Ankle & Foot Centers, PC
Medicine & Surgery of the Foot and Ankle

Mathew M. John, DPM, FACFAS

Patient Name_____ Date of Birth_____ Age _____

Social Security number: _____-_____-_____ ☐Male ☐Female ☐Single ☐Married ☐Divorced ☐Widow

Address _____ City_____ ST _____ Zip _____

Home phone: (_____) _____-_____ Cell phone: (_____) _____-_____

Email address: _____

Place of Employment _____

Address _____ City_____ST_____ Zip _____

Work #:(_____) _____-_____ Ext_____

Spouse/Responsible Party's Name _____Date of Birth: _____

Social Security number: _____-_____-_____☐Male ☐Female ☐Single ☐Married ☐Divorced ☐Widow

Address _____ City_____ ST _____ Zip _____

Home phone: (_____) _____-_____ Cell phone: (_____) _____-_____

Spouse/Responsible Party's Place of Employment_____

Address_____City_____ST_____Zip_____

Work# (_____) _____-_____ Ext _____

Relative or Friend for Emergency Contact

Name_____ Relation _____

Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____

Work Phone (_____) _____-_____

How did you hear about our office?

Referral Source: Doctor's full Name _____ Friend/relative _____

☐HMO/PPO Directory ☐Yellow Pages ☐internet ☐building/sign ☐employer ☐other referral ☐advertisement

Insurance Information – **PLEASE PRESENT INSURANCE CARD AND DRIVERS LICENSE OR IDENTIFICATION CARD TO RECEPTIONIST**

Primary Insurance _____ ☐HMO ☐PPO ☐POS

Policy Holder's Name _____ Policy # _____

Secondary Insurance _____ ☐HMO ☐PPO ☐POS

Policy Holder's Name(if different from above) _____ Policy #_____

I consent to treatment necessary for the care of the above named patient. I authorize the release of all medical records via fax transmittal or mail, to all referred physicians and to my insurance company when applicable. I authorize and request that insurance payment be made directly to Ankle & Foot Centers, PC, should they elect to receive such payments.

I have read and understand the above consent for treatment, release of medical information, insurance authorization and accept financial responsibility for all coinsurance, copays, and deductibles as applicable to my insurance policy. I understand that the cost of collection (30%) will be added to my account in the event it becomes delinquent and sent to a collection agency.

SIGNATURE **DATE**

FOR OFFICE USE ONLY

I acknowledge full financial responsibility for services and/or items not covered by my insurance and authorize to Ankle & Foot Centers, PC, all unpaid amounts to my Visa or MasterCard after 90 days from the date of service

Visa/MasterCard # _____ Exp date: _____

Signature Authorizing transfer _____ Date _____

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FINANCIAL POLICY

Our goal at Ankle & Foot Centers is to make sure your health care experience is delivered with thoroughness and the utmost quality. We want to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner, we ask that you adhere to the following guidelines:

1. You are ultimately responsible for payment of services rendered from our office.
2. It is your responsibility to provide us with your current address, telephone number and insurance information at each visit.
3. It is your responsibility to contact your insurance carrier to confirm that we participate in your specific plan.
4. All co-payments are due at the time of service. A $25.00 service fee will be assessed for failure to pay your co-pay at the time of service.
5. All co-insurance that is allowed by your insurance may be collected at the time of service if we have your insurance fee schedule. *We make every effort to confirm your insurance benefits prior to your appointment but cannot be responsible for incorrect information provided by your insurance.*
6. If you miss your appointment without prior notification to our office, you will be charged a no-show fee of $25.00 for each missed appointment.
7. There is a $25.00 fee for checks not honored by your bank
8. Copies of medical records are available to you for a $20 fee. Copies of xrays are available to you for a $20 fee. *By Federal and Georgia State law, we are required to keep your records for a period of 10 years and therefore cannot release original medical records or xrays.* Please allow 1 week for records and xray copies to be ready.
9. There is a $25 fee for completion of forms such as disability, FMLA, employer forms, etc.

☐ I understand and accept the above financial policy

_____ _____
Please Print Name Date of Birth

_____ _____
Patient/Parent Signature Date

2790 Sandy Plains Road, Suite 300, Marietta, GA 30066
PHONE (770) 977-3668 **FAX** (770) 578-0033
www.afcenters.com

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Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name:_____

I understand that Ankle & Foot Centers, PC is a healthcare provider and may share my health information for treatment, payment and healthcare operations only. I have been provided a copy of the organization's Notice of Privacy Practices brochure that describes how my health information is used and shared. I understand that Ankle & Foot Centers, PC has the right to change this notice at any time. **My signature is my acknowledgment that Ankle & Foot Centers has informed me of their compliance with HIPAA regulations and is not a release of medical records.** Release of medical records requires a separate authorization from the patient.
My signature below constitutes my acknowledgement that I have been provided access to a copy of the Notice of Privacy Practices brochure which is available at the front check in desk. If any person is physically unable to provide a signature OR signs with a mark, print his/her name on the appropriate line below and record the signatures of two responsible persons who witness that such a person understands the nature of this acknowledgement.

If the patient is not capable of acknowledging the notice because of age or medical condition, complete the following:
Patient is a minor (_____ years of age) OR Patient is unable to acknowledge because

_____

I am allowing Ankle & Foot Centers,PC to communicate my personal health record with the following persons: ☐spouse ☐son/daughter ☐grandchild ☐sibling ☐ex-spouse ☐other_____

I am allowing Ankle & Foot Centers,PC to leave messages on my ☐home phone ☐cell phone

Patient/Legal Guardian/Relative Signature Date Legal Guardian/Relative Relationship

……

Office use only

AF#_____ version 4/14

Patient did not sign due to:_____

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MEDICAL HISTORY

Patient Name_____ Age:_____ ☐Male ☐Female

Name of Primary Care Physician: _____ **Phone**: _____

Are you currently under the care of another physician? ☐**YES** ☐**NO**
If yes, name of physician: _____ **Phone:** _____
For what reason: _____

List all medications that you are currently taking and dosage amount:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

List any Medication Allergies:

_____
_____
_____
_____

Any Food allergies?

_____
_____

Please mark Medical Conditions you <u>currently have</u> or <u>have had</u> in the past:

☐ artificial joints (hip,knee)	☐ heart disease	☐ neurological disorder
☐ arthritis/rheumatism	☐ heart attack/surgery	☐ psychiatric/psychological care
☐ asthma/emphysema	☐ hepatitis/liver disease	☐ rheumatic fever
☐ back injury	☐ high blood pressure	☐ sickle cell anemia
☐ cancer (Type:_____)	☐ HIV positive	☐ stroke/CVA
☐ circulation problems	☐ kidney problems	☐ thyroid condition
☐ DIABETES	☐ Foot wound	☐ tuberculosis
☐ hyperlipidema/cholesterol	☐ mitral valve prolapse	☐ ulcers (stomach)
☐ epilepsy or seizures	☐ phlebitis or blood clot in leg	☐ OTHER_____

List previous surgery: **Approximate month/year**

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

Have you had problems with anesthesia in the past? ☐**YES** ☐**NO**

Do you drink alcohol? ☐YES ☐NO **Height:** _____ **Weight:**_____

Do you smoke? ☐YES ☐NO **Former smoker?** ☐YES ☐NO Shoe size:_____

Describe your foot or ankle problem:_____
_____
When did this problem begin?
_____
What types of treatment have you tried or had?
_____

Submit Forms via Outlook