THE FOOT AND ANKLE INSTITUTE OF GEORGIA
"HEAL. WALK. LIVE"

NEW PATIENT REGISTRATION

(PLEASE PRINT)

______________________ __________ ______________________

FIRST NAME MIDDLE INITIAL LAST NAME

DOB: ____________________ SS#: ____________________ GENDER: M / F

MARITAL STATUS: □ Single □ Married □ Separated □ Divorced □ Widowed □ Other

ADDRESS: ______________________________ CITY: ______________ STATE: ____ ZIP: ________

HOME #: ____________________ CELL #: ____________________ WORK #: ____________________

EMAIL: ____

PREFERRED METHOD OF COMMUNICATION (CIRCLE): CELL EMAIL HOME WORK

DO WE HAVE YOUR PERMISSION TO REACH YOU USING YOUR CHOSEN METHOD? __(Y) __(N)

EMPLOYMENT STATUS : ____

EMERGENCY CONTACT

NAME: ____

RELATIONSHIP TO PATIENT: ________________________

PHONE: ____

PRIMARY INSURANCE (PLEASE PROVIDE US WITH YOUR INSURANCE CARD)

Subscriber's Name: ______________________________ DOB: ________________________

Relationship to Patient: ___________________________ Group #: ______________________

Insurance Company: ______________________________ I.D. #: ________________________

SECONDARY INSURANCE

Subscriber's Name: ______________________________ DOB: ________________________

Relationship to Patient: ___________________________ Group #: ______________________

Insurance Company: ______________________________ I.D. #: ________________________

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THE FOLLOWING SETS FORTH THE GENERAL BILLING POLICY OF

THE FOOT AND ANKLE INSTITUTE OF GEORGIA, LLC

PLEASE REVIEW THIS INFORMATION AND INITIAL AND/OR SIGN WHERE INDICATED.

❁I understand that it is my responsibility to provide the office of **FAIOG, LLC**. information at the time of check in and to notify **FAIOG, LLC**. of any changes in this information. _________

❁I understand that it is my responsibility to know my specialty **co-pays**, **deductible** and **co-insurance** (which can be different than my Primary Care Benefits) and to pay it prior to services being rendered. I understand that this is a contractual agreement with my health plan collect co-pays, deductibles at the of service. __________

❁I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a **$35 NSF fee**. I further understand that to rectify understand that to rectify my account, I will be required to pay with either cash, a money order, cashier's check, or credit card. __________

❁I understand there is a **$25 fee to complete disability paperwork** associated with my case. I will be provided a standard form of charge; however, if additional disability forms (such as FMLA) require completion, I understand that the $25 fee that (payable prior to compilation) is required. ___________

❁I understand that FAIOG, LLC will verify my insurance eligibility, deductible amounts, any coinsurance amounts prior to any electives surgery that I may have. I further understand **that THE FEE I AM QUOTED IS AN ESTIMATE** based on **1) anticipated surgery to be performed and 2) current information provided to clinic by my insurance carrier**. ________

❁I understand that I will be billed for any amounts due by me (co-payments / co-insurance amounts / deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with **two (2) statements for any balance** due after insurance payment. I further that understand that if I have not made payment prior to the second statement being mailed, that the fulfill my financial obligations**. I also understand that I will be responsible for any collection, interest of legal expense associated with the collection efforts.** ________

❁I understand that **FAOIG, LLC** will obtain the necessary prior authorizations prior to rendering treatment. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier. _________

THANK YOU FOR AKING THE TIME TO REVIEW OUR FINANCIAL POLICY! YOUR COOPERATION IS

GREATLY APPRECIATED! IF YOU SHOULD HAVE ANY QUESTIONS AND / OR REQUIRE ANY ASSISTANCE,

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MEDICAL HISTORY FORM

Reason for visit: ____

Please, indicate current and past medical history

Diabetes Mellitus (TYPE 1 or TYPE 2) .... Y N
Hypertension (High Blood Pressure) .... Y N
Cancer .... Y N
Blood Clot (DVT / PE) .... Y N
Anemia .... Y N
Stroke .... Y N
Kidney Disease .... Y N
Peripheral Vascular Disease .... Y N
Rheumatoid Arthritis .... Y N
Gout .... Y N
Osteoarthritis (Arthritis) .... Y N
Hypercholesterolemia (High Cholesterol) .... Y N
Bleeding Disorder .... Y N
Other .... Y N

PLEASE INDICATE SOCIAL HISTORY

TOBACCO USE:
□ NEVER
□ FORMER SMOKER; QUIT _____ YRS AGO
□ CURRENT; _______ PACKS PER DAY

ALCOHOL USE:
□ NEVER
□ OCCASIONAL
□ MODERATE
□ DAILY

DRUG USE:
□ NEVER
□ HISTORY OF USE
□MARGINAL USE

PLEASE INDICATE ANY PAST SURGERIES

SURGERY/SERIOUS INJURY/ILLNESS	YEAR	PHYSICIAN	HOSPITAL

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HIPAA ACKNOWLEDGEMENT

I UNDERSTAND that I have the right to review **THE FOOT AND ANKLE INSTITUTE OF GEORGIA, LLC., FAIOG**, Notice of private practices prior to this consent. **I UNDERSTAND** that **FAIOG** reserves the right to change their notice and practices, and I will be given new notification if this occurs. **I UNDERSTAND** that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations, and the organization is not required to agree to restrictions requested. **I UNDERSTAND** that I may revoke this consent in writing, except to the extent that the organization has already acted in reliance thereon.

I UNDERSTAND that I am releasing all or any part of my medical record for the purpose of treatment, payment, or practice operations. This release may include records containing information regarding the diagnosis and/or treatment of HIV/AIDS, mental illness, and/or drugs and/or alcohol abuse to any person or corporation which is or may be liable under contract for all or part of the medical charges, including but not limited to: Medicare, Medicaid, DSHS, or other private or public health insurance programs, reviewing agencies, worker's compensation carriers, welfare agencies or patient's employer. The records may be needed in order to process a claim for medical services.

I AUTHORIZE FAIOG, LLC. To release information needed of billing purposes to entities that may provide services pertaining to my physician visit, such as reference laboratories:

____

Patient Signature Patient's Printed Name Date

If patient is unable to sign this Authorization, please complete the following:

____

Signature of Guardian/Representative Print Guardian/Representative Name Date

RELEASE OF MEDICAL INFORMATION TO FAMILY MEMBER(S)

During the course of your treatment it may become necessary or desirable to discuss your condition with a family member or Family friend. Below, please indicate with whom we may discuss your condition and/or treatment:

____

Print Family Member(s) or Friend(s) Name(s) Date of Birth

DOCUMENTATION OF FAILURE TO OBTAIN SIGNED ACKNOWLEDGEMENT

I presented this acknowledgement to the patient. The patient refused to provide a signature when requested.

____

Staff Member Signature Printed Name Date

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Please list your ALL medications (BOTH prescription AND over the counter) and dosage, doctor and date you started taking it.

PBM CONSENT:
Do we have your permission to obtain your medication list from your pharmacy? : (Y) (N)

PHARMACY NAME(S): ____
PHARMACY PHONE #: ____

MEDICATION	DOSAGE	PRESCRIBING PHYSICIAN	CURRENTLY TAKING (Y/N)

ALLIERGIES: ____________________________________ ☐ NO KNOWN ALLERGIES

I HAVE PERSONALLY REVIEWED THE ABOVE INFORMATION

PATIENT SIGNATURE: ____________________________________ DATE: __________