Midtown Foot Clinic, PC & Midtown Surgical Center, LLC

PATIENT INFORMATION

Name:_____ Soc. Sec. #:_____
Last Name First Name Initial

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email Address:_____ Date of Birth:_____

Sex: [] M [] F Age:_____ Marital Status: [] Single [] Married [] Widowed [] Separated [] Other

Ethnicity: [] Hispanic or Latino [] Not Hispanic or Latino [] Decline Information

Race: [] American Indian or Alaska Native [] Asian [] African American [] Caucasian
[] Native Hawaiian or Other Pacific Islands [] Other Race [] Decline Information

Preferred Language:_____ Family Physician:_____

Preferred Pharmacy:_____ Pharmacy Phone Number:_____

Preferred method of communication: [] Telephone [] Mail [] Email [] Patient Portal

Whom may we thank for referring you?
[] Advertisement [] Event [] Family [] Friend [] Health Fair [] Insurance Company
[] Internet [] Phone Book [] Physician [] Previous Patient [] Other_____

Patient Employed by:_____ Occupation:_____

Business Address:_____ Business Phone:_____

In case of an emergency, contact:_____ Home Phone:_____

Relationship to patient:_____ Work Phone:_____

In case of an emergency, contact:_____ Home Phone:_____

Relationship to patient:_____ Work Phone:_____

Patient:_____

INSURANCE INFORMATION

Do you have Medicare? [] Yes [] No If Yes, ID #:_____

Do you have Medicaid? [] Yes [] No If Yes, ID #:_____

Primary Insurance Co._____ Phone:_____

Policy / Subscriber #:_____ Group #:_____

Address:_____ City/State:_____ Zip:_____

Insured Name:_____
Last Name First Name Initial

Social Security # of Insured:_____ Insured Date of Birth:_____

Relationship to Patient:_____ Insured Employed By:_____

Secondary Insurance Co._____ Phone:_____

Policy / Subscriber #:_____ Group #:_____

Address:_____ City/State:_____ Zip:_____

Insured Name:_____
Last Name First Name Initial

Social Security # of Insured:_____ Insured Date of Birth:_____

Relationship to Patient:_____ Insured Employed By:_____

Person responsible for payment, if other then patient:

_____ Phone #:_____
Last Name First Name Initial

Address:_____ City/State:_____ Zip:_____

Patient:_____

MEDICAL HISTORY & INFORMATION

Shoe Size:_____ Weight:_____ Height:_____

Do you have any artificial joints or limbs?
Hip, [] Yes [] No Knee, [] Yes [] No Other:_____

Please circle if you have or have had any of the following:

Anemia	Depression	Healing Trouble	Liver Disease	Sickle Cell
Arthritis	Diabetes	Heart Disease	Lupus	Stomach Trouble/Ulcers
Asthma/COPD	Epilepsy	Heel Spurs	Neurological Disorder	Stroke
Back Problems	Fibromyalgia	Hepatitis	Numbness in Feet/Legs	Thyroid Problems
Bleeding Disorder	Flat Feet	High Blood Pressure	Phlebitis	Tuberculosis
Blood Clots	Frequent Infections	HIV Positive / AIDS	PVD/ Circulation	Tumors
Bunions	Gout	Hyper-cholesterol	Rheumatic Fever	Varicose Veins
Cancer	GERD	Joint Pain/Stiffening	Scarring Tendency	Unexplained Weight Loss or Gain
Cramps in Feet/Legs	Hammertoes	Kidney Disease		

Please circle or list allergies or sensitivities:

Adhesive Tape	Ibuprofen (Advil, Motrin)	Seasonal
Aspirin	Iodine	Sulfa Drugs
Betadine	Local Anesthetics	Xylocaine
Codeine	Novocaine	Other_____
Demerol	Penicillin	_____
Food_____	Seafood	_____

Please circle if there is a family history of:

Arthritis	Cancer	Gout	High Blood Pressure
Bleeding Disorder	Circulation Problems	Hammertoe	Neurological Disorder
Blood Clots	Diabetes	Heart Disease	Numbness in Feet/Legs
Bunions	Flatfeet	Heel Spurs	Stroke

Patient:_____

MEDICAL HISTORY & INFORMATION

Mother: [] Living [] Deceased [] Cause of death:_____
Father: [] Living [] Deceased [] Cause of death:_____
Brother(s): [] Living [] Deceased [] Cause of death:_____
[] Living [] Deceased [] Cause of death:_____
Sister(s): [] Living [] Deceased [] Cause of death:_____
[] Living [] Deceased [] Cause of death:_____

General: [] None [] Sudden weight loss or weight gain [] Fever
Skin: [] None [] Clammy [] Moist
Eyes: [] None [] Glasses/Contacts [] Discharge
Ears: [] None [] Deafness [] Ringing [] Frequent infections
Nose: [] None [] Nose bleed [] Loss of sense of smell
Mouth: [] None [] Frequent sores [] Gum bleeding
Neck: [] None [] Masses
Respiratory: [] None [] Cough [] Shortness of breath [] Wheezing
Cardiovascular: [] None [] Chest pain [] Leg pain while walking
Gastrointestinal: [] None []Vomiting blood [] Indigestion
Urology: [] None [] Kidney stones [] Frequent infections
Musculoskeletal: [] None [] History of injury [] Herniated disk
Neurological: [] None [] Headaches [] Fainting [] Tremors
Endocrine: [] None [] Increased thirst [] Increased urination
Hemato-Immunologic:[] None [] Anemia [] Slow clotting
Psychiatric: [] None [] Depression [] Agitation [] Anxiety

Do you currently smoke? [] No [] Yes, how long?_____Number of pack(s) per day?_____

Did you previously smoke? [] No [] Yes, how long?_____Number of pack(s) per day?_____

Do you drink alcohol or beer? [] No [] Yes, how often?_____

Employment: Do you? [] Sit at job [] Stand at job [] Stand and walk at job [] Retired

What problems bring you to our office?

_____

_____

How long have you had these problems? _____

Have you had any past surgical procedures on your feet or ankles? [] No [] Yes
If yes, what was done and when

_____

_____

_____

Midtown Foot Clinic
Dr. John M. Murrell, DPM
908 Abercorn Street Savannah, Georgia

Medication Reconciliation List

Name of Medication	Strength	How often do you take it?

Patient Name: _____ Date of Birth: _____
Patient Signature: _____ Date: _____

RELEASE OF MEDICAL RECORDS

I authorize the release of any medical or other information necessary to process my insurance claim.

X_____ _____

Signature of Patient or Authorized Person **Date**

AUTHORIZATION FOR PAYMENT

I authorize payment of medical benefits to Midtown Foot Clinic, P.C. & Midtown Surgical Center, LLC for services rendered. I understand that I am responsible for charges incurred as a result of services rendered.

X_____ _____

Signature of Patient or Authorized Person **Date**

AUTHORIZATION FOR TREATMENT

I hereby authorize Dr. John M. Murrell (or his designee) to administer podiatric care and to perform such minor operative procedures and/or other appropriate studies as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

I *understand* that my physician, Dr. John M. Murrell, will use his best skill and judgment to accomplish the desired result, but that Dr. Murrell cannot and does not warrant or guarantee such result; also that his forecast of length of time involved in therapy and/or recovery from surgery, the manner of recovery and the possible complication or untoward results is based upon the usual and average response in cases similar to mine, but that is not a promise since my results/response may be different from the usual.

On my part, I promise full cooperation with Dr. John M. Murrell and his staff in my treatment whether by surgical or nonsurgical means. I understand that if I do not follow my doctor's instructions, or the instructions of his staff, concerning my care and treatment including any necessary physical therapy, the outcome of my care and treatment could be put into jeopardy and a bad result may occur.

I hereby certify that I have read and fully understand this authorization for medical treatment.

_____ _____

Name of Patient Date of Birth

X_____ _____

Signature of Patient or Authorized Person **Date**

Signed for Patient by:_____

Relationship to Patient:_____

Reason why Patient cannot sign:_____

PATIENT COMMUNICATION AUTHORIZATION

It is the policy of Midtown Foot Clinic, P.C. & Midtown Surgical Center, LLC not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone, and/or pager. Whenever initiating or returning telephone calls and an answering machine picks up, we do not leave a message if the name and/or telephone number is not on the recorded message to identify the residence. Information will not be left with an unauthorized person who may answer the phone.

I authorize Midtown Foot Clinic, P.C. & Midtown Surgical Center, LLC to leave medical information pertaining to my care by the following methods and will assume responsibility to notify Midtown Foot Clinic, P.C. & Midtown Surgical Center, LLC whenever this information changes:

_____Yes _____No Home telephone number: _____

_____Yes _____No Cell phone number: _____

_____Yes _____No Work telephone number: _____

_____Yes _____No Answering machine

_____Yes _____No Voice mail

Please list names of authorized people who we may leave message with:

_____Yes _____No Spouse/Fiancé: _____

_____Yes _____No Parent(s): _____

_____Yes _____No Brother/Sister: _____

_____Yes _____No Son/Daughter: _____

_____Yes _____No Other: _____

_____ _____

Name of Patient Date of Birth

X_____ _____

Signature of Patient or Authorized Person **Date**

I authorize Midtown Foot Clinic, P.C. & Midtown Surgical Center, LLC to communicate with me via electronic newsletters, by e-mail, or by telephone about any activites, new services, or new products provided by Midtown Foot Clinic, P.C. & Midtown Surgical Center, LLC.

X_____ _____

Signature of Patient or Authorized Person **Date**

This authorization may be amended or revoked by you at any time. Revocation or amendments may be accomplished by advising us in writing of your desire to change or withdraw your authorization. Please allow us sufficient time to process your request.

PATIENT FINANCIAL POLICY

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, **you are responsible for all authorizations/referrals** needed to seek treatment in this office.

- Unless other arrangements have been made in advance by you, or your health insurance carrier, **payment for office services are due at the time of service**. We will accept VISA, MasterCard, Discover, cash or check.

- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. **If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.**

- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.

- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.

- All health plans are not the same and do not cover the same services**. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge**. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

- **You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied**.

- For most services provided in the hospital or Ambulatory Surgical Center, we will bill your health plan. **Any balance due is your responsibility.**

- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.

- **Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office. There is a service fee of $25.00 for all returned checks**. **Your insurance company does not cover this fee.**

_____ _____

Name of Patient Date of Birth

X_____ _____

Signature of Patient or Authorized Person **Date**

ASSIGNMENT OF BENEFITS, LIMITED POWER OF ATTORNEY, AND APPOINTMENT OF REPRESENTATIVE

I_____(Print Name) with insurance benefits through _____ (Employer Name, Medicare, Medicaid or Individual Plan) hereby *authorize benefits to be assigned to* **Midtown Foot Clinic, PC and Midtown Surgical Center, LLC,** for healthcare services provided to me by **Midtown Foot Clinic, PC and Midtown Surgical Center, LLC**. I hereby certify that the insurance information that I have provided **Midtown Foot Clinic, PC and Midtown Surgical Center, LLC** is true and accurate as of the date of service and that I am responsible for keeping it updated. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my medical bill is paid in full. I also understand that my insurance company may not pay 100% of the amount of the medical claim and I may be responsible for any and all amounts not payable by my insurance company including any portion paid and not applied to in network benefits for any out of network services.

I hereby authorize **Midtown Foot Clinic, PC and Midtown Surgical Center, LLC** to submit claims, on my behalf, to the insurance company providing benefits and provided to **Midtown Foot Clinic, PC and Midtown Surgical Center, LLC**, in good faith. I fully agree and understand that the submission of a claim does not absolve me of my responsibility to ensure the claim is paid in full

I hereby *irrevocably, designate, authorize and appoint* **Midtown Foot Clinic, PC and Midtown Surgical Center, LLC** as my *true and lawful attorney-in-fac*t. This power of attorney is hereby provided for the limited purpose of receiving all payments due under my policy/medical care plan on account of medical services and care rendered or to be rendered. This power of attorney shall automatically terminate, without formal action being taken, as soon as **Midtown Foot Clinic, PC and Midtown Surgical Center, LLC** has received payment in full and all remedies due under applicable regulatory guidelines for all medical care services provided or requested. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein. I authorize the release of any medical records required to obtain a full and fair review and all protected rights of appeal.

I hereby *appoint as representative* ***Midtown Foot Clinic, PC and Midtown Surgical Center, LLC*** *and authorize my insurer to assign and transfer any and all applicable plan benefits and rights to* **Midtown Foot Clinic, PC and Midtown Surgical Center, LLC** and any appointed business associates working with them for the sole purpose of making sure all protected rights and benefits under my plan or applicable Social Security Act, as well as any Federal, City or State government program are administered accurately, *including but not limited to the right to receive any applicable relevant documents pertaining to adverse benefit determination, relevant plan documents/remedies, disclosures, pursue appeals, administrative reviews and litigation on my behalf. This authorization includes any and all entitled benefits, protected rights and remedies permissible under state, federal laws or applicable Social Security Act. This is a direct assignment of my rights and benefits under any governing healthcare plan/policy.* This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. Upon receipt of said check, I authorize **Midtown Foot Clinic, PC and Midtown Surgical Center, LLC** to receive any such checks, endorse them for deposit only, and to deposit and apply all the proceeds toward payment on my account.

I hereby instruct and direct my Insurance Company to pay <u>all</u> entitled plan benefits at the stated plan benefit level directly to **Midtown Foot Clinic, PC and Midtown Surgical Center, LLC** for <u>all</u> services rendered by **Midtown Foot Clinic, PC and Midtown Surgical Center, LLC**. I understand under applicable ERISA, state and/or federal regulatory guidelines that I have the right and authority to direct where payment for services rendered is sent. If my current policy prohibits direct payment to the provider of service, I under my rights per state and federal ERSIA regulations hereby instruct and direct my Insurance Company to provide SPD documentation stating such non-assign ability clause to myself and **Midtown Foot Clinic, PC and Midtown Surgical Center, LLC**. <u>Upon proof of non-assign ability</u> documentation <u>I then instruct</u> that the insurer make out the check to me and mail it directly to the Provider and address listed on the submitted claim for the professional or medical expense benefits, and otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered. I agree and understand that any funds received by my insurance company due for services rendered by **Midtown Foot Clinic, PC and Midtown Surgical Center, LLC** will be immediately signed over and sent directly to **Midtown Foot Clinic, PC and Midtown Surgical Center, LLC**.

I authorize the release of any medical or other information pertinent to my case to any insurance company, Plan/Benefits Administrator, adjuster, or attorney involved in this case. I authorize **Midtown Foot Clinic, PC and Midtown Surgical Center, LLC** or appointed business associates to be my personal representative, which allows them as *my legally binding authorized representative* to: (1) submit any and all appeals when my insurance company denies me benefits to which I am entitled, (2) submit any and all requests for benefit information from my insurance company, and (3) initiate formal complaints to any State or Federal agency that has jurisdiction over my insurer and/or benefits. I fully understand and agree that I am responsible for full payment of the medical debt if my insurance company has refused to pay 100% of my stated plan benefits based on billed charges, within ninety (90) days of any and all appeals or request for information. Should the account be referred to an attorney or outside agency for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. All delinquent accounts bear interest at the legal rate. I also agree that any fines levied against my insurance company will be paid to **Midtown Foot Clinic, PC and Midtown Surgical Center, LLC** for acting as my personal representative.

I authorize **Midtown Foot Clinic, PC and Midtown Surgical Center, LLC** and its associates to provide medical care reasonable by today's standards.

A photocopy of this Assignment shall be considered as effective and valid as the original.

X_____ _____

Signature of Patient or Authorized Person **Date**

Midtown Foot Clinic, PC
John M. Murrell, DPM

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices of Midtown Foot Clinic, P.C. & Midtown Surgical Center, LLC and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____
Name of Patient Date of Birth

X_____ _____
Signature of Patient or Authorized Person **Date**

CONSENT TO PHOTOGRAPH

The undersigned hereby authorizes Midtown Foot Clinic and the attending physician to photograph or permit other persons to photograph _____ while under the care of the
Name of Patient
above medical organization, and agree that they may use or permit other persons to use the negative or prints prepared therefrom for such purposes and in such a manner as may be deemed necessary for medical care and coordiantion of care.

_____ _____
Name of Patient Date of Birth

X_____ _____
Signature of Patient or Authorized Person
Date

Midtown Foot Clinic, PC
John M. Murrell, DPM
P: (912) 233-5316 F: (912) 233-3859

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name _____ Date of Birth _____

SSN# _____

Authorization and consent is hereby given to allow Midtown Foot Clinic, P.C./Midtown Surgical Center, LLC to request a copy of the above referenced patient's Protected Health/Billing Information from the person(s) or organization listed below:

PERSON(S) _____

COMPANY _____

ADDRESS _____

CITY/STATE/ZIP _____

The specific information to be used or disclosed is:

[] Most recent progress note

I understand that this consent is subject to written revocation by me at any time except in those circumstances in which Midtown Foot Clinic, P.C./Midtown Surgical Center, LLC or its staff has taken action in reliance of it. A revocation should be sent to Midtown Foot Clinic, P.C. Practice Manager P.O. Box 30306 Savannah, GA 31410. Without such written express revocation, this consent will expire on the following date:_____. If a date is not specified, this consent will expire one (1) year form the date of signature.

_____ _____

Signature of Patient or Representative Date Signed

_____ _____

Print Name of Patient or Representative Relationship to Patient

The patient must sign authorization. If the patient is a minor or is an incompetent adult, their guardian must sign authorization. If there is no guardian appointed by the Court, the authorization must be signed by the nearest relative. If the patient is unable to sign this authorization, please state the reason: