PATIENT INFORMATION

Gary S. Fields, DPM, FACFAS
Kenneth M. Danis, DPM, FACFAS

DEMOGRAPHICS

First Name	Middle Initial	Last Name	Gender M F

SSN	Birthdate	Age	Email

Mailing address:	Apt #

City:	State:	ZIP Code:	Home Phone	Cell Phone

OTHER

Primary Physician	Date Last Seen	Primary Language

Race: ____American Indian/Alaska Native ____Asian ____Black/African America ____Native Hawaiian/Pacific Islander ____White

Ethnicity: (check one) ____Not Specified ____Hispanic/Latino ____Not Hispanic/Latino

Emergency Contact	Phone Number	Referral Source (How did you hear about us?)

BILLING

Marital Status ____Divorced ____Married ____Partner ____Single ____Widowed

Student Status ____Full Time Student ____Not a Student ____Part Time Student

Employment Status ____Employed Full Time ____Employed Part Time ____Unemployed

Employer Name	Phone Number

PREFERENCES

Contact Preferences

____Phone: ____Okay to leave a message with: ____Anyone ____Patient Only ____Patient or Spouse

____Mail	____E-Mail

INSURANCE INFORMATION

Primary Insurance Name	Policy Number	Group Number

Subscriber Name (If not patient)	Birthddate

Secondary Insurance Name	Policy Number	Group Number

Subscriber Name (If not patient)	Birthddate

PAYMENT POLICY

Thank you for choosing West Georgia Podiatry as your foot care provider. We are committed to providing you with quality and affordable health care. Please read the following office payment policy and feel free to ask us any questions that you may have. Once you accept this policy, kindly sign in the space provided. A copy will be provided to you upon request.

1. Insurance: We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have a current insurance card, payment will be required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. Co-payments and deductibles: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying at each visit.
3. Non-covered services: Please be aware that some of the services you receive may be uncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
4. Proof of insurance: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to verify insurance coverage. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. If required, obtaining the proper referral from your Primary Care Physician is your responsibility. Patients presenting to our office without a valid referral will be asked to pay in full. This payment will be held for 48 hours and will become non-refundable if the proper referral is not obtained by then.
5. Claims submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.
6. Coverage changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
7. Nonpayment: Invoices are sent out every 30 days. Your prompt payment will assist us in keeping the cost of healthcare down. A $10.00 rebilling fee will be charged for each additional invoice sent out after 30 days. Partial payments will only be accepted if prior-approved by our billing department. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. In the event this happens, our physician will only be able to treat you on an emergency basis.
8. Missed appointments: It is our policy to call you and confirm your scheduled appointment. There will be a $25.00 charge for missed appointments not canceled within a reasonable amount of time or for an understandable reason. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.
9. Forms and Documents: It is our policy to charge $15.00 for completion of all forms, such as disability applications, etc.
10. Fees: Our fees are representative of the usual and customary charges for specialists in our area.

Thank you for understanding our payment policy. Please let us know if you have any questions.

I have read and understand the payment policy and agree to abide by these guidelines.

Signature of patient (or responsible party) Date

MEDICAL INFORMATION

Patient Name: ____ Date: ______________

Patient # _____________________________________

The following information is important for our records and your health:

1. Describe your foot problem:

2. How long has it been bothering you? __________days __________ weeks __________ years

   Have you ever had any treatment for this condition? ___ yes ___ no

   Describe Treatment:

3. List any past problems you have had with your feet and/or ankles:

4. List any surgical procedures you have had on your feet:

5. Shoe Size: _______ Current Weight: ________ Height: ________ Age: _______

6. Medical History – Please mark "yes" or "no" if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No		Heart Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No		Heart Murmur	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No		Hepatitis/Jaundice	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No		High Blood Pressure	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No		Kidney Problems	☐ Yes	☐ No
Asthma	☐ Yes	☐ No		Liver Disease	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No		Lung Disease	☐ Yes	☐ No
Bleeding Disorder	☐ Yes	☐ No		Nerve Damage	☐ Yes	☐ No
Cancer	☐ Yes	☐ No		Phlebitis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No		Seizures	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No		Stomach Ulcers	☐ Yes	☐ No
Drug Dependency	☐ Yes	☐ No		Stroke	☐ Yes	☐ No
Foot of Leg Ulcers	☐ Yes	☐ No		Skin Disorders	☐ Yes	☐ No
Gout	☐ Yes	☐ No		Thyroid Disease	☐ Yes	☐ No
Hearing Loss	☐ Yes	☐ No		Varicose Veins	☐ Yes	☐ No

7. Please list any other medical conditions not listed above:

8. Please list the surgeries or hospitalizations you have had:

9. Please list your physician: __________________________ When were you last seen? ________________

10. Do you have a family history of: _____ Diabetes _____Heart Disease _____ Cancer _____ Arthritis

    _____ Gout _____Bunions _____ Flat Feet

11. Do you use tobacco products? No Yes # packs/cigars per day _____________

12. Do you drink alcohol, beer or wine? No Yes
    Light (1-2 per week)
    Moderate (1-2 per day)
    Heavy (More than 2 per day)

13. What is your occupation?
    Do you Sit at job?
    Stand at job?
    Stand and walk at job?

14. MEDICATIONS
    List all prescriptions, over-the-counter medications and vitamins you currently take:
    1.
    2.
    3.
    4.
    5.

ALLERGIES
Are you allergic to any of the following?

Adhesive Tape	Local Anesthetics
Aspirin	Penicillin
Codeine	Seafoods
Demerol	Sulfa
Iodine	

Other:

CONSENT
I certify that the above information is true and correct to the best of my knowledge. I give my permission to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my condition.

Signature Date

_______________ Initials

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT, AND TREATMENT CONSENT

Health and accident insurance policies are a contractual arrangement between an insurance carrier and the insured. It is the responsibility of the insured to verify eligibility for health care benefits. Possession of a medical insurance member ID card is NOT a guarantee of coverage. As a courtesy to you, we will gladly submit your medical bills to your insurance carrier.

1. **Primary Insurance**: I request that payment of authorized benefits be made on my behalf to **West Georgia Podiatry Associates, P.C.** for services furnished to me by **West Georgia Podiatry Associates, P.C.** I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the release of medical information necessary to pay the claim. **West Georgia Podiatry Associates, P.C.** accepts the charge determination of the carrier as the full charge, and I am responsible only for the deductible, coinsurance, co-pays and non-covered services. Copays, coinsurance and deductibles are based upon the charge determination of the carrier and are due at the time of service. Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to **West Georgia Podiatry Associates, P.C**. Secondary Insurance: I request that payment of authorized secondary insurance benefits be made on my behalf to **West Georgia Podiatry Associates, P.C**. if possible or otherwise to me, at which time I would forward all payments to **West Georgia Podiatry Associates, P.C.**

2. **Release of Information: West Georgia Podiatry Associates, P.C.** may disclose all or any part of medical record and/or financial ledger to any person or corporation (1) which is or may be liable or under contract with **West Georgia Podiatry Associates, P.C.** for reimbursement for services rendered and (2) any health care provider for continued patient care. **West Georgia Podiatry Associates, P.C.** may also disclose, on any anonymous basis, any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statutes, or regulation.

3. **Non-Covered Services:** I understand that **West Georgia Podiatry Associates, P.C.** contracts with health insurance plans. Accordingly, the undersigned accepts full financial responsibility for all items and services which are determined by the health care insurance plan as non-covered services.

4. **Financial Agreement:** As a courtesy we will file your insurance, but if after 6 weeks your insurance has not responded to the claim filed, you will be notified that the unpaid balance is now your responsibility and payable within 2 weeks of notification. I agree that in return for services provided to me by **West Georgia Podiatry Associates, P.C.** I will pay my account at the time service is rendered or will make financial arrangements satisfactory to **West Georgia Podiatry Associates, P.C.** for payment. If an account is sent to collections, I agree to pay collection expenses. I understand and agree that if my account is delinquent, I may be charged a service fee. It is understood that the undersigned and/or the patient are primarily responsible for the payment of the bill. **Furthermore, by signing below I acknowledge that I have been made aware that there is a $35.00 fee for all returned checks and a $25.00 fee for any missed appointments where a 24-hour notice is not given. The parent/legal guardian bringing the child to our facility will be responsible for required co-payments, coinsurances, deductibles, etc... at the time of service.**

5. **Privacy Plan:** I agree that I have been given the opportunity to read and receive a copy of **West Georgia Podiatry Associates, P.C.'s** Notice of Privacy Practices.

6. Notice: Anyone under the age of 18 will not be seen without a parent or guardian present unless you are an emancipated minor.

7. **Treatment Consent: By signing below I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me, as the doctor deems necessary.**

8. **Additional Disclosure Authority:** Please indicate any additional parties we are allowed to speak with regarding your account and release of medical information (please circle):

Spouse? Name ____ YES NO

Other? Name ____ YES NO

Immediate Family? Name ______________________________________ YES NO

Can we leave a message regarding your health information on your answering machine? YES NO

This assignment will remain in effect until revoke& by me in writing. A photocopy of this assignment is to be considered as valid as the original.

______________________________________ ______________________
Signature of Patient, Guardian or Representative Date

____________________ ____________________ ____________________
Please Print Name Relationship to Patient Patient's Date of Birth