New Patient Registration

First Name	Last Name		Middle Initial
Date Of Birth	SSN#		Gender(M/F)
Home Address	City	State	Zip Code
Home Phone	Work Phone		Cell Phone
Email	Employment Status		Employer
Emergency contact First Name	Last Name		Relationship To Patient
Emergency Contact Address	City	State	Zip Code
Emergency Contact Home Phone	Work Phone		Cell Phone

Do we have your permission to obtain your medication list from your pharmacy?Yes____No____.
Who is your primary care physician?_____Phone:_____

Marital Status:Married___Single___Seperated___Divorced___Widowed___Other_____
Race:Black/Non-Hispanic____American Indian/ Alaskan Native____Hispanic____
Asian Pacific/Islander____White/Non-Hispanic ____Other____.

Insurance Information

(Please Provide us with your insurance card)

Policy Holder Name:_____DOB:_____
Primary Insurance Name:_____ID#:_____
Secondary insurance Name:_____ID#:_____
How did you hear about us?_____

Past Medical History(check all that apply or write N/A)

Cancer:Lung____Skin____Cervical____Prostate____
Neurological:Stroke____neuropathy____Vertigo____Sezures____Migranies____
Skin:Eczema____Proriasis____Ulcers____Vitiligo____Dermatitis____Hives____
Psychiatric:Bipolar____Depression____Anxiety____Claustrophobia____Dementia____
Respiratory:Emphysema____Asthma____Shortness of Breath____COPD____
Eyes/Ears/Nose/Mouth/Throat:Cataracts____Glaucoma____Hearing Loss____
Cardiovascular:Heart Attack____Coronary Disease____Highblood Pressure____Irregular Heart Beat____
Musculoskeletal:Lupus____Osteoarthritis____Rheumatoid Arthritis____Fibromyalgia____Gout____
Back Pain____
Metabolic:Hypoglycemia____Diabetes____Hypothyroidism____Hyperlipidemia____
Other:_____

Past Surgeries and Hospitalization(check all that apply or write N/A)

Tonsils/Adenoids_____Amputations_____Other Vascular Bypass_____Appendiz_____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:None____Narcotics___NSAIDS___Penicillin___Asprin___Contrast___Laxtex___Iodine___
Shellfish___Tape___Gluten___Food Allergies___Metal___Other_____

Family History(Mom and Dad):_____

Social History:
Do You Smoke?Yes___No___, If so how many packs a day?_____
Do You Take Illegal Drugs?Yes___No___, If so what kind are you taking?_____
Do you drink?Yes___No___,If so how often?_____?

Vaccine:
Flu Vaccine:Yes___No___,If so when?_____
COVID Vaccine:Yes___No___,If so 1st Dose_____2nd Dose_____?
COVID Booster:Yes___No___,if so when?_____

Injury History:
Is There History Of Injury?Yes___No___,If yes date of injury?_____
Is This A Work Related InjuryYes___No___,If yes has claim been made?Yes___No___Date Of Injury_____
Is This Injury An Auto Accident?Yes___No___,If yes has claim been made?Yes___NO___Date_____

What name do you prefer to go by?_____

What is your chief complaint today?_____
_____

Where is your pain?Right Foot___Left Foot___Both Feet___Right Ankle___Left Ankle___Both Ankle's____
Both feet and ankle's____Right Leg___Left Leg___Both Legs___Toenails___

When Did this condition begin?Years____Months____Days_____

What is the nature of the pain?Stabbing____Radiating____Sharp____Dull____Burning____Aching____
itching___Other_____.

Is your condition getting better or worse?Yes____No____Rate your Pain 1 thru10_____

What seems to make your condition/pain worse?_____

What seems to make your condition/pain better?_____

Have you seen another doctor for this problem?Yes___No___
If Yes, Doctors
Name_____Facility?_____
Address_____Phone number_____

Has this condition/pain affected your ability to work, exercise or perform daily activities?Yes___No___
If yes,how?_____
_____

Women: Breastfeeding?Yes____No___
Are you Pregnant?Yes___No___If so, how many weeks are you?_____Due Date_____

What Pharmacy do you use?Name_____Phone Number_____
Address_____City_____State_____Zip_____

Do you have a primary care physician?Yes____No____,If yes Name of Doctor_____
Name of Practice_____Address_____
Phone_____Fax_____.

Any Other Information we need to know?_____
_____
_____

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

- I understand that it is my responsibility to provide the office of Georgia Blue Foot And Ankle,LLC as well as Soles To Heel Foot And Ankle,LLC information at the time of check in and to notify these offices of any changes to my medical or personal information._____
- I understand that it is my responsibility to know my specialty Co_pays,deductibles and coinsurance(which could be different from Primary care benefits)and to pay for service being rendered. I understand that contractual agreement with my health plan is to collect Co-pays, deductibles and coinsurance at the time of service._____
- I understand that there is a $65 fee to initially 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 require completion, I understand that a $65 fee is required._____
- I understand that GBFA and/or STH will verify insurance eligibility, deductible amounts and coinsurance amounts prior to any elective surgery that you may have. I further understand that the fee I am quoted is an estimate based on anticipated surgery to be performed and current information given to GBFA and/or STH by my insurance carrier._____
- I understand that I will be billed for any amounts due from my co-payment, coinsurance and deductible that my insurance may later hold me responsible for. I am aware that I have a financial responsibility to pay these amounts. I understand that I will be provided with three statements and an automated text message statement for any balance due. I further understand that if I have not made a 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 cost. I understand that, if my balance due is sent to collects, i will be charged an additional 30% of balance due.(addition to original balance)._____
- I understand that any remaining balance stated at time of follow up visit is due before seeing a physician, if said balance can not be paid in full at the time of appointment, I am aware that a card will be held on file and a payment arrangement will need to be set up. I am aware that no service will be provided with an outstanding balance, or without a payment arrangement being set up.____
- I understand that GBFA and or STH 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 bill not paid by my insurance carrier._____

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

_____ _____

Patient Signature Date

GEORGIA BLUE
FOOT AND ANKLE
"Where Soles Are Healed"

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(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, payment, or practice operations. This release may include records containing information regarding diagnosis and/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 person 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 patients employer. The records may be needed in order to process a claim or medical services.

I 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 Name Date

_____

Signature Of Guardian/Representative Printed 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. Names not stated on the form will not have access to information and/or discussion will be had until the patient updates HIPPA Form.

1_____,2_____,3_____

Family Member(s)/Friend(s)Name

1_____,2_____,3_____

Phone Number

Please Do Not Discuss My Treatment With:_____.

Name Of Family Member/Friend

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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FOOT AND ANKLE
"Where Soles Are Healed"

Late Arrivals/Cancellations/Missed Appointments Policy

Late Arrivals:

While we will attempt to accommodate patients who arrive late, later patients will have to be worked into the existing schedule. Patients are given a 15 minute grace period If the patient cannot wait to be worked in or if they are exceedingly late, the patient will be rescheduled. Patients who are continuously late may be subject to a fee equivalent to a canceled appointment.

Last Minute Cancellations and Missed Appointment:

We do require a minimum of 24 hour notice of cancelations, 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 any cancellations.

Patients who miss or cancel a clinical appointment less than 24 hours notice are subject to a $50 no show fee. All Fee's will be collected at the next scheduled appointment. Patients who have a third offense will not be scheduled again.

_____

Signature Of Patient Date

_____

Patient Printed Name

Welcome! Thank you for choosing Georgia Blue Foot And Ankle,LLC.

This sheet is meant to help explain and supplement information from our financial policy, which **all patients must sign before being seen**. It's written to make things easy to understand and help you feel confident about your visit and your payment process.

1. **WE KEEP A CARD ON FILE FOR YOU.**

We require all patients to keep a credit or debit card on file with us.

- Your card is kept **safe and secure in a trusted system**.
- **No one at our clinic** can see or use your full card number.

This helps make billing simple and worry-free for you, and for us!!!

2. **Why We Do This.**

When you visit our clinic, you're receiving care and treatment right away. Once your insurance finishes processing, we find out what part(if any) of the bill still needs to be paid by you.
If there is a **balance**, we ask that it be paid **within 30 days**. If we don't hear from you, we'll charge the **card on file** to keep things running smoothly.
There will be an extra $35.00 charge for each attempt to run a credit card that declines.
The charge is based on the **Explanation Of Benefits(EOB)** we receive from your insurance(the same one you receive also). This shows what part of your care is your responsibility. It may include:

- Additional Co-payments
- Deductible Amounts
- Coinsurance Cost

This policy helps us:

- Continue offering **top-quality** foot and ankle care.
- Keep our focus on **treating patients**, not chasing payments.

3. **YOU'LL BE NOTIFIED BEFORE WE CHARGE ANYTHING.**

You'll always get a notice first.

- We send a statement text along with a mailed paper statement. If you would like to pay a different way, or make a payment arrangement, just let us know- we're happy to help.

4. **DON'T WANT TO PUT A CARD ON FILE?**

That's ok. You have **TWO** options:

- We can reschedule your visit for another time.
- Or you can pay with cash at your visit-we'll refund any extra once insurance finishes processing.

QUESTIONS? WE'RE HERE TO HELP.
We understand healthcare payments can be confusing. If anything doesn't make sense, just ask. Our Team is always happy to explain and make sure you feel taken care of.

OUR INFO:
Georgia Blue Foot And Ankle,LLC
6554 Spring Street
Douglasville, GA 30134
P:404-217-2700
F:770-741-0775
Email: Georgiabluefoot@gmail.com

We appreciate your understanding and cooperation in helping us maintain timely and accessible care for all our patients. **By signing below I have a clear understanding of the policy and I agree to all terms stated above.**

Patient Printed Name:_____

Patient Signature:_____

Date:_____

Staff Signature: _____