NEW PATIENT INFORMATION

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

Smoky Mountain
foot & ankle clinic, PA

Last Name:_____ **First:**_____ **Middle Initial:** _____

Mailing Address: _____**City:** _____ **Zip:**_____

Home Phone # _____ **Cell Phone #** _____

DOB:_____ **SS #:**_____ **Sex: M/F**

Race: African American / Native American / Asian / Hispanic / White / Other_____

Marital Status:_____ **Employer:** _____

Your Weight? _____ **Your Height?** _____**Your Shoe Size?**_____

Primary Care Physician: _____ **Last Seen:** _____

Do you have a living will? ____ **Who can we thank for referring you?** _____

How did you hear about our practice? Physician / Internet / Phonebook / Newspaper _____

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 _____ **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. 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? _____

_____

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?

_____

_____

Preferred Pharmacy: _____**City:** _____

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

MEDICAL HISTORY

Primary Care Physician:

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? _____

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.

_____

_____

_____

_____

FAMILY HISTORY	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						

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 patient portal where you can log in 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