, any patient wanting their own copy may request a hard copy from the Intake Clerk at the front desk, or a digital copy can be viewed or downloaded from our website at www.no1footdoc.com.	

Financial Policy	**Initial**
I acknowledge I have read and understand Foot and Ankle Center of Middle Georgia's Financial Policy. I understand that I am responsible for all charges for services rendered regardless of my insurance status, and that all payments are due at the time services are rendered, or immediately upon receipt of a statement, and failure to pay in full will result in a $5 per month rebilling fee.	

Release of Information	**Initial**
The medical records concerning patient care are the property of Foot and Ankle Center of Middle Georgia and are maintained for the benefit of the patient, the medical staff and the Center. I hereby authorize FACMGA to release information and/or copies of my medical records to physicians, any guarantor of payment on my account, insurance companies, and/or any other third party payers. This authorization includes information pertaining to psychiatric and/or psychological care, alcohol and/or substance abuse, and laboratory test results, including those pertaining to HIV/AIDS testing and other communicable diseases.	

Medicare Patients (& for patients 62 years of age and older)		**Initial**
Patients with Medicare or those who are 62 and older must complete this section. Check the **ONE** box that best describes your Medicare status.	☐ I am <u>not enrolled</u> in Medicare Part B. ☐ I have Medicare Part B for my **primary** insurance. ☐ I have Medicare Part B as my **secondary** insurance.	You <u>MUST</u> provide your Medicare card along with any other insurance card.

Assignment of Benefits	**Initial**
The undersigned, whether signing as a patient, representative, or guarantor, hereby authorize direct payment of any insurance benefits otherwise payable to, or on behalf of, the patient to Foot and Ankle Center of Middle Georgia, LLC (herein after referred to as FACMGA). I hereby assign to FACMGA, all medical benefits otherwise payable to me by virtue of my visit to FACMGA. I hereby direct insurer to pay such benefits directly to FACMGA in consideration of professional services rendered to me or my dependent child I understand I may be responsible for payment of any services not covered/ denied by my health insurance.	

Females Only – Radiology Release	**Initial**
I understand that if my condition warrants radiology procedures, it is my responsibility to inform the medical staff if I am pregnant, if pregnancy is a possibility, or if I am unsure of my pregnancy status. I understand that failure to disclose this information could result in harm to my unborn child, and for which I release Foot and Ankle Center of Middle Georgia, LLC from any and all liability, seen or unforeseen, by me or my unborn child, and hold harmless their providers, employees, associates, affiliates, etc. now and forever.	

My signature below acknowledges that I have disclosed accurate information, and that I have read and understand all sections above, including any documents incorporated by reference, and I have had any and all questions answered in a manner understandable by me. Although my signature below is a collective acknowledgement of this document, it also serves as a separate signature for each section individually.

Patient Name (Print) _____ Signature _____ Date ____/____/____

IF PATIENT IS A MINOR:

Parent/Guardian Name (Print) _____ Parent/Guardian Signature _____ Date ____/____/____

Foot & Ankle Center of Middle GA Witness _____ 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

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X _____ Patient/Guardian Signature _____ Date _____