

PATIENT INFORMATION

Name (First) _____ (Middle Initial) _____ (Last) _____

Address: _____ City/State: _____ Zip Code: _____

Home Phone # (_____) _____ Cell Phone (_____) _____ Work Phone (_____) _____

Birth date _____ Age _____ Sex: Male / Female (Circle One) Social Security # _____

Marital Status: Single / Married / Divorced / Widow/Widower (Circle One) Email Address: _____
 Employer: _____ Occupation: _____

Employer Address: _____ City _____ State: _____ Zip _____

ALLERGIES

Do you have any drug allergies or sensitivities? If so, please list them. _____

Pharmacy Name: _____

Pharmacy Location: _____

MEDICATIONS List all medications you are currently taking. Include over-the-counter products.

INSURANCE

Primary Insurance Information

Name of Subscriber _____

Subscriber ID #: _____ Group ID# _____

Relationship to Patient ___ Self ___ Other

(If other, complete the following information)

Name of Insured _____

Insured's Date of Birth _____

Insured's Social Security # _____

Is this patient covered by additional insurance?

___ Yes (Complete the following information) ___ No

Secondary Insurance Information

Name of Subscriber _____

Subscriber ID# _____ Group ID # _____

Insured's Name _____

Relationship to Patient ___ Self ___ Other

(If other, complete the following information)

Insured's Employer _____

Insured's Social Security # _____

Insured's Date of Birth _____

FOOT HEALTH INFORMATION

What type of problem(s) are you currently experiencing? _____

When did the problem(s) begin? _____

Have you received any treatments for this condition? _____

Shoe Size _____ Height _____ Weight _____

IN CASE OF EMERGENCY CONTACT:

Name _____

Relationship _____ Phone _____

Who is your Primary Care Physician?

Date of last visit? _____

Physician's Address or Location

Phone _____

Are you under a doctor's care for any specific condition? If yes, describe briefly. _____

How did you hear about us? ___ Friend ___ Physician

___ Yellow Pages ___ Radio ___ TV ___ Other

Please list all types of previous surgeries and dates.

MEDICAL HISTORY Please check Yes or No to indicate if you previously had or have any of the following conditions:

AIDS/HIV	Yes ___ No ___	Hepatitis	Yes ___ No ___
Arthritis	Yes ___ No ___	High Blood Pressure	Yes ___ No ___
Asthma	Yes ___ No ___	High Cholesterol	Yes ___ No ___
Back Problems	Yes ___ No ___	Kidney Problems	Yes ___ No ___
Blood Clots	Yes ___ No ___	Liver Problems	Yes ___ No ___
Cancer	Yes ___ No ___	Parkinson's Disease	Yes ___ No ___
Diabetes	Yes ___ No ___	Psychiatric Problems	Yes ___ No ___
Epilepsy	Yes ___ No ___	Stomach Ulcers	Yes ___ No ___
Eye Problems	Yes ___ No ___	Stroke	Yes ___ No ___
Foot/Leg Cramps	Yes ___ No ___	Thyroid Problems	Yes ___ No ___
Gout	Yes ___ No ___		
Heart Problems?	Yes ___ No ___		
Are you a smoker?	Yes ___ No ___	Do you drink alcohol?	Yes ___ No ___
Other: _____		If so, how much? _____	

Consent for Care: I hereby give my consent for treatment to Advanced Foot & Ankle Care of Memphis, LLC, Dr. Nathan Lucas, including treatment or services, and which may include but not limited to laboratory procedures, examination, medical treatment or procedures rendered for me/my dependent under the general and specific instructions of the patient's physician.

Signature: _____ **Date:** _____
Patient, Parent or Guardian

Authorization to Obtain/Release Medical Records: I authorize Advanced Foot & Ankle Care of Memphis, LLC, Dr. Nathan Lucas, or any person designated by them, to obtain/release copies of my medical records to any physician or institution for the purpose of evaluation and/or comparison with examination and testing being performed on me/my dependent.

Signature: _____ **Date:** _____
Patient, Parent or Guardian

Authorization to Pay Benefits to Physician: I hereby authorize payment to Advanced Foot & Ankle Care of Memphis, LLC, Dr. Nathan Lucas, for services rendered to me or my dependents. I also authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for any balance not covered by insurance and/or collection costs and legal fees incurred in any attempt to collect said balance.

Signature: _____ **Date:** _____
Patient, Parent or Guardian

Authorization to Leave Message: I hereby authorize Advanced Foot & Ankle Care of Memphis, LLC, Dr. Nathan Lucas, to leave a message regarding pending appointments and/or tests at my residence. You may notify me of lab/test results, matters relating to prescriptions, my physician or an Advanced Foot & Ankle Care of Memphis representative by leaving a message (Check all that applies.) ___ on my answering machine/home voice mail; ___ with my spouse; ___ a family member (Please specify name of the family member: _____)

Signature: _____ **Date:** _____
Patient, Parent or Guardian

**NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT**

**ADVANCED FOOT & ANKLE CARE OF MEMPHIS
2900 KIRBY PARKWAY, SUITE 5
MEMPHIS, TN 38119**

I understand that, under the **Health Insurance Portability & Accountability Act of 1996 (HIPAA)**, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request, in writing, how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that Advanced Foot & Ankle Care of Memphis is not required to agree to my requested restrictions. However, if Advanced Foot & Ankle Care of Memphis does agree with my request, then you are bound to abide by such restrictions as detailed in Health Insurance Portability & Accountability Act of 1996.

If you would like to receive more information regarding HIPAA, please feel free to speak with someone in our office.

PATIENT NAME:

DATE:

PATIENT SIGNATURE: _____

**ADVANCED FOOT & ANKLE
FINANCIAL POLICY**

**ALL CHARGES ARE DUE AND PAYABLE WITHIN 45 DAYS OF
THE BILLING DATE.**

As a courtesy to the patient, Advanced Foot and Ankle and/or Dr. Nathan Lucas, will bill your **primary** insurance company only.

It is your responsibility as a patient to pay your deductible/co-insurance and/or co pay for **each** visit before services are rendered. If you have secondary insurance, the co pay and/or deductible must still be paid.

The patient is responsible for payment of the account within forty five (45) days as stated in the financial policy above. In the event, your insurance company denies payment, or no action is taken by the insurance company on the claim within 45 days, the patient will be billed for the balance due.

If you provide incorrect insurance information and your claim is denied, you are required to pay the balance due. It is then your personal responsibility to re-submit your claim directly to the appropriate insurance company.

The courtesy of a twenty four hour notice is expected should you need to cancel or reschedule an appointment. A fee of \$25.00 will be charged for repeat failed appointments. This fee must be paid at the next visit before services are rendered.

All accounts referred to the attorney for collections will be charged applicable interest and the appropriate attorney fees.

I authorize the release of any medical information necessary to process my insurance claims. I authorize payment of medical benefits to Advanced Foot & Ankle and/or Dr. Nathan Lucas. I understand that I am financially responsible to Advanced Foot and Ankle and/ or Dr. Nathan Lucas for charges not covered or paid by my insurance company.

I have read and understand the credit policy and agree to accept responsibility for full payment of my account.

DATE

PATIENT NAME (Print)

PATIENT SIGNATURE