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NEW PATIENT WELCOME

Date of Appointment _____

With Physician _____

Appointment Time _____

Office Location _____

Patient's Name _____

If you are unable to keep this appointment, please phone us immediately at the appropriate office location phone number shown below.

Please complete the paperwook attached BEFORE your visit and bring it with you on your appointment date. This will reduce the amount of wait time you experience upon arrival.

It is important that you bring any x-rays or MRI film that have been completed at another facility, as some insurance companies will not pay for additional x-rays. Our doctors will need these on your first visit.

Thank you for choosing Parkwood Podiarty Associates. We are looking forward to your visit with us.

2500 Starling Street, Suite 301 • Brunswick, GA 31520 • 912.265.4766 I 600 Oglethorpe Highway • Hinesville, GA 31313 • 912.368.3036
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NEW PATIENT FORM - PAGE ONE

Full Name _____

Home Address _____

Billing Address _____

City _____ State _____ Zip _____

Home Phone _____ Mobile _____ Social Security Number _____

Date of Birth _____ Age _____ Male _____ Female _____

Employer _____ Phone _____ Position _____

Employer Address _____

City _____ State _____ Zip _____

Spouse/Guardian _____ Social Security Number _____ Date of Birth _____

Employer _____ Work Phone _____

Emergency Contact _____ Phone _____

Primary Care Physician _____ Date of Last Visit _____

Who referred you to our office? _____

We MUST have a copy of your insurance card(s) in order to file your insurance. Please provide to the front desk.
If insured is other than self, ALL fields must be filled out in order for us to file your insurance.

Primary _____ Insured's Name (if different from self) _____

Insured's DOB _____ Insured's SSN _____ Relation to patient _____

Secondary _____ Insured's Name (if different from self) _____

Insured's DOB _____ Insured's SSN _____ Relation to patient _____

Signature _____ Date _____

If under the age of 18, a parent or legal guardian must sign above in order for services to be rendered.

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NEW PATIENT FORM - PAGE TWO

Name _____ Age _____ Date of Birth _____

Please describe the problem you are having: _____

_____

When did it start? _____

Please describe any treatment: _____

_____

Medical Information - Please circle any conditions that apply.

AIDS/HIV	Anemia	Arthritis	Asthma	Bleeding Problems	Blood Clots
Cancer	Diabetes	Gout	Herat Disease	Hepatitis	Seizures
High Cholesterol	Kidney Problems	Leg Cramps	Liver Disease	Phlebitis	Poor Circulation
High Blood Pressure	Sickle Cell	Stomach Ulcers	Stroke	Thyroid Disease	Other _____

Are you currently taking any medications? If yes, please list: _____

_____

_____

Allergies - Please Circle any medicines to which you are allergic.

Codeine Iodine Penicillin Demerol Novacaine Sulfa Other _____

Have you had any previous surgeries? If yes, please list all surgeries: _____

Family medical problems _____

Do you smoke? YES or NO Drink alcohol/beer/wine? NONE 1 daily 2+ daily 1-2 weekly

Height _____ Shoe Size _____ Weight _____

The information stated above is true and correct to the best of my knowledge.

Signature _____ Date _____

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NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT

This notice describes how health information may be used and disclosed and how you can access this information. Please review it carefully. At Parkwood Podiatry Associates, we have always kept your health information secure and confidential. Federal law requires us to use or disclose your health information to those involved in your treatment. For example, a review of your file by another physician we may involve in your care. We may disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company. We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy. We may use your information to contact you. For example, we may call to confirm your appointments. As we will need to contact you from time to time, we will use whatever address or telephone number you prefer. If you are not home, we may leave this information on your answering machine or with the person answering the phone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law. If this practice is sold, your information will become property of the new owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any use or disclosures we make with your health information beyond the above normal uses. You have the right to transfer copies of your health information to another practice. We will mail your files for you. You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee. You have the right to request an amendment to your health information. Give us your amendment request in writing. We will include your file. If we agree to an amendment, we will not remove, nor alter earlier documents, but will add new information. You have a right to receive a copy of this notice. If we change and of the details of this notice, we will notify you in writing. You may file a complaint regarding your personal health information with the Department of Health and Human Services, 200 Independence Avenue S.W., Room 509F, Washington D.C. 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our offices at the addresses listed at the bottom of this notice. This notice is effective March 17, 2011.

I have read and/or requested a copy of Parkwood Podiatry Associates' Notice of Privacy Practices.

Patient Name (please print) _____ Date _____

Parent or Authorized Representative (if applicable) _____

Signature _____ Date _____

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FINANCIAL POLICY

To provide the best possible care to ALL of our patients, we must work hard to keep our finances in order. To achieve this goal, we would like to clarify the financial policy that governs our practice:

1. We share your concerns about the increasing costs of quality health care. Asking for payment at the time of service helps us to lower our expenses and keep costs down.

2. Our services are provided to our patients, NOT to insurance companies. The financial responsibility is yours, regardless of insurance coverage. Health insurance is a contract between you and your insurance carrier, to reimburse you for covered medical services. Unfortunately, more and more services are not covered and more deductibles apply.

3. Insurance coverage is determined by your contract with the insurance company. As a courtesy, we will file your insurance for you, but again, you will still be responsible for any unpaid fees.

4. **We do not participate in several PPOs, however, it is the responsibility of the patient to verify if we are PPO In-Network providers with their insurance company. New patients' insurance cannot be filed unless we receive a copy of the insurance cards on first visit. In addition, it is the patient's responsibility to manage referrals or authorizations if required by his/her insurance carrier.**

5. Bills not paid by insurance remains the responsibility of the patient. Claims not paid by the insurance company within 90 days will be billed to the patient.

6. Failure to pay on accounts over 60 days will result in the account being turned over to collections and incurring additioinal fees.

7. A 24-hour notice must be given when cancelling an appointment or a fee may be charged. I hereby authorize the release of any medical information necessary for processing insurance claims and payment of medical benefits to myself or the party who accepts assignment.

I understand the financial policy states above, and understand, as a patient, I have certain obligations for my care.

Signature _____ Date _____