SMOKY MOUNTAIN FOOT & ANKLE CLINIC, P.A.

Waynesville * Asheville * Sylva * Franklin * Murphy

PATIENT INFORMATION

Last Name:_____ First:_____ Middle:_____

DOB:_____ SS #:_____ GENDER:_____

Marital Status: ***Circle One*** **Single/Married/Widowed**

Address: _____ City/State/Zip_____

Home Phone # _____ Cell Phone # _____ Other:_____

Race: ***Circle One*** **African American/Native American/Caucasian/Asian/Hispanic/Other**

Primary Language:_____

Employer: _____ Occupation: _____ Phone: _____

Primary Care Physician: _____ Phone #: _____

Address:_____ Date Last Seen: _____

Preferred Pharmacy: _____ Phone: _____

Address: _____

How did you find out about our practice? Physician/Internet/Phonebook/Family Member/Friend

Who can we thank for referring you? _____

What is the reason for your visit today? _____

The pain quality is: (*Circle All That Apply)* Burning/Constant/Dull/Sharp/Shooting/Throbbing/Tingling

How long has this bothered you? _____ days/weeks/months/years *(Circle One)*

Is condition due to an accident/injury? Yes/No Date of accident/injury_____

Please list any over-the-counter or prescription products you have tried: _____

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INSURANCE AND BILLING INFORMATION

Primary Insurance: _____

Policy #: _____ Group #: _____

Address: _____

Subscribers Name: _____ DOB: _____

Relationship to patient: ***Circle One*** **Spouse/Child/Self/Other**

Address _____ Phone #: _____

Secondary Insurance: _____

Policy #: _____ Group #: _____

Address: _____

Subscribers Name: _____ DOB: _____

Relationship to patient: ***Circle One*** **Spouse/Child/Self/Other**

Address _____ Phone #: _____

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

Responsible Party's Name: _____ DOB _____ Sex: M/F

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. 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.

SIGNATURE: _____ DATE: _____

Patient Name:_____

MEDICAL HISTORY

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

__Stroke	**__Diabetes**	**__Congenital Heart Disease**	**__High Blood Pressure**
__Cancer	**__Kidney Problems**	**__Cardiovascular Disease**	**__Venereal Disease**
__Gout	**__Liver Problems**	**__Poor Circulation**	**__Fainting Spells**
__Hepatitis	**__Arthritis**	**__Blood Clots**	**__Jaundice**
__Ulcers	**__AIDS**		

Other_____

FAMILY HISTORY

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

Patient Name:_____

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:_____

_____

OTHER SURGERIES

Please list all other surgeries:_____

_____

MEDICATIONS AND ALLERGIES

MEDICATIONS

Please list all MEDICATIONS you are currently taking:_____

_____

_____

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

SOCIAL HISTORY

Use of tobacco… ___Never Previously, but quit:_____ Current packs per day:____
Use of alcohol… ___Never ___Rarely ___Moderate ___Daily
What is your weight? _____

What is your height? _____

What is your shoe size?_____

Women – Are you pregnant? YES/NO

Patient Name:_____

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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 discuss your medical care or leave.

Last Name, First Name **Telephone Number** **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 delivery if you would like to sign up for our IQ Health where you can log in to check your lab results, request an appointment and more, please inquire with the front desk.

PLEASE READ AND SIGN:

I certify that all information on my intake form(s) is correct to the best my knowledge. I understand that it is my responsibility to notify the physician and/or staff of any and all updates to my information. I understand that providing incorrect information can be dangerous to my health. I hereby authorize Smoky Mountain Foot & Ankle Clinic to retrieve my medical and/or medication history and perform the necessary services I may need.
SIGNATURE: _____ DATE: _____

Patient Name:_____

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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.

ALL PATIENTS MUST COMPLETE OUR INFORMATION, INSURANCE FORM AND SIGN THE FINANCIAL AGREEMENT BEFORE SEEING THE DOCTOR.

SIGNATURE:_____ DATE:_____

******IF PATIENT IS UNDER THE AGE OF 18, PATIENT'S GUARANTOR MUST SIGN ALL FORMS.******

Patient Name:_____

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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

Patient Name:_____