Atlanta Foot & Leg Clinics

Jonesboro · Stone Mountain · Sandy Springs

PATIENT INFORMATION FORM

ALL PATIENTS OR RESPONSIBLE PARTIES MUST COMPLETE THIS FORM AND PROVIDE A PICTURE ID AND INSURANCE CARD BEFORE SEEING THE DOCTOR

LAST NAME:___________________________________FIRST NAME:______________________________M.I._________

ADDRESS:____CITY:________________________

STATE:_____________ZIP:______________(HOME) PHONE:_____________________(WORK):______________________

(CELL):_______________________ BIRTHDATE:_________________________________ Sex (M)________ (F)________

E-MAIL ADDRESS:____

PATIENT'S EMPLOYER:____

INSURED'S EMPLOYER (If Patient is not the Insured):____

RACE (Please Circle): Asian Black Hispanic White Refuse Other:______________MARITAL STATUS: S M W D

PREFERRED LANGUAGE:_______________________________ETHNICITY (Please Circle): Hispanic Not Hispanic Refuse

REFERRAL SOURCE:____

EMERGENCY CONTACT NAME:____PHONE:_______________________

INSURANCE CARRIER:____

INSURED'S NAME:____INSURED'S BIRTHDATE:_______________

RELATIONSHIP TO PATIENT:____

SECONDARY INSURANCE CARRIER:____

INSURED'S NAME:____INSURED'S BIRTHDATE:________________

IF PATIENT IS A MINOR, COMPLETE THE NEXT TWO LINES

FATHER'S NAME:____PHONE:_____________________

MOTHER'SNAME:____PHONE:______________________

IN ORDER TO MAINTAIN CONTINUITY OF CARE, I GIVE PERMISSION TO ATLANTA FOOT & LEG CLINICS TO RELEASE MY MEDICAL RECORDS TO ANY SPECIALISTS, HOSPITALS, OR MEDICAL FACILITIES ASSOCIATED WITHMY CARE PLAN. I UNDERSTAND THAT ATLANTA FOOT & LEG CLINICS ABIDES BY HIPAA REGULATIONS AND THAT ONLY THE RECORDS PERTINENT TO THE VISIT WILL BE RELEASED.

SIGNED:____DATE:_______________________

Atlanta Foot and Leg Clinics

Financial Policy

This is an agreement between Atlanta Foot & Leg Clinics and the Patient/Debtor names on this form.

In this policy the words "you", "your", and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us", and "our" refer to Atlanta Foot & Leg Clinics.

Insurance: We participate in most insurance plans, including Medicare. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Proof of Insurance: All patients must complete our demographic form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance card at the time of your appointment, you may have to be self-pay for your appointment.

Coverage Changes: If your insurance changes, please notify us when you check-in for your appointment to help you receive your maximum benefit.

Co-payment, Deductible, and Co-Insurance: It is your responsibility to pay any deductible, co-pay, co-insurance or any portion of the charge as specified by your plan. This is your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your portion of the charges at each visit.

Non-Covered Services: Please be aware that some – and perhaps all- of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You agree to pay any portion of the charges that is not covered by insurance.

Budget Plans: The business office can set up a budget plan for any outstanding large balance; you will need to leave a credit card on file for our office to run on the specified date each month until your balance is paid off.

Claim Submission: As a courtesy to you, we will submit your claims and assist in any way we reasonable can to help get your claims paid. We will file both your Primary and Secondary insurance policy only. We do not file Tertiary plans. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. If your insurance company does not respond within 60 days, you are responsible for the remaining balance. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Payments: Unless other arrangements are approved in writing, you are responsible to pay your balances within 30 days of services being rendered. Once we send you a statement, the balance on your statement is due and payable upon receipt.

Non-Payment: If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless approved by us in writing. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from the practice. If this occurs, you will be notified by regular or certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

No-Show Appointments: Our policy is to charge for missed or no-show appointments. If you do not show up for an appointment, or do not cancel within 24 hours, there will be a missed appointment fee of $25.00. These charges will be your responsibility and billed directly to you. Please help is serve you better by keeping your regularly scheduled appointment.

Returned Checks: There is a fee (currently $35) for any checks that are returned from the bank. It is our policy to not accept a personal check for future appointments in this situation.

Motor Vehicle Accident Claims: We must have a current lien on file from your attorney prior to your initial appointment. All statements will come to you and it is your responsibility to see that your claims are paid at the settlement of your case. Should settlement be made and no payment for your claims is received in our office you become responsible for the balance.

Workers Compensation Claims: Prior to your appointment we must have written authorization from your Case Manager to evaluate and treat you. We must have your date of injury, your claim number, and the claims address that we are to file claims to.

ASF (Administrative Service Fees): There is a "Fee per form" for such forms as Disability, Handicap Permits, FMLA, Work/School information, Social Security, etc. These fees range from $25-$150 depending on the length of the paperwork.

Effective Date: Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

****Please be aware we only verify you have active insurance and we can file a claim on your behalf. We are not always given specific details regarding your coverage for Podiatrists.**

Patient/Guardian Name:____Patient DOB:_____________

Responsible Party (if not the patient):________________________Contact Phone #:_______________

Signature:____Date:_________________________

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_________HIPAA Authorization Form

I authorize the following individuals to have full access to my health information.

_________________________   ___________________________   _______________

Print Name   Relationship   Date

_________________________   ___________________________   _______________

Print Name   Relationship   Date

I,________________________________ give my permission for you to leave any medical information for me at the following phone numbers:

Home #	
Mobile #	
Work #	

Receipt of Notice of Privacy Practices

Written Acknowledgement Form

I,____have received a copy of

Atlanta Foot & Leg Clinics Notice of Privacy Practices.

________________________________   ___________________________

Signature of Parent or Guardian   Date

Atlanta Foot and Leg Clinics

On April 14, 2001, the Health Insurance Portability and Accountability Act became law, with an effective date of April 14, 2003. This law impacts on many aspects of the healthcare industry, and expands your rights as a patient to the protection of your Individually Identifiable Health Information (IIHI). We have posted a detailed policy on our website (www.atlantafootandleg.com) and our patient portal **https://portal.traknetsolutions.com/p/atlantafootandleg,** which you are encouraged to read and download. Copies will be available, upon request, at your next visit.

Our Responsibility:

Our practice is dedicated to maintaining the privacy of your IIHI. In conducting our business, we will create electronic medical records regarding you and the treatment and services we provide to you. We are required by law to provide you with this important information concerning our procedures relative to the use of your IIHI and you rights as a patient to know as to how we will use or disclose your IIHI, your privacy rights in your IIHI, and our obligations concerning the use and disclosure of your IIHI.

We may use and disclose your Personal Healthcare Information (PHI) in the day to day operations of our offices as pertains to Treatment, Payment, and Operations (TPO). This relates to the continuum of care between Dr Kalish and consulting or referring physicians as well as other healthcare workers on our staff. We may be required to share your PHI with your insurance carrier as related to healthcare issues or payment events. Or we may use your PHI within our practice to evaluate our quality of care or conduct cost-management or business planning activities.

Further, we may use your IIHI to contact you for medical purposes, or for appointment reminders; to inform you of certain treatment options or alternatives; or as may be requested or directed by you to release said information to family or care giving personnel.

We may, from time to time, be required to release your PHI as a result of federal or state mandate, or by competent legal directive.

Your Rights:

You have a right to request that we communicate with you in a certain manner or location, for example, appointment reminders at work or at home.

You have the right to request a restriction to use or disclose of your IIHI to certain individuals or entities.

You have the right to inspect or obtain a copy of the IIHI. This request must be made in writing.

You may ask to amend health information, if you believe that it is incorrect or incomplete, and you may ask for amendment of your PHI, subject to restrictions as established by the HIPAA law.

You have the right to request an accounting of the disclosures of your PHI, again, the request must be in writing.

This represents a summary of our legal mandate, with the details to be found in the published Policy Notice. You can be assures that we will make every effort to honor your privacy, and to maintain our record of confidentiality. You may contact our office relative to any questions you may have regarding this law.

Renee G.
Administrator and HIPAA Compliance Officer ph. 678-961-9636