Kent E. Kronowski, D.P.M
FASPS
Board Certified*

THE FOOT AND ANKLE GROUP, P.C.
*Meeting All Your Podiatric Needs*
www.footandanklegroup.net
*Certified by the American Board of Podiatric Surgery

Mary L. Ottinger, D.P.M.
FASPS
Board Certified*

Dear Patient,

Thank you for choosing The Foot and Ankle Group to meet your podiatry needs. Please remember to bring the following to your appointment:

- Insurance card(s)
- Government-issued Photo ID (preferably driver's license)
- Current list of medications
- Co-pay (if your insurance requires one)- we are considered a SPECIALIST. Co-pays must be collected at the time of your visit. If you do not have your co-pay, your appointment will be rescheduled.

Effective June 1, 2018 our office will charge a $30 fee for all no-show appointments. This fee is not billable to your insurance company. Appointments that are changed or cancelled within 24 hours will not be charged.

Please bring the enclosed paperwork completed with you to your appointment. We ask that you do not mail it in. Please contact our office if you have any questions.

1515 Laney Walker Blvd
Augusta, GA 30904
Phone: 706-724-0586
Fax: 706-724-4468

1519 Laney Walker Blvd
Augusta, GA 30904
Phone: 706-724-7000
Fax: 706-722-3338

4434 Columbia Rd, Ste 106
Martinez, GA 30907
Phone: 706-651-0052
Fax: 706-651-0097

**The Foot and Ankle Group, PC**
**Patient Information**

Today's Date:_____

## Demographic Information:

First Name: _____ Middle:_____ Last Name: _____

Date of Birth: _____ Age:_____ Gender: _____ SSN:_____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Email: _____

Ethnicity (circle one): Hispanic/Latino non Hispanic/Latino

Race (circle one): Native American/Alaskan Asian African American/Black Caucasian/White
Native Hawaiian/Pacific Islander Decline Other:_____

Marital Status (circle one): Single Married Divorced Partner Widowed Legally Separated

Student (circle one): Not a Student Full-Time Student Part-Time Student

Employment Status (circle one): Not Employed Full-Time Part-Time Retired

Employer: _____ Occupation/Position: _____

Address: _____ Phone: _____

Primary Care Physician: _____ Date Last Seen: _____

Referring Provider: _____

Referral Source (circle one): Physician/doctor insurance friend/family internet Yellow Pages

Emergency Contact Name: _____ Phone: _____

Preferred Pharmacy: _____ Address: _____

*Responsible Party: Name: _____ Date of Birth: _____ SSN: _____

**Insurance Information:**

Primary: _____ Insured name: _____ Date of Birth: _____

Guarantor: Name: _____ Date of Birth: _____ SSN: _____

Secondary: _____ Insured name: _____ Date of Birth: _____

Guarantor: Name: _____ Date of Birth: _____ SSN: _____

## Medical Information:

**Reason for Today's Visit:**

_____

Date of Injury (if applicable): _____ How long has this been a problem? _____

Other doctors who treated you for this: _____

Medications: _____

_____

_____

Allergies (circle all applicable): None Penicillin Sulfa Aspirin Codeine Tetanus Adhesive Tape Other: _____

Height: _____ Weight: _____ Shoe Size: _____

Last A1C if diabetic: _____

## Medical History- circle any that you have currently or had in the past:

AIDS/HIV
Alcoholism
Allergies
Anemia (low blood)
Angina (chest pain)
Arteriosclerosis
Arthritis
Asthma
Cancer (type) _____
Heart attack
Heart disease
Colon disease
Congestive heart failure
Diabetes
Dialysis
Edema (Swelling)
Emphysema
Epilepsy
GERD (reflux)
Gout
Hepatitis
Hyperlipidemia (Cholesterol)
Hypertension (high BP)
Kidney problems
Low back pain
Lymphedema
Neuropathy
Mumps
Murmur (heart)
Osteoporosis
Phlebitis
Polio
Psychiatric Problems
Peripheral Arterial Disease
Rheumatic Fever
Scarlet Fever
Stroke
Varicose Veins
Write other problems below:
_____
_____
_____
_____
_____

## Surgical History- circle any that you have had and write in the year:

Abdominal surgery _____
Amputation _____
Ankle Surgery _____
Back Surgery _____
Bladder Surgery _____
Bowel/Colon Surgery _____
Brain Surgery _____
Breast Surgery _____
Cardiac Catheterization _____
Carpal tunnel _____
Cataract extraction _____
Cholecystectomy (gall bladder) _____
Coronary Artery Bypass _____
C-Section _____
Discectomy _____
Ear surgery/tubes _____
Eye Surgery _____
Foot Surgery _____
Hand/wrist Surgery _____
Hip Replacement _____
Hysterectomy _____
Kidney Surgery _____
Knee surgery _____
Pacemaker _____
Rotator Cuff _____
Spinal Fusion _____
Stent insertion _____
Vascular surgery _____
Vein stripping _____
Write other surgeries below:
_____
_____

## Social History:

Who do you live with? _____ How many children do you have? _____

Smoking (circle one): Former Less than 1 pack per day One or more pack per day Never

Illicit drug use (circle one): Current Never Previously

Alcohol use (circle one): Heavy Moderate Recovering alcoholic Social Drinker Never

Caffeine use per day (circle one): 1-2 cups 3-5 cups 6-9 cups 10+ cups

Exercise (circle one): Never 1-2 times per week 3-7 times per week

## Family History- circle F for Father and M for Mother :

Arthritis F M
Depression F M
Diabetes F M
Cancer F M
Emphysema F M
Heart disease/attack F M
High Blood Pressure F M
Kidney Problems F M
Lung Problems F M
Stroke F M
Vein Problems F M

Write in any other problems below:

_____ F M
_____ F M
_____ F M
_____ F M
_____ F M

## Review of Systems- circle if you presently have any of these symptoms or conditions (circle none if none):

- Allergy: food intolerance itching nasal congestion sneezing
- Constitutional: chills convulsions dizziness fever none
- Cardiovascular: high blood pressure pacemaker shortness of breath varicose veins chest pain heart palpitations none
- Ear/Nose/Mouth/Throat: bleeding gums dentures difficulty hearing ringing in ears none
- Eyes: blurred vision glasses loss of vision none
- Endocrine: diabetes delayed wound healing dry skin hair loss none
- GI: abdominal pain blood in stool constipation diarrhea nausea acid reflux none
- GU: blood in urine kidney(flank) pain kidney dialysis kidney failure pregnant none
- Immune: allergies arthritic flare-up asthma gouty attack none
- Integumentary (skin): athlete's foot blistering dry, scaly skin itchy skin rash ulcers/open wound none
- Lymph/Blood: anemia bleed easily none
- Musculoskeletal: back pain bone pain difficulty walking foot pain heel pain knee pain joint pain joint swelling leg cramps muscle tenderness neck pain other pain: _____ none
- Neurological: migraine paralysis seizure tremors numbness tingling burning none
- Respiratory: asthma attack shortness of breath sleep apnea wheezing none
- Psychiatric: addiction depression bipolar other: _____ none

How much pain are you in currently on a scale from 0-10 (0 being no pain, 10 being worst pain)?

**0 1 2 3 4 5 6 7 8 9 10**

Have you received a flu vaccine for the current season (circle one)? Yes No

If no, what was the reason (circle one)? Allergy Declined Unavailable

**For patients age 65 and older:**

Do you have a living will or someone to make decisions on your behalf (circle one)? Yes No

Have you had a pneumonia vaccination (circle one)? Yes No

# HIPPA NOTICE OF PRIVACY PRACTICES

# THE FOOT AND ANKLE GROUP, P.C.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related healthcare services.

**Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business and operational activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review of activities, training of students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We will share your protected health information with third party 'business associates' that perform various activities for the practice (i.e. billing, transcription services). We may use and disclose your protected health information for marketing activities such as a newsletter about our practice and services, or treatment alternatives, or products or services we believe may benefit you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by Law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Admininstration requirement: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates: Required Uses and Disclosures: Under the Law, we must make disclosures to you and when required by Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by Law.

You may revoke this authorization at any time in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**INTIAL:** _____

# Please initial each section and sign at the bottom.

**Authorization to Release Information:**

I Hereby authorize this practice to make uses and disclosure of my protected health information to the named person(s) below:

Name of family member or friend: _____

Relationship to patient: _____

**Patient Initial:** _____

**Signature on File:**

I authorize use of this form on all my insurance submissions.

I authorize release of information to all my insurance companies.

I authorize my doctor to act as my agent in helping obtain payment for services rendered.

I authorize payment directly to my doctor.

I permit a copy of this authorization to be used in place of the original.

I understand if my insurance requires a referral to a specialist that **I am responsible for obtaining all referrals prior to being seen** by any physician of The Foot and Ankle Group.

I understand and I am responsible for providing all information needed to file insurance claims.

I understand that **I am responsible for my bill and copayments.**

I am responsible for providing the office with current and correct insurance information.

I understand that fees may be applied for paperwork to be completed by my doctor (i.e. FMLA, Worker's Comp, Disability, etc.) and are not billable to my insurance.

I understand that a **$30 charge will be made for no-show appointments**. Appointments that are changed, cancelled, or rescheduled 24 hours prior to the appointment time will not be charged. This charge is not paid by your insurance.

We file your insurance as a courtesy- payment is ultimately your responsibility.

**Patient Initial:** _____

**Acknowledgement of receipt of "Notice of Privacy Practices":**

I acknowledge that, if I so chose, I was provided with a copy of the Notice of Privacy Practices and that I have read (or had read to me), and understand the notice.

**Patient Signature:** _____ **Date:** _____

**Witness Signature:** _____ **Date:** _____