

Patient Last Name:	First Name:	Middle Initial:
	Date of Birth:	Male / Female
Address:	Address 2	City:
State:	Zip:	Email address:
Preferred Phone #: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work		Other Phone #: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work
County:	Preferred Language:	
Employer:	Occupation:	Work #:
Pharmacy Name:	Pharmacy Phone:	
Pharmacy Address:		
Primary Care Physician Name:	Last appointment date:	Primary Care Physician Phone #:
Spouse's Name / Parent or Guardian Name if a Minor:		

Responsible Party/Guarantor

Last Name	First Name	
Date of Birth:	Relationship to Patient:	
Policy Holder's Full Address:		
Policy Holder's Phone #:	Employer Name:	
Member ID #:	Group ID #:	SSN:

Emergency Contact Information

Person to Notify In case of Emergency:	Relationship to Patient:	
Home #:	Cell #:	Work #:
Referred by: <input type="checkbox"/> Physician: _____ <input type="checkbox"/> Patient: _____		
<input type="checkbox"/> Yellow Pages <input type="checkbox"/> Insurance Co. (<input type="checkbox"/> Web or <input type="checkbox"/> Book) <input type="checkbox"/> Other _____		

I understand that the above information is correct to the best of my knowledge. I also understand that it is my responsibility to inform Marietta Podiatry Group of any changes to my medical status and demographics. I hereby consent and authorize Marietta Podiatry Group and staff to perform any service deemed appropriate by attending physician(s) to make a thorough diagnosis. I also authorize Marietta Podiatry Group and staff to perform any procedures, forms of treatment, medication, and therapy in connection with my diagnosis and treatment plan.

Signature: _____

Today's Date: _____

To ensure your privacy, please answer the following questions and notify the Front Office Staff whenever this information changes.

1. Do we have permission to leave a message on the phone number(s) you have provided to us?
YES or NO
2. May we discuss your Medical Information with family and friends?
YES or NO
3. If yes, to question 2, please list the names of people we can discuss your medical care with:

Name: _____ Phone #: _____

Patient's Relationship to contact: Spouse Parent Child Friend

Name: _____ Phone #: _____

Patient's Relationship to contact: Spouse Parent Child Friend

Name: _____ Phone #: _____

Patient's Relationship to Patient: Spouse Parent Child Friend

4. If someone calls for you or asks for you while you are in our office, do we have permission to tell the individual you are here? YES or NO

Patient Name (Printed)

Date

Patient Signature

FINANCIAL POLICY

Thank you for choosing **Marietta Podiatry Group** as your ankle and foot care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our financial policy is important to our professional relationship. Please understand that payment for services is part of that relationship. Payment will be due at the time services are rendered. In order to serve you better, we accept Cash, Check, and all major Credit Cards. In our ongoing effort to make sure that all your medical needs are met, our staff is available to discuss our fees, policies, and your responsibilities with you. We ask that all responsible parties read and sign our financial policy as well as complete the patient information forms prior to your scheduled visit. As the responsible party, please understand and **initial the following**:

- _____ 1. Insurance is a contract between you and your insurance company. In most cases, we are NOT a party to this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company, we require that you disclose all insurance information, including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in the patient's responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. **If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.**

- _____ 2. Certain health insurances (HMO, POS, etc.) require that you obtain a referral or prior authorization from your Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. **Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company**, and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if not obtained.

- _____ 3. Our office will verify your insurance benefits as a courtesy. However, **verification is NOT a guarantee of payment.** Even if we are told a **procedure, visit, or product is covered**, your insurance company may later **deny the claim** or apply it to your **deductible, coinsurance, or non-covered services.**

- _____ 4. Fees for services, which include unpaid balances, deductibles, co-payments, co-insurances, and non-covered over-the-counter products, are due at the time of service unless previous arrangements have been made with a billing coordinator or practice administrator. Absolutely no post-dated checks will be accepted. You understand and agree that if you fail to make payments for which you are responsible in a timely manner, such default will result in referral to a collection agency. You will be responsible for all costs of collecting monies owed, including collection agency fees.

- _____ 5. The charge for a returned check is **\$35.00**, payable by cash or credit card. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash or credit card-only basis following any returned check. Unpaid returned check fees and balances will be subject to collection placement.

- _____ 6. I understand that payment for services, procedures, and treatment forms is solely and ultimately my responsibility. I understand that payment for services is due at the time that services are rendered, unless other financial arrangements have been made. I hereby authorize and request that all payments be made directly to Marietta Podiatry Group.

- _____ 7. Completion of Forms (e.g., Disability or Family Medical Leave) and Copies of Medical Records are not a billable reimbursement by insurance carriers. Therefore, you are responsible for the **\$10 - \$50.00 fee** related to the completion of these documents. Payment is due when forms are presented for completion or when forms are completed and are being picked up in person.

This financial policy helps Marietta Podiatry Group provide quality care to our valued patients. If you have any questions or need clarification regarding any of the above policies, please feel free to contact our billing department at 770-422-9856.

I UNDERSTAND THE ABOVE INFORMATION AND WILL BE RESPONSIBLE FOR THE PATIENT LISTED BELOW

Print Name of Patient _____ Date _____

Signature of Patient or Responsible Party _____

Name and Relationship if other than patient _____

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY
PRACTICES**

SUMMARY OF NOTICE OF PRIVACY PRACTICES

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation, and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization.

In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care.
- For certain limited research purposes.
- For purposes of public health and safety.
- To Government agencies for purposes of their audits, investigations, and other oversight activities.
- To government authorities to prevent child abuse or domestic violence.
- To the FDA to report product defects or incidents.
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders.
- When required by court orders, search warrants, subpoenas, and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information.
- To receive an accounting of certain disclosures we have made of your health information.
- To request restrictions as to how your health information is used or disclosed.
- To request that we communicate with you in confidence.
- To request that we amend your health information.
- To receive notice of our privacy practices.

If you have a question, concern, or complaint regarding our privacy practices, please contact the practice administrator at 770-422-9856.

I acknowledge the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient Name (Please print)

Date

Signature

If a patient is not capable of acknowledging the notice because of age or medical condition, please complete the following:

Patient is a minor _____ (years of age)

Patient is unable to acknowledge due to _____ medical condition.

Parent or Authorized Representative (if applicable) Print

Date

Signature

Relationship

MEDICAL HISTORY

Patient's Name: _____ **Date of Birth:** ___/___/___

My primary foot or ankle problem today is: _____

Primary Care Physician's name: _____ **Primary care Physician Phone:** _____

Are you under the care of this physician now? Yes No

If yes, when was the date of your last medical examination? _____

Pharmacy Name/Location _____ **Pharmacy Number:** _____

What is your Height? _____ Feet _____ Inches **Shoe Size?** _____ **What is your weight?** _____ pounds

Have you ever had any of the following? (check boxes that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Skin Ulcer |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis or Liver Disease | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleeding Abnormality | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cancer/Tumor | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> MRSA | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Sickle Cell | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Epilepsy/Seizure | <input type="checkbox"/> Skin Rash/Hives | |

If you checked above that you have High Blood Pressure, what medication(s) are you taking?

Have you received an Influenza Vaccine? Yes Date: _____ No

Are you a Diabetic? Yes No

If Diabetic when was your last eye exam? _____

Who performed your last eye exam? _____

If Diabetic what was your last A1C Level? _____

Are you pregnant? Yes _____ weeks No **Are you breastfeeding?** Yes No

Date of last menstrual cycle: _____

Please list all major surgeries you have had, and the date performed:

Date	Surgery	Provider
1.		
2.		
3.		
4.		
5.		
6.		

Are you allergic or have you had an adverse reaction to any of the following:

PENICILLIN	<input type="checkbox"/> YES	<input type="checkbox"/> No	OTHER ANTIBIOTICS	<input type="checkbox"/> YES	<input type="checkbox"/> No
LOCAL ANESTHESIA	<input type="checkbox"/> YES	<input type="checkbox"/> No	GENERAL ANESTHESIA	<input type="checkbox"/> YES	<input type="checkbox"/> No
CODEINE	<input type="checkbox"/> YES	<input type="checkbox"/> No	ASPIRIN	<input type="checkbox"/> YES	<input type="checkbox"/> No
SULFA DRUGS	<input type="checkbox"/> YES	<input type="checkbox"/> No	TAPE OR BAND-AIDS	<input type="checkbox"/> YES	<input type="checkbox"/> No
IODINE	<input type="checkbox"/> YES	<input type="checkbox"/> No	LATEX	<input type="checkbox"/> YES	<input type="checkbox"/> No
SEDATIVES	<input type="checkbox"/> YES	<input type="checkbox"/> No	SHELLFISH	<input type="checkbox"/> YES	<input type="checkbox"/> No
OTHER	<input type="checkbox"/> YES	<input type="checkbox"/> No	OTHER	<input type="checkbox"/> YES	<input type="checkbox"/> No

Please list below or attach a list of any medications/supplements you are currently taking on a regular basis:

Medication Name	For What Medical Condition	Start Date	Dosage	Reaction / Side Effects
1.				
2.				
3.				
4.				
5.				
6.				

FAMILY HISTORY

Please note family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	RELATIONSHIP TO YOU
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
COPD/Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

SOCIAL HISTORY

Do you currently smoke cigarettes? YES NO (never smoked) NO (former smoker) quit date? _____

Do you use any of these tobacco products Cigars Pipes Chewing tobacco Vape Nicotine

Alcohol Use: Never 2-3 times per month 2-3 times per week 2-3 times per day

Do you use recreational drugs? YES NO

If yes, what type: _____

REVIEW OF SYSTEMS FORM

PLEASE CHECK THE BOX IF ANY APPLY; OR INITIAL ANYWHERE ON THE PAGE IF NONE

Constitutional: fever weight gain weight loss appetite change night sweats
 fatigue chills N/A

Eyes: blurry /double vision vision loss tearing redness pain sensitivity to light
 glaucoma N/A

Ears, Nose, Mouth, Throat: hearing loss ringing in ears ear pain nasal congestion nasal drainage
 nosebleeds mouth/throat irritation tooth problem N/A

Cardiovascular: chest pain/pressure heart racing palpitations sweating leg swelling
 high/low blood pressure N/A

Pulmonary: cough yellow/green sputum blood in sputum shortness of breath wheezing

Gastrointestinal: nausea vomiting diarrhea constipation pain blood in stool or vomitus
 heartburn difficulty swallowing N/A

Genitourinary: incontinence abnormal bleeding abnormal discharge urinary frequency
 urinary hesitancy pain impotence sexual problem infection
 urinary retention N/A

Musculoskeletal: pain joint stiffness redness/warmth arthritis back pain weakness
 muscle wasting sprain/fracture N/A

Neuro: headache weakness dizziness change in voice change in taste
 change in vision change in hearing loss/change sensation trouble walking
 balance problem coordination problem shaking speech problem N/A

Endocrine: cold or heat intolerance blood sugar problem weight gain/loss
 missed periods hot flashes/sweats change in body hair change in libido
 increased thirst increased urination N/A

Heme/Lymph: swelling bleeding problem anemia bruising enlarged lymph node
 N/A

Allergic /Immunologic: itch post-nasal drip watery/itchy eyes nasal drainage
 immunosuppressed N/A