GEORGIA BLUE FOOT AND ANKLE

SOLES 2 HEEL FOOT AND ANKLE CENTERS

New Patient Registration

First Name	Last Name	Middle Initial
Date of Birth	Social Security Number	Gender (M/F)
Home Address	Apt # City State	Zip code
Home Phone	Work Phone	Cell phone
Email Address	Employment Status	Employer
Emergency Contact First Name	Last Name	Relationship to patient
Address Apt # City State		Zip code
Home Phone	Work Phone	Cell phone

Do we have permission to obtain your medication list from your pharmacy? Yes or No
Who is you primary care doctor? _____ Phone: _____

Marital Status (Circle) Married Single Separated Divorced Widowed Other

Race (Circle) Black/ Non-Hispanic | American Indian/ Alaskan Native | Hispanic | Asian Pacific/ Islander | White- Non-Hispanic | Other

Insurance Information

(Please provide us with your insurance cards)

Subscribers Name:_____ DOB:_____
Primary Insurance Company: _____ ID #:_____
Secondary Insurance Company:_____ ID #:_____

How did you hear about us?

_____

Past Medical History (circle all that apply) NONE

Cancer: Lung SkinCervical Prostate
Neurological: Stroke Neuropathy Vertigo Seizures Migraines
Skin: Eczema Psoriasis Ulcers Vitiligo Dermatitis Hives
Psychiatric: Bipolar Depression Anxiety Claustrophobia Dementia
Respiratory: Emphysema Asthma Shortness of breath COPD
Eyes/Ears/Nose/Mouth and Throat: Cataracts Glaucoma Hearing Loss
Cardiovascular: Heart Attack Coronary Disease High Blood Pressure Irregular Heart Rhythm
Musculoskeletal: Lupus Osteoarthritis Rheumatoid Arthritis Fibromyalgia Gout Back Pain
Metabolic: Hypoglycemia Diabetes Hypothyroidism Hyperthyroidism Hyperlipidemia
Other:_____

Past Surgeries and Hospitalizations (circle all that apply) NONE

Tonsils / adenoids Amputations Other Vascular Bypass Appendix

Gallbladder Hysterectomy Hernia Angioplasty Coronary / Heart Bypass

Other:_____

Please list or attach a complete list of all CURRENT MEDICATIONS (Include how much and how often taken), including vitamins and supplements.

_____
_____
_____

Allergies: (Circle) NONE/Narcotics/NSAIDS/Penicillin/Aspirin/Contrast/Latex/Iodine/Shellfish/
Tape/Gluten intolerance/Food allergies/Metal/Other:_____

Family History:_____
_____

Social History:
Do you smoke? Yes/No If so, how many packs a day? _____
Do you take illegal drugs? Yes/No If yes, what illegal drugs are you taking?
Do you drink? Yes/No If yes, how often do you drink?

Vaccine
Did you get your flu vaccine this year? Yes/No If so, when?_____
Are you vaccinated to protect against COVID 19? Yes/No
If so, when 1st Dose:_____ 2nd Dose?_____
Did you get your COVID 19 booster? Yes/No If so, when?_____

DATE:

Patient's Name:_____ Sex : M/F DOB:_____
What name do you go by? _____ SS#:_____
What is your Chief complaint today?_____Where?_____
When did the condition start? ____years _____months _____days ago
What is the nature of your pain? (Circle one): Stabbing/Radiating/ Sharp/ Dull/ Burning/ Aching/Itching/ Other :_____
Is your condition getting better or worse ?_____ Rate your pain: 0 1 2 3 4 5 6 7 8 9 10
What seems to make your condition/pain worse?_____
What seems to make your condition/pain better?_____
Have you seen another physician for this problem? YES/NO
If yes, doctors name:_____
Has this condition affected your ability to work, exercise or perform other daily activities? YES/NO
If yes, how?_____
Is there a history of injury? YES/NO If yes, date of injury? _____
Is this a work-related injury? YES/NO If yes, has claim been made? YES/NO
Is this from an auto accident ? YES/NO If yes , has a claim been made? YES/NO

Women: Breastfeeding? YES/NO?
Are you pregnant? YES/NO If yes, how many weeks are you?_____ Due date: _____

Any other information we need to know ?

_____
_____

GEORGIA BLUE
FOOT AND ANKLE

The following sets forth the general billing policy of Georgia Blue Foot and Ankle, LLC
(GBFA, LLC) and or Soles to Heel Foot and Ankle, LLC(STH, LLC) . Please review this information and initial and/or sign where indicated.

- I understand that it is my responsibility to provide the office of GBFA, LLC and STH, LLC information at the time of check in and to notify GBFA, LLC and/ or STH, LLC of any changes to this information. _____
- I understand that it is my responsibility to know my specialty co-pays, deductibles and coinsurance (which could be different from my primary care benefits) and to pay for services being rendered. I understand that contractual agreement with my health plan to collect co-pays and deductibles at the time of service. _____
- I understand that there is a $50 fee to complete disability paperwork associated with the care. Additional pages will cost $5 per page. I will provide a standard form of charge, however, if additional disability forms (such as FMLA) require completion, I understand that a $50 fee is required. _____
- I understand that GBFA, LLC and/ or STH, LLC will verify insurance eligibility, deductible amounts, and co-insurance amounts prior to any elective 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 to GBFA, LLC and/STH, LLC by my insurance carrier. _____
- I understand that I will be billed for any amounts due from me (co-payments/ co-insurance/deductibles) and that I have a financial responsibility to pay these amounts.I understand that I will be provided with three (3) statements for any balance due after insurance payment.I further understand that if i have not made payment in full prior to being sent a third statement, my balance due will be sent to collections. I also understand that I will be responsible for all costs and fees incurred in the collection process, including attorney fees and costs.I understand that, if my balance due is sent to collections, i will be charged an additional 30% of my balance due (in addition to my balance)._____
- I understand that GBFA, LLC and or STH, LLC will obtain the necessary prior authorization to render 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. _____

I have personally reviewed the above information and agree to the terms:

_____ _____

Patient signature Date

HIPAA ACKNOWLEDGEMENT

I understand that I have the right to review Georgia Blue Foot and Ankle, LLC (GBFA) and Soles to Heel Foot and Ankle, LLC (STH) notice of privacy practices prior to this content. I understand that GBFA reserves the right to change their notice of practices, and I will be given a new notification if this occurs. I understand that I have the right to request restrictions as to how my health information may be used to carry out my treatment, payment or health care operations, and the organization is not required to agree to restrictions when requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

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

Authorize GBFA and/or STH to release information needed for billing purposes to entities that may provide services pertaining to my physician visit, such as reference laboratories.

Patient's Signature | Printed Signature Name | Date

Signature of Guardian/ Representative | Printed Guardian Name | Date

Release of Medical Information to Family Member(s)
During 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 | Date of Birth | Phone Number

Please do not discuss my treatment with:

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

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 Date

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Late arrivals/ Cancellation/ Missed Appointment Policy

Late Arrivals:

While we will attempt to accommodate patients who arrive late , later patients will have to be worked into the existing schedule. If the patient cannot wait to be worked in or if they are exceedingly late, the patient will be rescheduled. Patients who are consistently late may be subject to a fee equivalent to a cancelled appointment.

Last Minute Cancellations and Missed Appointments:

We do require a minimum of 24 hours' of notice on all cancellations. We do recognize that situations may arise that are out of your control; however , it is imperative that you contact our office immediately to notify us of an cancellation.

Patients who miss or cancel a clinical appointment less than a 24 hours' notice are subject to a $50.00 no show fee. Patients who you have a third offense will not be scheduled again.

_____ _____

Signature Date