****

**NEW PATIENT INFORMATION**

**Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial: \_\_\_\_\_**

**Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_**

**Home Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M / F SS #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Race:** African American / Native American / Asian / Hispanic / White / Other\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ethnicity:\_\_\_\_\_\_\_\_\_\_\_\_Primary Language: \_\_\_\_\_\_\_\_\_\_\_\_\_Marital Status:\_\_\_\_\_\_\_\_\_\_\_**

**Patient Employer or student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #: \_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Seen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_**

**How did you hear about our practice?** Physician/ Internet/ Phonebook/ Newspaper or other (circle one)

**Name of person (or other) for referring you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INSURANCE AND BILLING INFORMATION**

**Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #: \_\_\_\_\_\_\_\_\_\_\_**

**Relationship to patient: Spouse / Child / Self / Other \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*If someone else (other than patient) is responsible for payment (co-pays, deductibles, etc), please complete the following:**

**Responsible Party’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PLEASE READ AND SIGN:**

**The undersigned guarantees payment to Smoky Mountain Foot and Ankle Clinic, P.A. of all charges and services provided to the patient. I understand that I am personally responsible for all charges not covered by my insurance and that it is my responsibility to understand the individual health insurance coverage. Attached is a copy of our financial policy. I authorize the release of medical information necessary to process any claim. I authorize payment of benefits to Smoky Mountain Foot and Ankle Clinic, P.A., as agreed upon at the time of treatment. I certify that all information provided by me is correct on all intake forms. I hereby authorize Smoky Mountain Foot Clinic to retrieve my medical and/or medication history and perform the necessary services I may need.**

**SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What is the reason for your visit today?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Your Weight? \_\_\_\_\_\_\_\_\_\_ Your Height? \_\_\_\_\_\_\_\_\_Your Shoe Size?\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pain Quality?** (circle all that apply)Burning / Constant / Dull / Sharp / Shooting / Throbbing or Tingling • Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is this condition due to an injury?** Yes or No

**How long has this been bothering you?** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**List any over-the-counter, prescribed medicine, or other treatments you have tried? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICAL HISTORY**

CHECK ANY OF THE FOLLOWING CONDITIONS THAT YOU HAVE/HAD:

\_\_\_\_ Stroke \_\_\_\_ Diabetes \_\_\_\_ High Cholesterol

\_\_\_\_ High Blood Pressure \_\_\_\_ Cancer \_\_\_\_ Kidney Problems

\_\_\_\_ Cardiovascular Disease \_\_\_\_ Stomach Ulcers \_\_\_\_ Liver Problems

\_\_\_\_ Poor Circulation \_\_\_\_ Fainting Spells \_\_\_\_ Arthritis

\_\_\_\_ Blood Clots \_\_\_\_ Jaundice \_\_\_\_ Gout

**Other:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If diabetic, provide last A1C \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you had a flu shot?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When? \_\_\_\_\_\_\_\_\_\_\_\_

**Have you had a pneumonia shot?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ When? \_\_\_\_\_\_\_\_\_\_\_\_

**Do you have a living will? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICATIONS**

**Please list all MEDICATIONS you are currently taking or provide printed list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ALLERGIES**

**Are you allergic to any of the following? *(Circle all That Apply)***

**LATEX LOCAL ANESTHETICS SULFA DRUGS SLEEPING PILLS TOPICAL SOLUTIONS FELT/GLUE PENICILLIN BARBITURATES ANTIBIOTICS ADHESIVE TAPE SEDATIVES CODEINE MOLE SKIN IODINE. OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No Known Allergies**

**SURGICAL HISTORY**

**Have you ever had any surgical procedure on your foot/ankle? *(Circle)* Yes / No**

**If Yes list type of surgery, date(s) and surgeon:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please list all other surgeries you have had.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Mom** | **Dad** | **Sister** | **Brother** | **Grandmother**  **Indicate mom or dad’s side** | **Grandfather**  **Indicate mom or dad’s side** |
| Alcohol Abuse |  |  |  |  |  |  |
| Arthritis |  |  |  |  |  |  |
| Bleeding Disorder |  |  |  |  |  |  |
| Cancer  Please indicate type of cancer |  |  |  |  |  |  |
| COPD |  |  |  |  |  |  |
| Coronary Heart  Disease |  |  |  |  |  |  |
| Diabetes Mellitus |  |  |  |  |  |  |
| High Blood Pressure |  |  |  |  |  |  |
| HIV |  |  |  |  |  |  |
| Kidney Disease |  |  |  |  |  |  |
| Poor Peripheral Circulation |  |  |  |  |  |  |
| PUD –Peptic Ulcer Disease |  |  |  |  |  |  |
| Seizure |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |

**SOCIAL HISTORY**

**Tobacco: Never: \_\_\_\_\_\_\_Previously, but quit on: \_\_\_\_\_\_\_\_\_\_\_ Current: packs per day:\_\_\_\_\_**

**Use of alcohol? Never\_\_\_\_\_\_\_Rarely\_\_\_\_\_\_\_\_Moderate\_\_\_\_\_\_\_\_\_Daily\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Women – Are you pregnant? YES / NO**

|  |
| --- |
| **PRIVACY INFORMATION PREFERENCES**  **Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Relationship to you:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Please circle all phones where we may leave voicemail regarding your care:**  **Home Cell Work**  **Please list any individuals with whom we may dicuss your medical care or leave**  **Last Name, First Name Phone # Relationship**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Will you allow us to send internet based (email) delivery of information and newsletters? Yes / No**  **If yes please provide your email address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **In addition to email, if you would like to sign up for our patient portal to check your lab results and more, please see nurse at time of visit.** |

**FINANCIAL POLICY**

**Smoky Mountain Foot & Ankle Clinic, P.A. appreciates the confidence you have shown in choosing us to provide your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. This financial policy contains important details about billing and payments for our professional services. It outlines your responsibility concerning billing and payment for our services.**

**Our practice participates with many health insurance companies. As a convenience, our office will submit the claim for any services rendered. It is the patient’s responsibility to provide us with current insurance information and to confirm that our facility is participating in their insurance plan at the time of service. The burden of proof is the patient’s responsibility and not the physician’s or facility’s responsibility.**

**Please be aware that some services provided may be considered non-covered and may not be payable by your insurance plan. Your insurance policy is a contract between you and your insurance policy. It is the patient’s responsibility to know their co-payment and deductible amounts. Co-payments, coinsurance, deductible and any service not covered by patient’s insurance plan are the patient’s responsibility and payment in full is expected at the time of service.**

**It is the patient’s responsibility to ensure that any required authorization or referral for treatment is provided prior to the visit. In the absence of the required authorization or referral, the patient’s visit may be rescheduled or the patient may be personally responsible for payment for the services rendered.**

**If your insurance company has not paid your account in full within 45 days, the balance will be billed to the patient. Unresolved balances may be placed with an outside collection agency. If your account has been turned over for collection, future appointments may not be made until you speak with our billing department and pay your bill in full.**

**Medicare patients are responsible for their 20% co-insurance and yearly deductible.**

**Having secondary insurance DOES NOT mean that your services are covered 100%. Secondary insurers will pay based on your primary carrier. We will bill your secondary carrier as a courtesy. You are responsible for any remaining balance.**

**Written or verbal authorizations from insurance plans are not a guarantee of payment.**

**Patients with no insurance or self-pay will be expected to pay for all services at time of visit. A minimum of $100 may be required at check-in. The balance will be due at check-out.**

**We reserve the right to charge interest in the amount of 1.5% per month as provided by state law on unpaid balances. We reserve the right to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.**

**Accepted forms of payment are CASH, CHECK, VISA, MASTERCARD, DISCOVER and AMERICAN EXPRESS.**

**HIPAA ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under law. You have the right to review our Notice before signing this acknowledgement. The terms of our Notice may change; if we change our notice you may request a revised copy by contacting our office or you will receive a new notice the next time you are treated at our office.

You have the right to request that we restrict how we use protected health information about you for treatment, payment, and health care operations. We are not required to agree to this restriction if your request is not feasible or it impedes our ability to provide treatment you need, but if we do accept your request, we shall honor that agreement.

The practice provides this form to comply with the Health Information Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

* • The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
* • Protected health information may be disclosed or used for treatment, payment, or health care operations.
* • The practice reserves the right to change the notice of privacy practices.

I acknowledge receipt of Notice of Privacy Practices.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Patient or Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

Relationship to Patient (if other than patient) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Mark if patient refused to take copy of Notice of Privacy Practices

State reason for refusal, if known:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name – Practice Representative

Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date