



# ANKLE & FOOT

## ASSOCIATES, LLC

David P. Murphy, D.P.M., FACFAS  
Gregory J. Kramer, D.P.M., FACFAS  
Robson S. Spinola, D.P.M., FACFAS  
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Nicole E. Wilson, D.P.M.  
Robert D. Yant, D.P.M.

Welcome and thank you for choosing Ankle & Foot Associates, LLC. Please complete the enclosed information packet and bring the entire packet to your appointment. Please make every effort to have your paperwork completed to bring with you to the appointment. We will need a photo ID and a copy of your insurance information at the appointment as well.

If for some reason you are unable to complete your paperwork we ask that you come in for your appointment twenty minutes earlier for assistance. If you are in need of assistance completing the paperwork we ask that you **bring a list of your current medication with you to your appointment.** Please make every effort to complete this before your appointment.

Once again, we appreciate you choosing Ankle & Foot Associates, LLC, we look forward to seeing you at your appointment.

Ankle & Foot Associates, LLC.

[anklesandfeet.com](http://anklesandfeet.com)

501 West Oneida Street - Waycross, Georgia 31501 - (912) 283-6471  
204 Westside Drive - Douglas, Georgia 31533 - (912) 384-4121  
331 Peachtree Street - Jesup, Georgia 31545 - (912) 427-9990  
39 Kent Road, Suite 9 - Tifton, Georgia 31794 - (229) 382-3338  
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5102 Paulsen Street, Building 3 - Savannah, Georgia 31405 - (912) 777-4604  
17 Grady Johnson Road - Statesboro, Georgia 30458 - (912) 681-8000  
1700 North Patterson Street - Valdosta, Georgia 31602 - (229) 247-7707

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## REGISTRATION FORM (Please Print)

PATIENT INFORMATION											
Patient's last name:		First:		Middle:		<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.		Marital status: Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Widow <input type="checkbox"/>			
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No		If not, what is your legal name?		(Former name):		Birth date:		Age:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Street address:			Social Security #:			Phone #: (    )			Secondary Phone #: (    )		
P.O. Box:		City:				State:		Zip Code:			
Occupation:		Employer:					Employer phone #: (    )				
Chose clinic because/referred to clinic by (Please check one box)											
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work		<input type="checkbox"/> Yellow Pages		<input type="checkbox"/> Other					
Other family members seen here:											
Physician Referral: No _____ Yes _____ Physician _____ Ph# _____											
Would you like for us to leave a message? If so, what number _____											
INSURANCE INFORMATION											
(Please give your insurance card and photo ID to the receptionist)											
Person responsible for bill:		Birth date:		Address (If different)				Home phone no.: (    )			
Is the person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No											
Occupation:		Employer:		Employer address:				Employer phone no: (    )			
Is the patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No											
Please indicate primary insurance		<input type="checkbox"/> BCBS		<input type="checkbox"/> UHC		<input type="checkbox"/> Principal		<input type="checkbox"/> Aetna		<input type="checkbox"/> I <sup>st</sup> Health	
<input type="checkbox"/> Medicare		<input type="checkbox"/> Medicaid		<input type="checkbox"/> Supplement		<input type="checkbox"/> Worker's Compensation			Other:		
Subscriber's name:		Subscriber's S.S. no:		Birth date:		Group #:		Policy #:		Co-payment: \$	
Patient's relationship to subscriber:		<input type="checkbox"/> Self		<input type="checkbox"/> Spouse		<input type="checkbox"/> Child		<input type="checkbox"/> Other			
Name of secondary insurance (If applicable):			Subscriber's name:				Group no.:		Policy no.:		
Patient's relationship to subscriber:		<input type="checkbox"/> Self		<input type="checkbox"/> Spouse		<input type="checkbox"/> Child		<input type="checkbox"/> Other			
Name of local friend or relative:					Relationship to patient:			Phone no.: (    )			
Patient/Guardian signature _____					Date _____						



# ANKLE & FOOT

ASSOCIATES, LLC

**PLEASE COMPLETE THE FOLLOWING IF THE PATIENT IS A CHILD**

**Patient Name**\_\_\_\_\_

**Date of Birth**\_\_\_\_\_

**FATHERS**

**Name**\_\_\_\_\_

**Date of Birth**\_\_\_\_\_

**Address**\_\_\_\_\_

**Phone**\_\_\_\_\_

**City, State, Zip**\_\_\_\_\_

**SS#** \_\_\_\_\_

**MOTHERS**

**Name**\_\_\_\_\_

**Date of Birth**\_\_\_\_\_

**Address**\_\_\_\_\_

**Phone**\_\_\_\_\_

**City, State, Zip**\_\_\_\_\_

**SS#** \_\_\_\_\_



Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

### Patient Medical History

What is the primary reason for your visit today: \_\_\_\_\_

Family Doctor (full name): \_\_\_\_\_ Date Last Seen: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Pharmacy Address: \_\_\_\_\_

Pharmacy Phone No. \_\_\_\_\_

Do you smoke? ☐ No ☐ Yes How much? \_\_\_\_\_ Drink Alcohol? ☐ No ☐ Yes How much? \_\_\_\_\_

Is there a family history of: Heart Disease \_\_\_\_\_ Cancer \_\_\_\_\_ or Diabetes \_\_\_\_\_

Do you exercise on a regular basis? ☐ No ☐ Yes

Shoe Size: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Do you take regular medications? ☐ No ☐ Yes; If Yes, please list on the attached form.

Are you allergic to any medications? ☐ No ☐ Yes; If Yes, please list on the attached form.

Have you had any falls with injury in the past year? ☐ No ☐ Yes;

Please list all previous surgeries and dates: \_\_\_\_\_

Please list any other problems for which you have a physician that we should be aware of: \_\_\_\_\_

Do you have an Advance Directive? ☐ No ☐ Yes

### PLEASE CHECK ALL THAT APPLY

\_\_\_\_ Diabetes Type I or II

\_\_\_\_ Hepatitis

\_\_\_\_ Stomach Ulcers/Hernia

\_\_\_\_ Chronic Cough/Wheezing/Asthma

\_\_\_\_ High Cholesterol

\_\_\_\_ COPD

\_\_\_\_ Tuberculosis

\_\_\_\_ Kidney Stones or Infections

\_\_\_\_ Are you on Blood Thinners?

\_\_\_\_ Anemia

\_\_\_\_ Bleeding or clotting problems

\_\_\_\_ Heart Disease

\_\_\_\_ High Blood Pressure

\_\_\_\_ Heart Attack

\_\_\_\_ Seizures

\_\_\_\_ Arthritis

\_\_\_\_ Thyroid Problems

\_\_\_\_ Depression/Bipolar

\_\_\_\_ Cancer

\_\_\_\_ HIV/AIDS

\_\_\_\_ Headaches

\_\_\_\_ Stroke



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Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_  
\_\_\_\_\_

MEDICATION	DOSAGE

Verified By: \_\_\_\_\_



## FINANCIAL POLICY

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Thank you for choosing us as your health care provider. We are committed to providing you with the, best possible medical care. In order to achieve this goal, we need your assistance, and your understanding of our payment policy. Please Initial each section indicating you have read and understand this Policy.

**PAYMENT FOR SERVICE IS DUE AT THE TIME SERVICES ARE RENDERED**

We accept cash, personal checks, Mastercard and Visa. Returned checks are subject to a service charge of \$20.00 or 5% of the face value of the check, whichever is greater, and you will lose your privilege to write checks in our office.

**CANCELED APPOINTMENTS** - Patients who do not cancel appointments will be charged an office visit after the third no-show.

**MEDICARE** - Your deductible and 20% of the allowable charges are due at the time of service. If we do not know the allowable charge for a specific service, we will bill you after Medicare pays. Please bring your Medicare Explanation of Benefits showing you have met your deductible.

**WORKERS' COMPENSATION** - We will call your employer to authorize your visit prior to your appointment. We will file with your company's insurance. In the event you fail to prosecute the claim for Worker's Compensation for this illness or condition, or it is determined by the Worker's Compensation board that the illness or condition is not a result of a compensable Worker's Compensation case, you agree to pay the usual and customary fees for services rendered to you in this case.

**CHILDREN OF DIVORCED PARENTS** - PAYMENT IS DUE AT THE TIME OF SERVICE no matter who is responsible by order of the divorce decree. The person presenting the minor child for treatment is responsible for any charges incurred.

**FINANCIAL AGREEMENT** - We will gladly discuss your proposed treatment and do our best to answer any questions to your insurance. You must realize, however that:

1. Your insurance is a contract between you, your employer, and the insurance company. we are not a party to that contract. We charge what is Usual & Customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual & customary rates.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover (e. g., orthotics)
3. We will file a claim with your insurance company as a courtesy to you. Any charges that have not been paid after 90 days will automatically be due and payable by you. Any payments received by the insurance company after that date will be refunded to you, providing there was a zero balance on the account.

We must emphasize that as your medical care providers, our relationship and concern is with you and your health, not your insurance company. **ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED.**

On any balance on your account after 90 days, Including those that Insurance has not paid, collection action will be taken. We realize that emergencies do arise and may Affect timely payment of your account. If such extreme cases do occur, please contact us promptly for assistance in the timely management of your account. If it becomes necessary to collect any sum due through an attorney, then the patient agrees to pay all reasonable attorney's fees, whether suit is filed or not.

If you have any questions about the above information, or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

I will pay my co-payment / deductible amount today by \_\_\_\_\_ Check \_\_\_\_\_ Cash \_\_\_\_\_ Credit Card.

I have read and understand the above Financial Policy.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

Ankle & Foot Associates, LLC

Name: \_\_\_\_\_

DOB \_\_\_\_\_

**AUTHORIZATION**

I, the undersigned certify that I (or my dependent) has insurance coverage as listed above and assign directly to Ankle & Foot Associates, LLC. I understand that I am financially responsible for all charges whether or not paid by insurance. I remain responsible for payment of co-pays, deductibles, non-covered services, and any other charges not paid by insurance within 30 days. I hereby authorize Ankle & Foot Associates, LLC, to release all information necessary to secure payment of benefits. I authorize the use of this signature for all insurance claims.

X Signature \_\_\_\_\_ Date \_\_\_\_\_

Are you the Guarantor? Yes \_\_\_ No \_\_\_ If not please see receptionist.

**CONSENT FOR TREATMENT**

Having voluntarily presented myself (or my dependent) Ankle & Foot Associates, LLC, I acknowledge recognition of the fact that the evaluation and treatment received, advised or deemed necessary, to be the judgment of the Physician.

X Signature \_\_\_\_\_ Date \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE (HIPPA)**

By signing this form, you acknowledge that Ankle & Foot Associates, LLC, has offered or given to you a copy of its Privacy Notice, which explains how your, health information will be handled in a various situation. We must attempt to have you sign this form on your first date of service with us after April 14, 2003. This includes the situation where your first date of service occurred electronically. If your first date of service with us was due to an emergency, we must attempt to give you this notice and get your signature acknowledging receipt of this notice as soon as possible after the emergency.

☐ I have received a copy of the Privacy Notice of Ankle & Foot Associates, LLC.

☐ Ankle & Foot Associates, LLC< has offered me a copy of the Privacy Notice which I have declined and has given me the chance to discuss my concerns and questions about the privacy of my health information.

X Signature \_\_\_\_\_ Date \_\_\_\_\_

**ADDITIONAL PERSON(S) AUTHORIZED TO MAKE THE USE OR DISCLOSURE OF MY MEDICAL HISTORY**

We at Ankle & Foot Associates, LLC, value and do everything in our power to protect your privacy. Your medical information will not be given to any individual (Including spouses, parents, children, or any significant others without your written consent). If you want anyone other than your referring physician to have access to your medical information please list their name, address, relation, and phone number below. (Note: Uses and disclosures may be permitted without prior consent in an emergency.)

Name \_\_\_\_\_ Relation \_\_\_\_\_

Name \_\_\_\_\_ Relation \_\_\_\_\_

Name \_\_\_\_\_ Relation \_\_\_\_\_

☐ This will never expire ☐ This will expire on \_\_\_\_\_

X Signature \_\_\_\_\_ Date \_\_\_\_\_

The staff of Ankle & Foot Associates, LLC should complete this section if Acknowledgement Form is not signed by the Patient:

1. Does the patient have a copy of the Privacy Notice? Yes \_\_\_ No \_\_\_
2. Please explain why the patient was unable to sign an acknowledgement form and our efforts in trying to obtain the patient signature: \_\_\_\_\_

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_



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Ankle and Foot Associates is now offering our patients easy and private access to their medical information online, so that you can view your personal health record whenever and wherever you have access to the internet. To gain access to our secure server on Patient Portal and become web-enabled, simply sign-up by providing us with a personal (non-work) e-mail address.

Patients Name:

DOB:

E-Mail Address:

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