Practice: Gainesville Podiatry Clinic, Inc. Today's Date:

Name: _____ DOB: _____ Chart Number: _____

Sex: ☐M ☐F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced SS#: _____

E-mail: _____ Spouse/Partner Name: _____

E-mail newsletters, reminders, statements, etc. Emergency Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Other #: _____

Employer: _____ Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance: _____ Are you the insured? ☐Yes ☐No

Insured Information

Subscriber Name: _____ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐ other

Phone #: _____ Sex: ☐Male ☐Female DOB: ___/___/___

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

Secondary Insurance: _____ Are you the insured? ☐Yes ☐No

Insured Information

Subscriber Name: _____ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐ Other

Phone #: _____ Sex: ☐Male ☐Female DOB: ___/___/___

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

How did you find out about our practice? ☐ Physician ☐ Internet ☐ Telephone book ☐ Family member ☐ Friend

☐ Other: _____

What is the reason for your visit today? _____

_____ Result of accident or work injury? ☐Yes ☐No

How long has this bothered you? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | ☐ days ☐ weeks ☐ months ☐ years

What treatments have you tried & have they been effective? _____

_____

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? ___/10

The pain quality is: ☐burning ☐constant ☐dull ☐sharp ☐shooting ☐throbbing ☐tingling Other: _____

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

Practice: Gainesville Family Clinic, Inc. Today's Date:

Name: _____ Chart #: _____ Date of birth: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to specify

Race: ☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American

☐ White ☐ Native Hawaiian or other Pacific Islander ☐ Declined to specify

Preferred Language: _____ ☐ Declined to specify

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____ City, State, Zip: _____

Primary Care Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

Referring Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

Privacy Information Preferences

Do you want to be exempt from public reporting? ☐ Yes ☐ No Can we send mail to the address on file? ☐ Yes ☐ No

Can we call the phone number on file? ☐ Yes ☐ No Can we leave voicemail on machine? ☐ Yes ☐ No

Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? ☐ Yes ☐ No

If yes, please provide your e-mail address: _____

Who can we leave messages with? ☐ Wife ☐ Husband ☐ Daughter ☐ Son ☐ Other:

Name(s): _____

Smoking Status

☐ Current Every Day ☐ Smoker, Current Status Unknown

☐ Current Some Day ☐ Heavy Tobacco ☐ Unknown If Ever

☐ Former ☐ Never ☐ Light Tobacco ☐ I decline to answer

Vital Signs

Blood Pressure: _____ / _____

Height: _____ Weight: _____

Current Medications

~~☐ No Known Medications ☐ I take the following medications:~~

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Use the back of this form if more room is needed

Allergies

~~☐ No Known Allergies ☐ No Known Drug Allergies~~

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Use the back of this form if more room is needed

Last Flu Shot Date: _____ Did you get a pneumococcal vaccination? ☐ Yes ☐ No

Have you fallen in the last 12 months? ☐ Yes ☐ No Were you injured from the fall? ☐ Yes ☐ No

Have you completed any Advanced Directives? ☐ Yes ☐ No

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. *(Assignment of Benefits)*: I authorize payment of medical benefits to the practice named above. *(Release of Information)*: I authorize the release of any medical information necessary to process this claim. *(HIPAA Privacy)*: I acknowledge that I received my HIPAA Privacy Practices Notice. *(Medication History)*: I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____ Date: _____

Rev 1/21/2015

History and Physical

Medical History:
☐ Alcoholism ☐ Blood disorders ☐ Circulation problems ☐ Musculoskeletal ☐ Breathing issues
☐ Liver ☐ Sleep apnea ☐ Gout ☐ Allergies ☐ Heart disease ☐ Asthma
☐ Heart murmur ☐ Stomach/bowel ☐ Depression ☐ Anxiety disorder ☐ Mental illness ☐ Kidney disease
☐ Blood clot ☐ High cholesterol ☐ High blood pressure ☐ Cancer ☐ Hepatitis
☐ Neuropathy *(specify)* _____ ☐ Thyroid disease *(specify)* _____ ☐ Diabetes (type 1, type 2)
☐ Arthritis *(specify)* _____ ☐ other *(specify)* _____ ☐ HIV ☐ CVA
Are you pregnant? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No ☐ Skin disorders ☐ Stroke

Surgical History ☐ None ☐ Appendectomy ☐ C-Section ☐ Angioplasty ☐ Bypass ☐ Cataracts ☐ Cholecystectomy
Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? ☐ Yes ☐ No
If yes, please describe: _____
Do you have any artificial joints? ☐ Yes (where? _____) ☐ No Do you have an artificial heart valve? ☐ Yes ☐ No

Social History
Do you smoke? ☐ Yes ☐ No If yes how many packs per day? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 For how long?
Do you drink alcohol? ☐ Yes, everyday (5-7 days/week) ☐ Yes, occasionally/socially ☐ No/Rarely
Substance abuse: ☐ Yes, I have a current substance abuse problem. Please specify: _____
☐ Yes, I had a past substance abuse problem. Please specify: _____
☐ No, I have never had a substance abuse problem
What is your occupation? _____ Does it involve mostly ☐ standing or ☐ sitting
Do you exercise regularly? ☐ No, I do not exercise regularly ☐ Yes, I do the following regular exercise: _____

Family History Is there any family history *(blood relative)* of: *(Please indicate family member)*

☐ Alzheimer's	_____	☐ Depression	_____
☐ Arthritis	_____	☐ Diabetes	_____
☐ Bleeding disorders	_____	☐ Emphysema	_____
☐ Blood clot	_____	☐ Heart disease	_____
☐ Cancer	_____	☐ High Blood Pressure	_____
☐ Cataracts	_____	☐ Neurological	_____
☐ Circulation problems	_____	☐ Strokes	_____
☐ Other (specify):	_____		_____

Review of Systems *(Please check the box if you currently have any of these symptoms or check "NONE")*

Cardiovascular	☐ leg pain when walking	☐ fever	☐ chest pain/pressure	☐ leg swelling	☐ cold hands/feet	
	☐ fainting	☐ palpitations	☐ vascular disease	☐ valve problems	☐ NONE	
Genitourinary	☐ blood in urine	☐ hesitancy	☐ incontinence	☐ increased urgency		
	☐ decreased frequency	☐ excessive urination	☐ kidney disease	☐ kidney stones	☐ NONE	
Gastrointestinal	☐ abdominal pain	☐ heartburn	☐ blood in stool	☐ vomiting	☐ ulcers	☐ constipation
	☐ diarrhea	☐ trouble swallowing	☐ decrease appetite	☐ increase appetite	☐ NONE	
Integumentary	☐ athletes foot	☐ nail abnormalities	☐ keloids	☐ itchiness	☐ dry, scaly skin	☐ NONE
Hematologic	☐ lower leg ulcers	☐ sickle cell disease	☐ anemia	☐ blood thinners	☐ clotting disorders	☐ NONE
Neurological	☐ tingling	☐ weakness	☐ seizures	☐ numbness	☐ headaches	
	☐ tremors	☐ paralysis			☐ NONE	
Musculoskeletal	☐ back pain	☐ joint swelling	☐ muscle weakness	☐ muscle pain	☐ neck pain	
	☐ sciatica	☐ joint stiffness	☐ joint pain	☐ joint instability	☐ arthritis	☐ NONE
Respiratory	☐ chest pain	☐ wheezing	☐ COPD	☐ coughing	☐ snoring	
	☐ shortness of breath	☐ emphysema			☐ NONE	

PLEASE READ AND SIGN
The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

INFORMATION DISCLOSURE

Every once in a while, we may need to contact you. If you are not available, is there someone else we could speak to regarding your account, such as a spouse, family member, or caretaker? Please list their name and check the box indicating what information we may share with them. A phone number is not necessary.

Name of contact:	Relationship/Phone #	What may we speak to them about? ALL	Appts	Medical	Billing/Ins
_____	_____	☐	☐	☐	☐
_____	_____	☐	☐	☐	☐
_____	_____	☐	☐	☐	☐
_____	_____	☐	☐	☐	☐

- There may be times when this office will call and leave messages and/or appointment information.
- We will continue to rely on the information on this form when communicating with friends or family members or others involved in your care unless you request changes. Please promptly notify us if you wish to change your list of contacts.
- This will be effective until patient or guardian revokes it in writing, which may be done at any time.

Please sign indicating that what is written above is correct and you understand it.

Signature/Guadian: _____ Date: _____

PAYMENT AUTHORIZATION

I request that payment of authorized insurance benefits may be made to Dr. Daniel or Dr. Bordenkecher (Gainesville Podiatry Clinic, Inc) for any service furnished to me by the provider. I understand I am responsible for any portion of my bill not covered by my insurance company. I authorize the release of any medical or other information about me necessary to determine benefits or those payable for related services. This authorization will remain in effect unless revoked by me in writing. I also understand that I am responsible for paying the patient portion of my account balance and that there will be a monthly repeat billing charge of $10.00 added to accounts more than 60 days old. I agree to pay not only my account balance but the billing charges as well. I understand I will also be responsible for any collections fees and/or legal fees incurred if my account is sent to collections.

Signature: _____ Date: _____

GAINESVILLE PODIATRY CLINIC, INC.
Wesley L. Daniel, D.P.M.
Jeane P. Watson, D.P.M.
1975 Beverly Road, Suite B Gainesville, GA 30501-2034 770.536.9908 or 1.800.562.0296 Fax 770.532.7102
All Family Foot, Ankle, & Leg Care Since 1975

RELEASE OF MEDICAL RECORDS

I authorize Gainesville Podiatry Clinic to retrieve medical information including medication history form any and all of my medical providers. This form will stay in effect until withdrawn by writing.

Print Name _____ Date of Birth _____

Patient Signature _____ Today's Date _____

Parent or Legal Guardian _____ Today's Date _____

BILL OF RIGHTS

1. The patient has the right to considerate and respectful care.
2. The patient has the right to obtain complete current information concerning diagnosis, treatment and prognosis in terms they can be reasonable expected to understand. When medically advisable to give such information to the patient, the information should be made available to an appropriate person on their behalf. A patient has the right to know by name the physician responsible for coordinating their care.
3. The patient has the right to receive from their physician any information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include, but not necessarily be limited to the specific procedure and or/treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information. The patient also has the right to know the name of the person responsible for the procedure and/or treatment.
4. The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of this action.
5. The patient has the right to expect all communications and records pertaining to their care be treated as confidential.
6. The patient has the right to every consideration of privacy concerning their own medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discretely. Those not directly involved in treatment must have the permission of the patient to be present.
7. The patient has the right to expect that within its capacity, an office must make reasonable response to the request for services. Medical facilities must provide evaluation service and/or referral as indicated by the urgency of the case. When medically permissible, the patient may be transferred to another facility only after receiving complete information and explanation concerning the needs for an alternative transfer.
8. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by name, who are treating them.
9. The patient has the right to expect reasonable continuity of care, as well as, the right to know in advance what appointment times and physicians are available.

POLICIES & PROCEDURES

1. Verification of Insurance and filing Claims: When verifying benefits, it is never a guarantee of payment per your insurance company's disclaimer. You are responsible for all deductibles, co-pays, co-insurance amounts and non-covered services. It is the Patients responsibility to know what their insurance carrier considers a covered or non-covered service. Due to the continuing changes with insurance networks, we do not always know if your insurance is in a network in which we are contracted. All insurance claims that are not paid within 90 days become the responsibility of the patient for payment. Secondary insurance is filed as a courtesy and will only be filed one time. If the Claim is not paid within 30 days, payment is your responsibility. If you are an established patient and your insurance has changed since your last treatment, it is your responsibility to inform the office staff prior to your next treatment. We must have a valid insurance card and driver's licenses at the time of your visit.
2. Referral Policies: Obtaining a referral is the patient's responsibility not our office staff. We will assist you with all of the necessary information needed to obtain the referral. Please give your primary care physician ample time to obtain a referral. Some primary care physician offices will issue a referral when you call, others require up to a 72 hour notice. Make sure that you bring your referral with you at the time of your visit. If necessary, call our office prior to your appointment to see if we have received your referral from your primary care physician. Patients will not be seen at the original scheduled time if we do not have a current referral when you arrive. Your appointment will be rescheduled. Some insurance companies will issue a back dated referral and some will not. These rules are for your protection so that we will not be forced to bill you directly for services received without a valid referral. Remember that referrals are not a guarantee of payment.
3. Payment Policy: All co-pays and deductibles are due at the time of treatment. We accept cash, checks (not two-party), money orders, Visa and MasterCard. If you have no insurance coverage, payment is due in full at the time of the service. All past due accounts (more then 31 days) are subject to a monthly service fee and/or late payment fee. If your account is forwarded to an outside collection agency a 35% collection fee will be added to your balance. Attorney's fees may also be added for collection processing. Once an account is sent to collections all payment arrangements must be made with that agency and no appointments will be scheduled until that balance is paid in full. All returned checks are subject to a $35.00 fee. All future payments must be made by money order, cash, or credit card after a bad check is written.

   Insurance foot restrictions or limitations for treatment and/or supplies: Some insurance policies have yearly foot limitations, exclusions and restrictions for podiatry services. Due to the restrictions outlined by each individual insurance company, some supplies and/or services performed within our office may be considered "non-covered" or routine. Due to many plans with which we participate and the extreme variances between policies, our office does not always know in advance which supplies and/or services will or will not be covered. Some of the supplies and/or services may include, but are not limited to, custom molded orthotics or over the counter orthotics, walking casts, foot/ankle supports, and durable medical equipment such as cam walkers or braces and debridement's of corns, calluses and toenails.

   Fee of "No-Show" Appointments: Due to the continued growth of our practice it has become necessary to charge a $25.00 no-show fee for each appointment not cancelled within a 24 hour period. You may leave a message on our answering machine if you need to cancel after hours. An appointment not kept on the same day, with no message on answering machine of phone call 24 hours prior to appointment will result in a $25 service fee. INITIAL THAT NO SHOW POLICY HAS BEEN READ: _____

   Disability Paperwork: As a courtesy to our patients we will supply the first set of disability paperwork to the patient's place of employment. Any and all additional paperwork afterward will be subject to a $20 processing/service fee.

   This list is a general guideline of our office policies. If you do not understand or have any questions regarding these guidelines, please speak with the office manager.

I have read, understand and agree to the terms of this agreement. This signed agreement will be included in my permanent medical records.

X _____ X _____

Patient or Gaurdian Witness