Foot & Ankle SPECIALISTS of Middle Tennessee

## GENERAL INFORMATION

Date: _____

Patient Name: _____ Date of Birth: _____ Sex: M / F

Social Security Number _____-_____-_____ Preferred Language: _____

Race: (please circle) American Indian/Alaska Native Asian Black/African American White

Native Hawaiian/Pacific Islander Hispanic Other Decline

Ethnicity: (please circle) Hispanic or Latino NOT Hispanic or Latino Decline

Marital Status: [ ] Married [ ] Single [ ] Widowed [ ] Divorced [ ] Other

Address: _____Apt#:_____City:_____ State: _____Zip: _____

Home Phone: _____Work Phone: _____ Cell: _____

Primary (please circle) Home Work Cell E-mail Address: _____

Employment Status: [ ] Employed [ ] Unemployed [ ] Retired [ ] Disabled [ ] Student

Employer: _____ Occupation: _____

Employer Address: _____

Employer Phone: ( ) _____

## EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____ Relationship: _____

Contact Phone: ( ) _____

Preferred Pharmacy Name & Address: _____

Pharmacy Phone: ( ) _____

## FINANICAL INFORMATION

- Payments for co-pays, deductibles and non-covered services are due at the time of service, unless other arrangements have been made in advance with our billing staff.
- Insurance balances are billed to patient on receipt of notice from your insurance carrier and are due in 30 days from the date billed from Foot & Ankle Specialists of Middle Tennessee, PLLC.
- Unpaid patient balances over 120 days will be turned over to our collection agency and a fee for collection will be added to the account. The collection fee is $75 or 20% of collection balance, whichever is greater.
- Delinquent accounts will result in discharge from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative podiatric care. During that 30-day period, our physician will only be able to treat you on an emergency basis.
- Foot & Ankle Specialists of Middle Tennessee has a policy of billing primary and secondary insurances; however, if you have a tertiary insurance you will be responsible for any balance and it is up to you to file and seek reimbursement from the tertiary carrier.

Person Responsible for Account: _____Relationship to Patient: _____

DOB: _____ Social Security Number: _____

**Address (if different from patient):**_____

## BILLING & INSURANCE INFORMATION

**Primary Insurance Name**: _____

Policy# (or Member ID): _____ Group #: _____

Policyholder Name: _____ DOB: _____

Relationship: _____

**Secondary Insurance Name**: _____

Policy# (or Member ID): _____ Group#: _____

Policyholder Name: _____ DOB: _____

Relationship: _____

## Assignment, Release and Acknowledgement:

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above mentioned insurance company, and assign directly to Foot & Ankle Specialists of Middle Tennessee, 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 hereby authorize payment of benefits to be made to the physician rendering services. I also understand that I will be held responsible for any costs, which are not covered by my insurance carrier, including any deductible, co-insurance, co-pay, denial, or any uncovered services. I understand that if I am examined by a physician who does not participate with my insurance, I will receive payment directly from the insurance carrier. I understand fully that it is my responsibility to sign over all payments, including the Explanation of Benefits (EOB), to the examining provider. I hereby authorize Foot & Ankle Specialists of Middle Tennessee to release all the information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand I am fully responsible for all fees incurred for service(s) rendered including collection agencies and attorney's fees. I also understand if I do not have insurance coverage all fees incurred for service(s) rendered are due at the time of service. I understand the payment policies as outlined above.

Patient/Responsible Party Signature: _____ Date: _____

## Medicare Authorization:

I request that payment of authorized Medicare benefits be made to Foot & Ankle Specialists of Middle Tennessee for any services furnished to me by Foot and Ankle Specialists of Middle Tennessee. I authorize the release of information about me or any information needed to determine benefits or the benefits payable for related services to the Health Care Financing Administration and its agents. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If another health insurance is indicated, or electronically submits claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient/Responsible Party Signature: _____ Date: _____

## Consent:

I hereby consent to be routinely treated by the doctors of Foot and Ankle Specialists of Middle Tennessee, PLLC, who are deemed necessary to evaluate and/or treat foot and ankle injuries for myself or the patient mentioned above for who I am responsible. I acknowledge that no guarantees have been made as to the nature of examination and/or procedures recommended or performed. If further diagnostic testing is required, it is my decision whether to proceed with the testing recommended after it has been fully explained to me by the physician.

Patient/Responsible Party Signature: _____ Date: _____

## X-Rays & Photographs:

I understand that in the course of my treatment I may have radiographs (X-Rays); I agree to inform the doctor or technologist if I am or may be pregnant. I authorize the physician and his assistant to take photographs. The term "photograph" includes Polaroid's, digital, 35mm slide, standard photographs, videotapes, etc. These photographs are property of Foot and Ankle Specialists of Middle Tennessee and will be a permanent part of the record. These may be used for teaching, lectures, educational conferences, or publications.

Patient/Responsible Party Signature: _____ Date: _____

Foot & Ankle SPECIALISTS of Middle Tennessee

## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

**Summary:**
By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this notice.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

If you have any questions or concerns about this Notice, please contact our Privacy Officer, at (615) 896-9493.

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### Acknowledgement of Notice of Privacy Practices

"I hereby acknowledge that I have received a copy of this practice's **NOTICE OF PRIVACYPRACTICES**. I understand that if I have questions or complaints regarding my privacy rights that I may contact the Privacy Officer. I understand that the practice will offer me updates to this **NOTICE OF PRIVACY PRACTICES** should it be amended, or changed in any way."

- I, _____, authorize my physicians and his/her staff to contact me by the designated means noted below.

  Please check all that apply.

  [ ] Home Phone [ ] Home Answering Machine/Voice Mail [ ] Cell Phone/Voice Mail

  [ ] Office/Work Place/Voice Mail

*I authorize my physicians and his/her staff to communicate information regarding appointments, medical results, and billing issues to the following person(s). Please print name and indicate your relationship.

Name _____ Relationship _____

Name _____ Relationship _____

**Patient or Representative Signature**: _____ **Date**: _____

[ ] Patient refused to sign [ ] Patient was unable to sign because _____

Foot & Ankle SPECIALISTS of Middle Tennessee

## HEALTHCARE QUESTIONAIRE

**Patient Name:** _____ **DOB:** _____

**How did you hear about our Practice?** _____

**Primary Care Physician:** Name: _____ Phone #:_____
Date Last Seen: _____

**Referring Physician:** Name: _____ Phone #: _____
Date Last Seen: _____

## CHIEF COMPLAINT

Why are you here today? _____

Where is the problem area? _____

How long have you had this problem? _____

Have you been evaluated or treated for this problem elsewhere? **No** **Yes**

(If yes) When? _____ and Where? _____

## PERSONAL MEDICAL HISTORY Please Circle All That Apply

| | | | |
|---|---|---|---|
| AIDS/HIV | Congestive Heart Failure | Hemophilia | Radiation/Chemo |
| Alcoholism | Depression | Hepatitis – A B C | Respiratory Disease* |
| Allergies/Hay Fever | Diabetes* | High Blood Pressure | Rheumatic Fever |
| Alzheimer's | Drug/Chemical Dependency | High Cholesterol | Sinus Problems* |
| Anemia | Ear Problems* | High Triglycerides | Skin Problems* |
| Arthritis* | Eye Problems* | Kidney/Bladder Problems* | Sleep Apnea |
| Asthma* | Fibromyalgia | Liver Disease* | Stroke |
| Back Problems* | Gallbladder Disease | Low Blood Pressure | Thyroid Problems* |
| Bleeding Disorders* | GERD/Hiatal Hernia | Medical Implants* | Tuberculosis (TB) |
| Blood Clots/DVT/PE* | GI Ulcers | Osteopenia | Varicose Veins |
| Cancer* | Gynecological Problems* | Osteoporosis | Venereal Disease |
| Chronic Diarrhea | Headaches | Nervous System Disorder | Vertigo |
| Circulatory Problems* | Heart Disease* | Psychiatric Care* | Other: _____ |

Foot & Ankle SPECIALISTS of Middle Tennessee

**INFECTIONS** List current or previous infections

[ ] MRSA: Date _____ [ ] Hepatitis B: Date _____ [ ] Hepatitis C: Date _____

[ ] TB: date _____ [ ] Other: _____ Date: _____

**HOSPITALIZATIONS & SURGERIES**

Have you been hospitalized or had **any surgeries** in the past? **No** **Yes --- Please list below**

1) _____ Date: _____
2) _____ Date: _____
3) _____ Date: _____
4) _____ Date: _____
5) _____ Date: _____
6) _____ Date: _____

**MEDICATIONS**

Do you currently take oral contraceptives? **No** **Yes** --- Medicine Name: _____

Please check if no medications are currently being taken. [ ] None

**PLEASE LIST ALL PRESCRIBED AND OVER THE COUNTER MEDICATIONS INCLUDING VITAMINS/SUPPLEMENTS. PLEASE USE THE BACK IF NEEDED.**

| | **Name of Medication** | **Dosage** | **How often do you take?** |
|---|---|---|---|
| 1. | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ |
| 4. | _____ | _____ | _____ |
| 5. | _____ | _____ | _____ |
| 6. | _____ | _____ | _____ |

**ALLERGIES** Please Check All That Apply

[ ] No Known Allergies [ ] Iodine [ ] Penicillin [ ] Latex [ ] Aspirin
[ ] Adhesive Tape [ ] Demerol [ ] Codeine [ ] Sulfa [ ] Seafood
[ ] Local Anesthetics (example: Novocain) [ ] Other: _____

**FAMILY HISTORY** Please Circle All That Apply

[ ] Heart Disease; Please indicate relationship: Father Mother Brother Sister Son Daughter

[ ] Cancer; Please indicate relationship: Father Mother Brother Sister Son Daughter

Type of cancer _____

[ ] Diabetes; Please indicate relationship: Father Mother Brother Sister Son Daughter

[ ] Other: _____ Relationship: Father Mother Brother Sister Son Daughter

**SOCIAL HISTORY**

**Do you participate in any exercise regimen on a regular basis?**

**No** **Yes** If yes, what type and how often? _____

**Do you or have you ever smoked or chewed tobacco?**

**Never**

**Not Currently** Date quit: _____

How long tobacco was used for: _____ How much tobacco was used daily: _____

**Yes** If yes, how many / much per day? _____ Year started: _____

**Do you use recreational drugs?** **No** **Yes**

**Do you consume any alcohol?** **No** **Yes** If yes, how much and how often? _____

**Current Height: _____ (Ft) Current Weight: _____ (Lbs) Shoe Size: _____N M W**

**CERTIFICATION**

I certify that the information provided above is true, correct, and complete to the best of my knowledge, information, and belief.

Signature of Patient or Legal Guardian _____ Date Signed_____

Printed Name of Patient or Legal Guardian _____