Patient Information Form

Please provide your Insurance Card/Picture I.D./and be prepared to pay any applicable Co-Payment

Patient's Name: _____
Title First M.I. Last Perferred Name

Address (Home): _____
Street City State ZIP County

Address (Billing): _____
(If Different from Home) Street City State ZIP County

Phone Home: _____ **Email:** _____
Area Code and Number

Phone Mobile: _____ **Phone Work:** _____
Area Code and Number Area Code and Number

Date of Birth: _____ **Race:** _____

Social Security Number: _____ **Ethinicty:** ____ Hispanic or Latino
____ Not Hispanic or Latino

Sex: _____

Marital Status: _____ **Language:** _____
Preferred Language

Primary Care Provider: _____ **Referred By:** _____
Dr's Name Dr's Name

_____
Dr's Address

Preferred Pharmacy: _____ **Mail Order Pharmacy:** _____

Responsible Party: _____
Either Self or Name of individual responsible for patient's insurance or finances

If the patient is a dependant or has a reponsible party, please provide the following information:

Name: _____ **Relationship:** _____
(Responsible Party) First M.I. Last (To Patient)

Address: _____
(If Different From Patient's) Street City State ZIP County

Phone Home: _____ **Phone Mobile:** _____
Area Code and Number Area Code and Number

Phone Work: _____ **Email:** _____
Area Code and Number

Date of Birth: **Social Security Number:**

Patient Information (Page 2) **Patient's Last Name and DOB:** _____

Insurance Information

Primary Insurance Company/Plan: _____

Subscriber's Name: _____ **Relationship:** _____
(If other than self) First M.I. Last (If other than self)

Subscriber/Member # _____ **Group#** _____ **Subscriber DOB** _____

Co-Payment for Specialist: $ _____ **(If applicable)**

Secondary Insurance Company/Plan: _____

Subscriber's Name: _____ **Relationship:** _____
(If other than self) First M.I. Last (If other than self)

Subscriber/Member # _____ **Group#** _____ **Subscriber DOB** _____

Patient Information: (Page 3) Patient's Last Name and DOB: _____

Chief Complaint/Injury Details

Are you seeking treatment for (Circle One): Chronic Pain Injury

Describe your complaint: _____

_____

If injury, please provide the following information:

Date of Injury: _____ Part of Foot/Leg Injured: _____

Type of Injury (Circle One): Sports Work Accident Home Other: _____

Does your injury limit your mobility? (Circle One) Yes No

Are you in Pain? (Circle One) Yes No

How did your injury occur? _____

_____

List of ALL Current Care Providers

Primary Care Provider: _____ Cardiologist: _____

Endocrinologist: _____ Kidney: _____

Other: _____ Other: _____

Allergies and Medications

Are you allergic to latex? (circle one) Yes No

Are you allergic to any medication? (circle One) Yes No

If Yes, List all medications you are allergic to and reactions: _____

_____

List ALL current Prescriptions, OTC Medication and Vitamins / Dosages you are taking:

_____ _____

_____ _____

_____ _____

Patients's Last Name and DOB: _____

General Medical History

(Mark all that apply)

- ☐ Alcoholism
- ☐ Allergies/Hayfever
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Heart Attack
- ☐ Cancer (Type):_____
- ☐ Cardiovascular Disease
- ☐ CHF
- ☐ Cirrhosis/Liver Disease
- ☐ Colitis
- ☐ COPD
- ☐ Kidney Disease
- ☐ Dialysis
- ☐ Stroke/TIA
- ☐ Depression
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Epilepsy
- ☐ DVT
- ☐ Gastric Ulcer
- ☐ Gastrointestinal Disease
- ☐ GERD
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Crohn's Disease
- ☐ Kidney Stones
- ☐ Migraine
- ☐ Multiple Sclerosis
- ☐ Alzheimers
- ☐ Osteoporsis
- ☐ Pulmonary Embolism
- ☐ Pulmonary Disease
- ☐ Rheumatoid Arthritis
- ☐ Sleep Apnea
- ☐ Parkinsons
- ☐ HIV/Aids
- ☐ Other

Surgical / Procedural/Date

(Mark all that apply)

- ☐ No prior surgical history
- ☐ Anethesia Complications
  Date: _____
- ☐ Appendectomy
  Date: _____
- ☐ Arthoscopic Surgery
  Date: _____
- ☐ Carpal Tunnel Surgery
  Date: _____
- ☐ Cataract Surgery
  Date: _____
- ☐ Colectomy
  Date: _____
- ☐ Extremity/Bone/Joint Surgery
  Area of surgery:_____
  Date: _____
- ☐ Fracture(s)
  Area of fracture:_____
  Date: _____
- ☐ Gall Bladder
  Date: _____
- ☐ Heart Surgery
  Date: _____
- ☐ Hemorrhoids
  Date: _____
- ☐ Hernia
  Date: _____
- ☐ Hysterectomy
  Date: _____
- ☐ Joint Replacement
  Area of surgery:_____
  Date: _____
- ☐ Mastectomy
  Date: _____
- ☐ Oophorectomy
  Date: _____
- ☐ Other
  Date: _____
- ☐ Orthopedic
  Date: _____
- ☐ Tonsil/Adenoidectomy
  Date: _____

Tobacco / Alcohol Assessment

Tobacco Usage (circle one): Never Ex-Smoker Current Smoker:#_____/Day, X_____Years

Alcohol Use (circle one): Never Occasional Social Drinker: #_____/Week Heavy Drinker: #_____/Day

Patient's Last Name and DOB: _____

Review of Symptoms

(Please MARK the area which you are experiencing issues and CIRCLE the symtom(s) that apply.)

	Constitutional	Weight loss, Poor appetite, Fatigue, Weight gain, Insomnia, Night sweats
	Eyes	Blurry vis., Eye pain, Discharge, Redness, Decreased Vis., Dry eyes, Double Vis.
	ENT	Sore throat, Hoarseness, Ear pain, Hearing loss, Discharge, Nose bleed, Tinnitus, Sinusitis
	Cardiovascular	Heart murmur, Poor circulation, Foot/leg swelling
	Respiratory	Chronic cough, Coughing blood, History of turberculosis
	Gastrointestinal	Nausea, Vomiting, Diarrhea, Constipation
	Genitourinary	Urinary frequency, Blood in urine, Incontinence, Urinary retention, Frequent UTIs
	Skin	Rash, Hives, Hair loss, Skin loss, Ulcers/open wounds, Itching, Nail changes
	Musculoskeletal	Joint pain, Muscle aches, Muscle weakness, Bone pain, Joint swelling, Back/neck pain
	Psychiatric	Anxiety, Depression, Alcohol/drug dependence, Use of anti-depressants
	Endocrine	Goiter, Heat/cold intolerance, Increased thirst, Increased sweating
	Neurological	Seizures, Tremors, Migraines, Numbness, Dizziness/vertigo, Loss of balance
	Hem/Lymphatic	Low blood count, Prolonged bleeding, Blood Clots, Transfusions
	Allergic/Immune	Allergia reactions, Hay fever, Frequent Infections, Hepatitis, HIV, Posititve TB skin test

Family History

(Mark all that apply)

- ☐ Adopted
- ☐ Unknown Paternal History
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Birth Defects
- ☐ CAD
- ☐ Cardovascular Disease
- ☐ CHF
- ☐ Cancer (Type):_____
- ☐ Denial of any knowledge of significant family history
- ☐ Unknown Maternal History
- ☐ Congenital Anomaly
- ☐ COPD
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ GERD
- ☐ High Cholesterol
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Hypothyroidism
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Mental Illness
- ☐ Pulmonary Disease
- ☐ Stroke

Riverside Foot and Ankle

5223 Riverside Drive, Suite 104
Macon, Georgia 31210

Phone: 478-200-7143
Email: info@riversidefoot.com

Fax: 478-254-9704
Website: www.riversidefoot.com

FINANCIAL POLICY AND PATIENT RESPONSIBILTY AGREEMENT

We would like to thank you for choosing Riverside Foot and Ankle as your healthcare provider. Riverside Foot and Ankle is committed to providing you with the best possible medical care. It is important that you understand that payment for this healthcare is your responsibility. The following information outlines your financial responsibilities related to payment for professional services.

For Our Patients with Medical Insurance Benefits:

We participate in most major health plans. We have contracts with many HMO's, PPO's, insurance companies and government agencies (Medicare and Medicaid). Our office will submit claims for any service rendered to a patient who is a member of one of these plans and will assist you in any way we reasonably can to help get your claim paid. It is the patient's responsibility to provide all necessary information before leaving the office. If you have a secondary insurance, we will automatically file a claim with them as soon as the primary carrier has paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. It is also your responsibility to inform Riverside Foot and Ankle of any changes to your health coverage (loss of coverage, employment changes, insurance provider changes). You are financially obligated for any services you receive.

- **Please bring your ID and insurance card with you at the time of your appointment**
- **If you are insured by a plan we are a provider for and don't have an insurance card with you, payment in full for each visit is required until we can verify coverage.**
- **Medical services that are considered by your insurance company to be non-covered, out of network, or not medically necessary will be your responsibility.**

Co-Payments/Co-Insurance/Deductibles:

Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under State and Federal Laws. For your convenience we accept cash, checks, or the following credit/debit cards: Visa, Mastercard, American Express and Discover. If you do not have your co-payment your appointment may be rescheduled.

You may have co-insurance and/or deductible amounts required by your insurance carrier. Until deductibles are satisfied, an upfront deposit of $75 will be requested at check-in for each visit. Any additional services rendered during your visit will be collected at check-out. Any outstanding balance on your account, after adjusting for all of your insurance's responsibilities, will be billed to you.

Waiver of Patient Responsibilities:

It is the policy of Riverside Foot and Ankle to treat all patients in an equitable fashion related to account balances. The practice will not waive, fail to collect, or discount co-payments, co-insurance, deductibles, or other patient financial responsibilities in accordance with State and Federal Laws, as well as participating agreements with payers.

For Our Patients with No Medical Insurance or Limited Plans:

If you do not have group/individual medical insurance or a limited plan, payment for all services is expected at the time of your visit. Please note, we do offer self-pay rates for patients without health insurance. A deposit of $100 for new patient appointments and $50 for follow up appointments will be required at check-in for every physician visit. Other fees may vary depending on the type of service.

Late Arrivals:

A patient who arrives more than 20 minutes after their scheduled appointment is considered a late arrival. A late arrival, not considered to be the responsibility of the practice, will be registered, and worked into the schedule as soon as possible or rescheduled.

Appointment No-Shows: - Effective August 1st, 2023

Any patient who fails to arrive for a scheduled non-surgical appointment without cancelling the appointment at least 24 hours prior to the scheduled time is considered a "No-Show" and will be charged a $50 no-show fee. Any patient who fails to arrive for a scheduled surgical appointment without cancelling the appointment at least 24 hours prior to the scheduled time is considered a "No-Show" and will be charged a $100 no-show fee. Any patient with an existing no-show fee on their account is required to pay that fee before they can be re-scheduled. I verify that I understand the no-show fee policy. _____

Delinquent Balance Appointment:

Patients with a delinquent balance are required to make payment in full for future services. A delinquent account is defined as a patient balance in excess of 120 days without payments or an attempt to seek assistance during this time. Services may be refused for patients with delinquent accounts. Delinquent accounts must be paid in full or brought back into current status prior to receiving any additional service.

Returned Checks:

Any payments by check that are returned as non-payable for any reason will incur a fee of $35. The amount of the original payment plus the returned check fee will be due immediately. You will be notified by phone, letter, billing invoice, or at the time of your next visit of a returned check. No future services will be rendered until the original payment and fee are paid in full.

Thank you for choosing Riverside Foot and Ankle. Please let us know if you have any questions or concerns.

By signing this Financial Policy and Patient Responsibility Agreement you acknowledge that you understand your responsibilities as a patient of Riverside Foot and Ankle:

Print Name (Patient or Responsible Party)

Signature (Patient or Responsible Party) Date

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS AND/OR FAMILY MEMBERS

In accordance with Federal Government Privacy Rules implemented through the Healthcare Portability and Accountability Act of 1996 (HIPAA), in order for your healthcare provider or staff of Riverside Foot and Ankle to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the Act stipulates that these rules may be waived.

Please initial one of the following that you authorize:

_____ **I do not** authorize Riverside Foot and Ankle to release any or all information concerning my medical care to any individual or family member except as set forth above.

_____ **I authorize** Riverside Foot and Ankle to release any or all information concerning my medical care to the following individuals:

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

By signing this authorization, I understand the decision made concerning release or non-release of my medical information:

Name (Patient or Responsible Party) _____ Date of Birth _____ Social Security Number _____

Signature (Patient or Responsible Party) _____ Date _____