CLAYTON OUTPATIENT SURGICAL CENTER
Division of Atlanta Foot & Leg Clinic
Patient Information Sheet
(Please Print)

Patient Name: _____ Maiden Name: _____ Sex: _____
Last First Middle

Date of Birth: _____ Marital Status: _____ E-Mail:_____

Race information is required by the state of Georgia, please circle the correct choice
White, Black/African American, Hispanic/Latino, Asian, American Indian/Alaska Native, Pacific Islander/Hawaiian.

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

Home Phone: _____ Business Phone: _____ Occupation: _____

Employer: _____ Street Address: _____

City: _____ State: _____ Zip: _____ IS THIS INJURY WORK RELATED? _____

IS THIS INJURY THE RESULT OF AN ACCIDENT? _____ IF YES, GIVE DATE: _____

PERSON RESPONSIBLE FOR BILL (OMIT IF SAME AS PATIENT INFORMATION)

Name: _____ Relationship: _____ Social Security No. _____
Last First Middle
Street: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____ Occupation: _____

Employer: _____ Street Address: _____

City: _____ State: _____ Zip: _____

IF PATIENT IS A MINOR, COMPLETE THE FOLLOWING:

Mother's Name: _____ Fathers Name_____Phone:_____

EMERGENCY CONTACT RESIDING AT A DIFFERENT ADDRESS (e.g., Friend or Relative)

Name: _____ Relationship: _____ Home Phone: _____

Address: _____ City: _____ State: _____ Zip: _____ Business Phone: _____

REFERRING DOCTOR:

Name: _____ Office Phone: _____
Last First Middle

PLEASE READ AND SIGN

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Clayton Outpatient Surgery Center to release to my insurance company any information acquired in the course of my examination or treatment.
ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment of my insurance directly to Clayton Outpatient Surgery Center of the surgical or medical benefits, if any, otherwise payable to me for the services as described of this form. I understand that I am financially responsible for those charges not paid by my insurance. I realize that my insurance is a contract between me and my insurance carrier and the fee is due the doctor regardless of the amount paid by insurance. I hereby authorize Clayton Outpatient Surgery Center to prepare and submit credit card slips using any of the above listed charge cards to recover losses due to: a) no payment by insurance within 45 days; b) no payment by patient if they have no insurance within 30 days. A COPY OF THIS AUTHORIZATION SHALL BE VALID AS THE ORIGINAL.

Signed _____ Signed_____- Date_____
(Insured Person) (Patient) (Parent if Minor)

PRIMARY INSURANCE:

INSURANCE CO. NAME: _____ EFFECTIVE DATE: _____

ADDRESS TO MAIL CLAIMS: _____ TELEPHONE: _____

CITY: _____ STATE: _____ ZIP: _____

NAME OF PERSON HOLDING CONTRACT (INSURED) _____

INSURED'S SOCIAL SECURITY NUMBER _____ BEGINNING COVERAGE DATE: _____

GROUP NUMBER: _____ POLICY NUMBER: _____

IS THIS A HMO OR PPO? _____

SECONDARY INSURANCE:

INSURANCE CO. NAME: _____ EFFECTIVE DATE: _____

ADDRESS TO MAIL CLAIMS: _____ TELEPHONE: _____

CITY: _____ STATE: _____ ZIP: _____

NAME OF PERSON HOLDING CONTRACT (INSURED): _____

INSURED'S SOCIAL SECURITY NUMBER _____ BEGINNING COVERAGE DATE: _____

GROUP NUMBER: _____ POLICY NUMBER: _____

IS THIS A HMO OR PPO? _____

WORKMAN'S COMPENSATION - Name and address of Employer and Employer's Insurance Company

Employer	Insurance Company
_____	_____
_____	_____
_____	_____

How did accident happen? _____

_____

Clayton Outpatient Surgery Center

Service Agreement

This agreement covers the charges for services rendered to me at **Clayton Outpatient Surgery Center** (referred to in this agreement as the "facility"). As a courtesy, I understand the facility will file a claim on my behalf with my insurance company, and is authorized to release any information necessary to get this claim paid.

I understand, at this time, the facility is not contracted with my insurance company. In some cases, the insurance company may mail payment directly to the patient or policy holder, instead of the facility. In the event this should occur and I receive payment directly from the insurance company, I understand that the payment is for the services rendered by **Clayton Outpatient Surgery Center** and is not money that is actually due to me. I agree to forward any payment received, along with the explanation of benefits directly to the facility **immediately upon receipt**. I understand that failure to comply with this agreement may result in additional fees and penalties to me, and is a violation of the **Official Code of Georgia 16-8-4**.

I have read and accept the terms of this agreement as explained above.

_____ _____

Patient/Guardian's Signature Date

_____ _____

Insured's Signature Date

_____ _____

Witness Signature Date

O.C.G.A. 16-8-4.

(a) A person commits the offense of theft by conversion when, having lawfully obtained funds or other property of another including, but not limited to, leased or rented personal property, under an agreement or other known legal obligation to make a specified application of such funds or a specified disposition of such property, he knowingly converts the funds or property to his own use in violation of the agreement or legal obligation.

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 assured 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

Clayton Outpatient Surgical Center

_____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 Clayton Outpatient Surgical Center's Notice of Privacy Practices.

_____	_____
Signature of Parent or Guardian	Date

Patient Rights and Responsibility Policy
Notice of Physician Ownership
Grievances
Advanced Directives

1. All patients are responsible for behavior, which shows respect and consideration for other patients, visitors, and personnel of Clayton Outpatient Surgical Center (COSC).
2. All patients are responsible for assuring that their financial indebtedness to the COSC is repaid in a timely manner.
3. All patients are responsible for their actions if they should refuse a treatment or procedure, or if they do not follow the instructions given to them by the physician or their health care team member.
4. All patients have the responsibility to provide COSC with an accurate past and present medical history. Said history to include, but not limited to, past illnesses, surgeries, hospitalization, medications, and complaints and other pertinent data.
5. All patients have the responsibility to follow the recommended plan of treatment as given to him/her by his/her physician at COSC or other personnel authorized by the COSC to so instruct patients.
6. All patients are responsible for notifying the COSC of any change in their condition.
7. All patients are responsible for keeping their appointment for surgery. If they anticipate a delay or must cancel surgery, it is their responsibility to notify the COSC as soon as possible.
8. All patients are responsible for carrying out their pre-operative orders as supplied by the COSC.
9. All patients are responsible for the disposition of their valuables, as the COSC does not assume this responsibility.

……..…...

1. All patients have the right to be treated with dignity and respect.
2. All patients have the right to expect their family and friends who accompany them to the surgical center to be treated with dignity and respect.
3. All patients have the right to a safe environment, and to safe practices of the health care team members.
4. All patients have the right to obtain a second opinion.
5. All patients have the right to be communicated with in a way, which he/she will understand. He/She has the right to use an interpreter.
6. All patients have the right to information regarding his/her diagnosis, treatment, cost, and prognosis. If it is medically advisable to withhold this information from the patient, a legally authorized representative should have the right to the information.
7. All patients have the right to know the names and professional status of members of the health care team.
8. All patients have the right to refuse treatment to the point where legal measures intervene. If the patient refuses treatment that would jeopardize his/her health or safety, he/she has the right to be advised of this jeopardy, and the health care team has the right to terminate treatment after reasonable notice has been given.
9. All patients have the right to an informed consent.
10. All patients have the right to know when an experimental procedure, treatment, or item is to be used on them.
11. All patients have the right to know where and why they are to be transferred to another facility if emergency situations arise, and transfer becomes necessary.
12. All patients have the right to an itemized statement and an explanation of charges and services.
13. All patients have the right to expect their care to be given without regard to their race, creed, sex, national origin, or ability to pay for their services.
14. All patients have the right to converse with or be seen by any person not affiliated with the ASC and involved in his/her treatment, insurance filing, medical records, or other support service personnel.

15. All patients have the right to an explanation when requested, to the ASC's policies, expectations of patients, and means of handling complaints.
16. All patients have the right to expect that any discussion of their case will be handled discreetly and only between health care team members involved with the case or ancillary personnel who need to be involved.
17. All patients have the right to expect their medical records to be handled with strict confidentiality. They have the right to release their record or portions of their record to outside institutions or individuals.
18. All patients have the right to expect privacy when being questioned or examined both visually and auditory.
19. All patients have the right to expect the means of payment and other financial arrangements to be held in confidence.

Notice of Physician Ownership

Investment Entity Name and Address:
Clayton Outpatient Surgical Center
6911 Tara Boulevard, Suite 104
Jonesboro, GA. 30236

Health Care Provider:
Stanley R. Kalish, DPM, F.A.C.F.A.S. GA License # 000382

Clayton Outpatient Surgical Center is owned entirely by Dr. Stanley R. Kalish.

Grievances

In order to maintain channels of communication and resolution of complaints and grievances, an internal procedure is available for the purpose of reporting problems which may arise. Management personnel are responsible for investigating and resolving complaints. The investigation and resolution of such complaints and grievances shall be prompt, impartial, and confidential. Submit the complaint directly to the surgery center's Office Administrator, Renee Grimsley, at 678-961-9636, within ten (10) days from the date of occurrence. You will be contacted within 5 business days by phone and/or in writing by the Office Administrator. If you are not satisfied with the resolution to your complaint, then:

You may also file a complaint with the following:

Department of Community Health
Healthcare Facility Regulation Division
Complaint Unit
2 Peachtree Street, Suite 31
Atlanta, GA. 30303
404-657-5726

Medicare Ombudsman
1-800-633-4227
www.medicare.gov
http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

Rev 3/2/15 rg

Advanced Directives

Clayton Outpatient Surgical Center is not an acute care facility; therefore regardless of the contents of any advanced directive or instructions from a healthcare surrogate, if an adverse event occurs during your treatment, we will initiate resuscitative or any other stabilizing measures & transfer you to an acute care setting for further evaluation. Any information regarding current health care directives of health care power of attorney will be shared with the facility where you are transferred.

As a patient you have the right to:

(1) Control all aspects of your personal care and medical treatment,
(2) Insist upon medical treatment,
(3) Decline medical treatment, or
(4) Direct that medical treatment be withdrawn.

State Law has provided statutory forms for both the living will and durable power ot attorney for health care.

I have executed an advanced directive or living will **and** will make a copy available for my records.	[ ] YES	[ ] NO
I have not executed advanced directive or living will, but would like more information.	[ ] YES	[ ] NO
I have not executed advanced directive or living will, and would ***not*** like more information.	[ ] YES	[ ] NO
I have been given a copy of Official GA State Advanced Directives forms.	[ ] YES	[ ] NO

By signing this form I acknowledge that I have received verbal and written notice of Patients' Rights and Responsibilities; including Notice of Physician Ownership, Advanced Directives, and Patient Grievance Process, prior to the start of my procedure.

Patient Signature

Date:_____Time:_____

Rev. 09/06/2012/rg

Welcome to Clayton Outpatient Surgical Center

There are many questions you will have in regard to your upcoming surgery. Often in the rush of preparing for surgery, there are many questions left unanswered. If you have any questions regarding the type of surgery, length of surgery or your recovery time, please discuss them with the registered nurse during your preoperative consultation. Any questions concerning charges can be answered by the administrative staff such as estimates on the cost of your surgery.

The patient can expect to receive statements from all or part of the following providers:

1. Dr. Kalish / Atlanta Foot and Leg Clinics
2. Clayton Outpatient Surgical Center
3. Metro Anesthesia
4. Physicians who provide the pre-operative clearance.

As a courtesy to our patients we will assist, in any manner necessary, with the filing of insurance claims; but the account remains the responsibility of the patient or the patient's legal guardian.

If you have any questions, regarding your surgery, please call the center or ask them at your preoperative visit.

Signature Date

PRE-HISTORY FORM:

1. State in your words your medical reason(s) for coming to our office. _____
   _____

2. Please list all medications that you use. _____
   _____
   _____

3. FOR WOMEN ONLY: Are you pregnant? _____ If so, how many months? _____

4. Family history: Please indicate the health or cause of death of members of your family as best you can.

	Age if Living	Age at Death	Indicate any serious diseases	Cause of Death	
Mother					
Father					
Brothers					
Sisters					
Children					
Spouse					
Others					

5. Please indicate by checking "yes" or "no" if you have had significant problems in the below areas.
   Please comment on special problems.

YES	NO	Nature of Problem	Comment and Give Approximate Date
		Recent Weight Loss	
		Headaches	
		Trouble with Vision	
		Trouble with Hearing	
		Allergies or Hay fever	
		Asthma	
		Allergic Reaction to Medicines	
		Thyroid	
		Diabetes	
		Skin	
		Anemia or Abnormal Bleeding	
		Heart	
		Circulation	
		High Blood Pressure	
		Chest Pain	
		Lungs (TB, Pneumonia, etc.)	
		Shortness of Breath (Cough, Pleurisy, Wheezing)	
		Liver Disease, Gallbladder Disease, or Jaundice	
		Stomach Trouble	
		Swelling in Feet or Ankles	
		Arthritis	
		Kidney Disease or Stones	
		Gout	
		Double Jointed	
		Joint Pain or Stiffness	
		Numbness in Feet or Legs	
		Cramps in Feet or Legs	
		Low Back Pain	
		Pain in Other Areas	
		Do you Smoke? How much?	

PRE-HISTORY FORM CONTINUED:

YES	NO	Nature of Problem	Comment and Give Approximate Date
		Do you Drink Alcohol? How much?	
		Do you take any drugs? (Legal or Illegal) How much?	
		Depression	
		Psychiatric	
		Fainting or Convulsions	
		Strokes	
		Other Illnesses or Problems:	

ANESTHESIA PRE-HISTORY:

6. Please indicate by checking "yes" or "no" if you have had significant problems in the below areas. Please comment.

YES	NO	Problem / Question
		Are you a free bleeder?
		Do you have any blood clotting problems?
		Have you ever had any blood transfusions?
		Do you have sickle cell trait or disease?
		Do you have any signs or symptoms that can be transmitted?
		Do you have or have you ever had exposure to any STD's or AIDS?
		Are there any other health problems not previously mentioned? If yes, what?
		Is this your first anesthetic?
		Have you had any problems with prior anesthesia?
		Have you had an uncontrolled fever after anesthesia?
		Has any family member had problems or very high fever after anesthesia?

7. Where will you be returning to after surgery? _____

8. Will someone be able to assist you in your recovery the first 24 hours? _____

9. Please give details of any:

	Approximate Date	Surgeon	Hospital
Operations			
Serious Injuries			

10. Have you previously had physical therapy? Please describe: _____
_____

11. Please inform us of any other important information. _____
_____

12. Is there anything you wish to tell your physician privately? YES _____ NO _____

PATIENT'S SIGNATURE: _____ DATE: _____
DD/07