Chattanooga
FOOT & ANKLE CLINIC

PATIENT INFORMATION

Last Name_____ First Name_____MI_____ Sex ☐ M ☐ F

Date of Birth_____ Age_____ Social Security #_____

Address _____ City_____ Zip _____

Who can we thank for referring you/how did you find us?_____

Family Physician_____ City_____Date of Last Visit_____

Pharmacy_____City_____

Height _____ Weight_____ Shoe Size_____

CONTACT INFORMATION

Home Phone_____ Cell Phone _____

Email _____

In case of emergency, please contact:

Name _____ Phone _____

EMPLOYMENT

Name of Employer _____ Address _____

At your job do you: O Sit mostly O Stand mostly O Sit and stand

Are you required to wear a specific type of shoe/boot? _____

MEDICAL HISTORY Please check all that apply

O AIDS/HIV	O Heart Disease	O Gout	O Diabetes(insulin)
O Diabetes (No insulin).	O Kidney disease	O Fibromyalgia	O Lung Disease
O Blood Clots	O Arthritis	O Hepatitis	O Artificial Joint
O High Blood Pressure	O Stomach problems	O Cancer: _____	
O Stroke (CVA)	O Anxiety/Depression	O Artificial joint	

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REVIEW OF SYSTEMS Please circle all that apply

Constitutional: weight loss/gain, fatigue, fever, loss of appetitie,

Eyes: eye pain/drainage, visual change, dry/irritated eye

HENT: ear pain/drainage, sinus infections, hearing loss/change,

Cardiovascular: chest pain/palpitations, heart murmur, fainting, Swelling feet/legs,

Respiratory: blood in sputum, wheezing, cough lasting >1 month

Gastrointestinal: abdominal pain, blood in stools, nausea/vomiting, indigestion,

Genitourinary: blood in urine, menstrual changes, urinating that is painful

Integument: rash, itching, new lesion, discharge from skin, change in skin color

ALLERGIES: Please circle ALL allergies

Codeine Penicillin Sulfa Tape Latex Cortisone (steroids) Iodine

Other Allergies:_____

_____

PAST SURGICAL HISTORY

Previous Surgeries: _____

PAST SOCIAL HISTORY

Do you smoke tobacco? O Yes O No If yes, how many packs per day?_____

Do you drink alcohol? O No O Occasional O Moderate O Heavy

PAST FAMILY HISTORY Please circle all that apply

Family history of: _____

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MEDICATIONS with dosage (Provide list for copy, if available)

REASON FOR VISIT

Reason for todays visit _____ How long?_____

Severity of pain: O Mild O Moderate O Severe O Severe at times

Type of pain: O Sharp O Dull O Stabbing O Aching O Burning Other_____

The problem is: O Improving O Worsening O Unchanged

What makes it worse:_____

What makes it better:_____

What treatments have you tried, if any?_____

*Do we have your permission to look at your previous medications from other doctors and or pharmacies? _____ Yes _____ No

_____ _____

Signature Date

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AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of information including claims, diagnosis, records, treatment, and radiology information. This information may be released to parties previously listed or physicians participating in my care.

Signature:_____ **Date:**_____

Printed Name:_____ **Relationship to patient:**_____

CONSENT FOR TREATMENT

I voluntarily consent for examination and treatment by Chattanooga Foot and Ankle Clinic, including diagnostic procedures, surgical and medical treatment, rendered by the Physician or authorized designees, as may in their professional judgement be necessary.

Signature:_____ **Date:**_____

Printed Name:_____ **Relationship to patient:**_____

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Please provide your insurance card and drivers license to the receptionist to be copied. Thank you.

Insurance Information

Primary Insurance: _____

Policy # / Subscriber ID #: _____

Relationship: ( ) Self ( ) Spouse ( ) Other Relation _____

Name of Policy Holder: _____

Policy Holder Date of Birth: _____

Policy Holder Social Security #: _____

Secondary Insurance: _____

Member #/Subscriber ID #: _____

Relationship: ( ) Self ( ) Spouse ( ) Other Relation_____

Name of Policy Holder: _____

Policy Holder Date of Birth: _____

Policy Holder Social Security #: _____

I acknowledge that the above is true to the best of my knowledge. I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read) as I so choose, and understand the notice.

_____ _____

Printed Name Date

_____ _____

Signature Parent or Authorized Representative (if applicable)

INSURANCE PATIENTS ONLY – (Please initial one & Sign Below)

_____ I understand that even though I am paying my copay or towards my deductible today that my insurance is being billed. I understand that I still may receive a bill and any remaining balances will be my full responsibility. (Even if I have a secondary insurance.)

_____ I understand that my insurance is Out-of-Network – and even though I am paying my copay or towards my deductible today that my insurance is being billed out of network and my coinsurance could be higher. I understand that I still may receive a bill and any remaining balances will be my full responsibility.

_____ I understand that even though I have insurance – I have decided to opt out and pay as a self-pay cash patient. I understand that my insurance WILL NOT be billed and fees for services rendered must be paid today.

_____ _____

Signature **Date**

NON-INSURED – CASH PATIENTS – (Please initial & Sign Below)

_____ I understand that I do not have any insurance and as a cash patient all fees must be paid today for services rendered. Please be advised that the cash-pay discount is only applicable when charges are paid in full at the time of service.

_____ _____

Signature **Date**

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FINANCIAL POLICY

We appreciate your selection of Chattanooga Foot and Ankle Clinic for your podiatry care and needs. Our goal is to provide every patient with excellent and affordable healthcare. Please review the financial policy and sign at the bottom of the page. This will be scanned in your chart, and available to you on request.

1. **PATIENT PAYMENT**: As part of your contract and arrangement with your insurance company, all copays and deductibles are to be paid at the time of service.
2. **INSURANCE**: If your insurance plan is not a plan we participate in, payment in full is expected at each visit. Please review your insurance benefits, as this knowledge is your responsibility. Contact your insurance company with any questions you may have regarding your coverage to receive maximum benefit. I understand the following:
    a. Any payment received by Chattanooga Foot and Ankle Clinic may be applied to any unpaid bills for which I am liable.
    b. I understand that different that different Payors have different requirements for payment including, but not limited to, referrals, authorizations, precertification or medically necessary services.
    c. I am financially responsible for any charges not covered on this policy and agree to pay the full balance that is not reimbursed by my medical provider benefits.
3. **REGISTRATION**: A copy of your current valid insurance card and drivers license is necessary to complete registration. It is your responsibility to provide up to date and accurate information to avoid being responsible for balance of the claim due to change in insurance or inaccurate information.
4. **CLAIMS**: We will submit claims to your insurance. It is your responsibility to comply with any information requested by your insurance. We are not party to the contract between you and your insurance contract.
5. **COLLECTIONS**: If you are account is more than 90 days past due, and have not made payment arrangements, your account is subject to collection action. If the account is sent to collections, and not addressed within 60 days, the patient may be discharged from the practice. You will be notified by regular and certified mail that you have 30 days to find alternative care. During that 30-day period, our physician will only treat you on an emergency basis.

I acknowledge that I have received and read the Financial Policy of Chattanooga Foot and Ankle Clinic.

Signature:_____ **Date:**_____

Printed Name:_____ **Relationship to patient:**_____

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

_____

This consent was signed by: _____ (PRINT NAME) Signature: _____

Date: _____

Witness (Practice Representative: _____ Date: _____