TENNESSEE FOOT & ANKLE CLINIC

PODIATRIC MEDICINE & SURGERY

125 TOWN CREEK ROAD E
LENOIR CITY, TN 37772
TEL: (865) 986-2700
FAX: (865) 986-8096

DAVID P. HAWK,DPM
LOUIS I. REPER II, DPM
JOHN N. GERNERT, DPM
ELELTA HAILEMICHAEL, DPM

WELCOME TO OUR OFFICE

DATE: _____

PATIENT NAME: _____ DATE OF BIRTH: ____/____/_____

ADDRESS: _____ CITY: _____ STATE: _____

ZIP: _____ SSN#: _____ - ____ - _____ ☐ MALE ☐ FEMALE

HOME PHONE: (____) ____ - _____ CELL PHONE: (____) ____ - _____

EMAIL: _____

EMERGENCY CONTACT: _____ PHONE: (____) ____ - _____

MARITAL STATUS:

☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

NAME OF SPOUSE/PARENT/GUARDIAN: _____ PHONE: (____) ____ - _____

RELATIONSHIP TO PATIENT: _____

ADDRESS (IF DIFFERENT FROM PATIENT): _____

PARENT/GUARDIAN EMPLOYER: _____ WORK PHONE: (____) ____ - _____

PATIENT'S OCCUPATION: _____ EMPLOYER: _____

EMPLOYER'S ADDRESS: _____

EMPLOYER'S PHONE: (____) ____ - _____

(OVER)

Spouse's Occupation: _____ Employer: _____

Employer's Address: _____

Employer's Phone: (____) ____ - _____

Family Doctor's Name: _____ Phone: (____) ____ - _____

Have you seen a Podiatrist in the past? If yes, name & location: _____

Whom may we thank for referring you? _____

Briefly describe your problem: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Patient: _____

Insured's Date of Birth: ____/____/_____ Insured's SSN#: _____ - ____ - _____

Insurance Company: _____ Member ID#: _____

Group #: _____ Mailing Address for Claims: _____

City: _____ State: _____ Zip: _____

Do You Have Additional Insurance? ☐ Yes ☐ No

If yes, complete the following:

Name of Insured: _____ Relationship to Patient: _____

Insured's Date of Birth: ____/____/_____ Insured's SSN#: _____ - ____ - _____

Insurance Company: _____ Member ID#: _____

Group #: _____ Mailing Address for Claims: _____

City: _____ State: _____ Zip: _____

Good, professional doctor-patient relations depend upon mutual respect and understanding. Thank you for your cooperation in filling out this form.

IS YOUR GENERAL HEALTH GOOD? ---------- YES NO

ARE YOU PREGNANT? ---------- YES NO

HAVE YOU HAD SERIOUS OPERATIONS OR INJURIES? ---------- YES NO

HAVE YOU HAD ANY SERIOUS ILLNESSES? ---------- YES NO

DO YOU HAVE TROUBLE HEALING? ---------- YES NO

DO YOU HAVE DIABETES? ---------- YES NO

DO YOU HAVE HIGH BLOOD PRESSURE? ---------- YES NO

DO YOU HAVE VASCULAR DISEASE? ---------- YES NO

ARE YOU TAKING ANY MEDICATIONS? ---------- YES NO

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? ---------- YES NO

I, UNDERSIGNED, GIVE CONSENT TO DR. DAVID HAWK, DR. LOUIS REPER II, DR. ELELTA HAILEMICHAEL, AND/OR DR. JOHN GERNERT AND THEIR STAFF TO EXAMINE, DIAGNOSE, AND TREAT MY FOOT CONDITION.

_____ _____

SIGNATURE DATE

I REQUEST THAT PAYMENT OF INSURANCE BENEFITS BE SENT TO THE TENNESSEE FOOT AND ANKLE CLINIC, INC. FOR ANY SERVICES FURNISHED TO ME BY THEM. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO BE RELEASED TO MY INSURANCE COMPANY AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE BENEFITS.

_____ _____

SIGNATURE DATE

OFFICE POLICY: Payment is required each time treatment is rendered. We do file insurance claims with any insurance company that we contract with.

A NOTE ABOUT INSURANCE: Please remember that any insurance is a contract between you and the insurance company. The amount paid by the insurance company is the amount of insurance you have purchased. The benefits are specified in your contract and bear no relation to the value of our service. Remember that you are responsible for any and all charges insured for treatment whether or not your insurance company pays the claim or not.

METHODS OF PAYMENT: Our office accepts assignment with Medicare and numerous other insurance companies. Please ask about your specific insurance company before being seen by the physician. We accept cash, checks, and credit cards. There is a 3% fee for all credit cards. No debit cards.

COLLECTION PROCEDURES: Should your account be turned over to any attorney or collection agency to collect any unpaid balance you hereby agree to pay all collections costs (not to exceed 35 (thirty-five) %) plus any court costs, which may be incurred.

(OVER)

I, _____, ACKNOWLEDGE AND AGREE THAT TENNESSEE FOOT AND ANKLE CLINIC, INC. AND ANY AFFILIATES OR VENDOR THEREOF, INCLUDING COLLECTION OR BILLING COMPANIES, MAY CONTACT ME BY TELEPHONE TO ANY NUMBER I HAVE PROVIDED TO YOU, AND ANY OTHER TELEPHONE NUMBER ASSOCIATED WITH MY ACCOUNT, INCLUDING WIRELESS OR MOBILE TELEPHONE NUMBERS. I FURTHER AGREE THAT YOU MAY USE ANY METHOD OF CONTACT TO THESE NUMBERS, SUCH AS A DIALING SERVICE OR PRERECORDED MESSAGE. I ALSO AGREE THAT I WILL NOTIFY TENNESSEE FOOT AND ANKLE CLINIC, INC. IF I HAVE GIVEN UP OWNERSHIP OR CONTROL OF ANY SUCH TELEPHONE NUMBER.

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PATIENT CONSENT AND PRIVACY PRACTICES ACKNOWLEDGEMENT

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 TREATMENT AMONG 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 UNDERSTAND THAT I MAY REQUEST IN WRITING THAT YOU RESTRICT HOW MY PRIVATE INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS. I ALSO UNDERSTAND YOU ARE NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS, BUT IF YOU DO AGREE, THEN YOU ARE BOUND TO ABIDE BY SUCH RESTRICTIONS.

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT YOU HAVE TAKEN ACTION RELYING ON THIS CONSENT.

PAYMENT POLICY

ALL CO-PAYS, DEDUCTIBLES, AND PATIENT BALANCES MUST BE PAID IN FULL PRIOR TO TREATMENT AND/OR A RETURN VISIT. THERE IS A 3% CONVENIENCE FEE ON ALL CREDIT CARD TRANSACTIONS. UNFORTUNATELY, WE CANNOT MAKE ANY EXCEPTIONS TO THE POLICY

CANCELLATION POLICY

WE REQUIRE A 24 HOUR NOTICE FROM THE PATIENT WHEN CANCELLING AN APPOINTMENT. ANY CANCELLATION LESS THAN 24 HOURS PRIOR TO APPOINTMENT WILL BE CHARGED A $25.00 CANCELLATION FEE. AFTER 2 CANCELLED APPOINTMENTS, WE WILL NO LONGER BE ABLE TO CONTINUE SEEING THE PATIENT IN THE CLINIC.

PATIENT SIGNATURE _____ DATE _____

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PATIENT DATE

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30 DAY CONTROLLED SUBSTANCE PRESCRIPTIONS

I, _____, HAVE RECEIVED THE FOLLOWING CONTROLLED SUBSTANCE PRESCRIPTIONS IN THE PAST 30 DAYS.

_____	_____
	PHYSICIAN
_____	_____
	PHYSICIAN
_____	_____
	PHYSICIAN
_____	_____
	PHYSICIAN
_____	_____
	PHYSICIAN
_____	_____
	PHYSICIAN
_____	_____
	PHYSICIAN
_____	_____
	PHYSICIAN

I USE THE FOLLOWING PHARMACY/PHARMACIES TO FILL MY PRESCRIPTIONS:

_____	_____
PHARMACY	PHARMACY

THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT WITHHOLDING PRESCRIPTION INFORMATION IS CONSIDERED FRAUD UNDER THE LAWS OF THE STATE OF TENNESSEE AND I CAN BE PROSECUTED FOR SUCH. I ALSO UNDERSTAND THAT TENNESSEE FOOT & ANKLE CLINIC, INC. AND IT'S PHYSICIANS HAVE THE RIGHT TO TERMINATE ME AS A PATIENT FOR FAILURE TO DISCLOSE ALL PRESCRIPTION INFORMATION TO THEM.

_____	_____
PATIENT SIGNATURE/DATE	WITNESS/DATE