North Fulton Podiatry

Patient Registration Form

PATIENT

Legal Name: Last | **First** | **Middle Initial** | **Social Security #**

Street Address | **Apartment #** | **Birthdate** | **Sex**

City | **State** | **Zip** | **Martial Status** **M S D W** | **Are you a student?** **No Yes (part-time) Yes (full-time)**

Home Phone | **Work Phone** | **Extension** | **Cell Phone**

E-mail | **Emergency Contact** | **Phone #** | **Relationship**

Employer | **Employer Address: Street** | **State** | **Zip**

Pharmacy Name | **Pharmacy Phone & Address**

SPOUSE

Legal Name: Last | First | Middle Initial | Social Security #

Street Address | Apartment # | Birthdate

City | State | Zip | E-mail

Home Phone | Work Phone | Extension | Cell Phone

Employer | Employer Address: Street | State | Zip

PRIMARY INSURANCE

Insurance Name

Address | Effective Date

City | State | Zip | Telephone #

Subscriber Name | Birthdate | Patient's Relationship to Subscriber (circle one) **SELF SPOUSE CHILD OTHER**

Policy/ Contract # | Group # | Subscriber's Social Security Number

SECONDARY INSURANCE

Insurance Name

Address | Effective Date

City | State | Zip | Telephone #

Subscriber Name | Birthdate | Patient's Relationship to Subscriber (circle one) **SELF SPOUSE CHILD OTHER**

Policy/ Contract # | Group # | Subscriber's Social Security Number

Primary Care Physician

Physician's Name

Street Address | Suite # | City | State | Zip

Office Phone | Fax

Referring Physician

Physician's Name

Street Address | Suite # | City | State | Zip

Office Phone | Fax

Authorization to File/ Release Information:
I hereby authorize North Fulton Podiatry to file a claim to my insurance company for medical services rendered to me. I further authorize North Fulton Podiatry to release any medical information to my insurance company or third part payors or its agents for completion of insurance claims and determination of benefits.

Medicare Patient's Signature:
I authorize any holder of medical or other information about me to be released to my insurance company or to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim.

Assignment of Benefits:
I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to my physician. Regulations pertaining to medical assignment of benefits apply. I recognize and accept responsibility for services rendered regardless of insurance coverage.

Financial Responsibility:
I understand that my payment is expected at the time of service. This includes, but is not limited to, coinsurance, co-payment, deductible, and non-covered services. I promise to pay all costs of collection, including reasonable attorneys' fees and collection agency costs that may be incurred in the collection of any and all indebtedness due to North Fulton Podiatry.

SIGN HERE:

_____

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

_____

Witness Date Witness Date

Office Policy:

PLEASE INITIAL THE LINE BESIDE EACH OFFICE POLICY

_ **A charge of $25.00 will be assessed for any appointments not cancelled within 24 hours prior to the appointment time or for no show appointments.**

_ **If you are scheduled for a specific procedure (i.e: nail trimming, callous trimming, etc..) and you do not show for the visit or cancel without 24 hours notice, you may be charged the full cost of that service.**

_ It is your responsibility to provide our office with complete, accurate insurance information at each visit. Please present your card for copying so that we may file your claims correctly. We must be informed immediately of any changes to your insurance and/or contact information.

_ Insurance is accepted as payment for our services only for those plans with which we are contracted. We will assist you in filing a claim for services rendered in our office. However, financial responsibility for medical services is the patient's, regardless of insurance coverage. Health insurance is a contract between you and your insurance carrier to reimburse you for covered medical services.

_ We will file secondary and tertiary insurance claims as a courtesy after your primary insurance has processed your claim. It is your responsibility to perform any follow-up necessary for your secondary insurance to pay your claim.

_ Managed Care Plans (HMO, PPO, POS): For managed care plans that require a specific referral from your Primary Care Physician, the referral must be presented on the day of service. The patient is responsible for obtaining referrals for additional visits from the Primary Care Physician.

_ Payment for all deductibles, co-insurance, co-payments, and non-covered services is due at the time of service.

_ Our office will contact your insurance for pre-authorization of medical benefits for surgical procedures. However, because of the disclaimer given by all insurance companies regarding benefits quoted to physician offices, patients are encouraged to verify benefit information given to our office. Ultimately the patient is responsible for knowing the benefits and requirements of his/her medical coverage.

_ There is a charge of $10.00 per form if you need the physician and/or his staff's assistance in completing paperwork other than that needed to file claims for services rendered by our office. This includes disability forms, claims for supplementary compensation plans, flex-spending accounts, etc.

_ A charge of $25.00 will be assessed for any returned checks.

_ *A service charge of $15.00 will be added monthly to all patient balances over 60 days past due.*

_ If it becomes necessary to refer your account to an outside agency for collection of a balance, the costs incurred from this action, up to 40% of your balance, will be assessed to you. Accounts referred for outside collections will be reported to the credit bureau.

_ If you have signed an advanced directive, it is your responsibility to provide our office with a copy for you medical chart.

_ In order to provide quality medical care, various services may be required such as the dispensing of durable goods, ordering of lab work or hospitalization. Unfortunately, because every healthcare plan can have different stipulations, these services or durable goods may not be a covered service. If you do not inform us of any special requirements in your contract and we subsequently order services, such as lab work or hospitalization, that are not covered, we or the selected medical facility will have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility. Providing quality medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance contract guidelines. Because benefits and requirements differ even within the same health plan, we must rely on patients to inform us any special considerations necessary in providing health care within the guidelines of your health plan.

Acknowledgement of Receipt of Notice of Privacy Practices

I understand that North Fulton Podiatry is a healthcare provider and may share my health information for treatment, payment and healthcare operations. At my request, I will be given a copy of the organization's Notice of Privacy Practices that describes how my health information is used and shared. I understand that North Fulton Podiatry has the right to change this notice at any time. I may obtain a current copy by contacting the Privacy Officer at 770-346-7500. My signature below constitutes my acknowledgement that I will be provided with a copy of the Notice of Privacy Practices if requested.

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 person understands the nature of this acknowledgement.

If patient/resident 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

_____

Patient/resident/client did not sign due to: _____

SIGN HERE:

Your signature below acknowledges that you have read and understand the Office Policy and Notice of Privacy Practices.

_____

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

NAME:_____ DATE:_____

SEX_____ AGE_____ HEIGHT_____ WEIGHT _____ SHOE SIZE_____

Chief Complaint

Main reason for today's visit? _____
_____

How long has your condition been present? _____

Is there a history of injury? _____If yes, place/date:_____

Has there been any previous treatment for your condition whether prescribed or over the counter?_____

What type of job do you perform? _____

List all medications you are currently taking:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Medical History: Please circle "Yes" or "No" to indicate if you have any of the following conditions (If family history positive, please note next to condition).

Heart Disease	Yes	No	Rheumatic Fever	Yes	No
Diabetes	Yes	No	Cancer	Yes	No
Hypertension	Yes	No	Venereal Disease	Yes	No
(High Blood Pressure)			Syphilis	Yes	No
Circulatory Problems	Yes	No	Gonorrhea	Yes	No
Thyroid Condition	Yes	No	AIDS	Yes	No
Asthma	Yes	No	Sickle Cell Anemia	Yes	No
Arthritis	Yes	No	Phlebitis/blood clots	Yes	No
Epilepsy	Yes	No	Other (Please List)	Yes	No
Bleeding Disorders	Yes	No			

Please list any ALLERGIES to the following:

Medications:_____
Foods:_____
Clothing:_____
Latex Gloves_____

List all previous surgeries and their dates:_____
_____

Do you use any of the following: Tobacco (How much per day)_____
Alcohol (Please list amount)_____
Drug Use (Marijuana,etc)_____

HIPAA RELEASE

I, _____, intend for any agent named in this release to be treated as I would be treated with respect to my rights regarding the use and disclosure of my individually identifiable health information and other medical records. This release authority applies to the information specified below which may be governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. 1320d and 45 C.F.R. 160-164:

___ All Information governed by HIPAA
___ Health Information
___ Financial Information
___ Insurance Coverage Information

I authorize the disclosure of information specified above and governed by HIPAA to be provided to the following persons:

Name_____ relation_____ phone_____

Name_____ relation_____ phone_____

Name_____ relation_____ phone_____

Accordingly, I hereby authorize any physician, health-care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health-care provider, any insurance company and the Medical Information Bureau Inc. or other health-care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services, to give, disclose and release to any agent who is named herein and who is currently serving as such, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse.

This authority given to any named agent shall supersede any prior agreement that I may have made with my health-care providers to restrict access to or disclosure of my individually identifiable health information. The individually identifiable health information and other medical records given, disclosed, or released to any named agent may be subject to redisclosure by a named agent and may no longer be protected by HIPAA. The authority given to any named agent herein has no expiration date and shall expire only in the event that I revoke this HIPAA Release in writing and deliver it to my health-care provider. There are no exceptions to my right to revoke this HIPAA Release.

_____ _____

(CLIENT SIGNATURE) (DATE)

Directions to Office:

Take Alpharetta Hwy. (Hwy 9) to Upper Hembree Rd. Once you turn on Upper Hembree Rd. look immediately on your right for a sign that says “1360 Alpharetta Medical Center”. Turn Right into that parking lot. Go to the back of the parking lot and look for the building that says “Alpharetta Internal Medicine”. We are inside this building. Go to the left of the counter you’ll see the sign for “North Fulton Podiatry”.

1380 Upper Hembree Rd.
Roswell, GA 30076