3193 Howell Mill Road, Suite 326
Atlanta, Georgia 30327
(404) 355-4522 | (404) 355-4512 FAX | www.AtlantaFoot.com

William C Stoll DPM & Associates

General Problem Information

To better understand Insurance Coverage, we prefer to call ahead to verify if certain services are covered by your insurance policy. Please place a check next to the main reason for today's visit:

_______ I think I have an Ingrown Toenail.

_______ I have heel, arch, or pain under the ball of my foot.

_______ I have twisted my foot/ankle or injured myself.

_______ I have a painful wart/callus/lesion on my foot.

_______ I think I have a bunion or a hammertoe

_______ I have stepped on something

_______ My foot has suddenly become flat

_______ My toenails are discolored or thick

How is Your Leg Circulation

Many people dismiss leg pain as a normal sign of aging. You may think it is arthritis or stiffness from the symptoms however it may be related to a blockage in your leg preventing adequate circulation. If you are having pain in your legs please answer the following questions as you may be suffering from a leg circulation condition which is important for the doctor to know prior to your visit.

1. Do you find yourself slowing down when walking or have trouble walking for a certain period of time? **Yes or No**
2. Do you have pain in your hips, thighs, calves or feet when walking and does the pain stop when you sit for a short period? **Yes or No**
3. Do you have any foot or toe wounds which will not heal quickly? **Yes or No**

Questions 4 thru 7 relate to problems with your leg veins (varicose veins)

4. Do you have swelling in or around your ankles after standing for an extended period of time? **Yes or No**
5. Is the skin on your legs darker or brownish in color? **Yes or No**
6. Do you have fatigue, heaviness, or leg cramps later in the day? **Yes or No**
7. Do you have any ulcers on or above your ankles? **Yes or No**

PATIENT INFORMATION

Date: ____/___/_____		
Last Name:	**First Name:**	**M.I.:**
SSN#:	**DOB: _____/___/_____**	**Sex: Male or Female**
Marital Status:	**Single Divorced Widowed**	**Married Partnered**
Referred by:	**Primary Care Physician:**	**Last Visit:___/___/_____**
Address:		
City:	**State:**	**Zip:**
Home:	**Cell:**	**Work:**
Employer:		
Email:		
Pharmacy Name:	**Pharmacy #:**	
Emergency Contact:	**Phone #:**	

INSURANCE INFORMATION

Primary Insurance Company Name:		
Policy #:	**Group #:**	**Effective Date:**
Insured Name:		
Relationship to Insured: ___ Self ____Spouse ____ Child ____ Other		
Secondary Insurance Company Name:		
Policy #:	**Group #:**	**Effective Date:**
Insured Name:		
Relationship to Insured: ___Self ____Spouse _____ Child ____ Other		

RESPONSIBLE PARTY INFORMATION

Name:	**Phone #:**	
Address:		
City:	**State:**	**Zip:**

What specifically brings you in:

____

____

____

____

Length of time current problem: _______

- ☐ **Days**
- ☐ **Weeks**
- ☐ **Months**
- ☐ **Years**

Patient Name:___________________________

CURRENT MEDICATIONS LIST

Height: ___feet ___inches Weight: ___lbs.

IMMUNIZATION STATUS

Tetanus : ____Current ___Over 5 years ___Over 10 years ___ Unknown

ALLERGIES:

__Penicillin __Sulfa drugs __Aspirin __Codeine __Iodine/Shellfish __Tape
__Local Anesthesia __General Anesthesia __Latex __Metal

Other Allergies(Medication, Food, Environmental):

____
____

Previous Injuries:	**Previous Surgeries:**	**Previous Hospitalizations:**
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

Patient Name: ____

Please check pertinent issues you have had recently or frequently:

☐ ***Diabetes***	☐ ***Use Blood Thinners***	☐ ***Gout***	☐ ***GI or Rectal Bleeding***
☐ ***Hypertension***	☐ ***Cancer History***	☐ ***Bleeding Disorder***	☐ ***Sickle Cell***
☐ ***Heart Disease or past Heart Attack***	☐ ***Arthritis, Oseto***	☐ ***Poor Circulation***	☐ ***HIV***
☐ ***Stroke***	☐ ***Arthritis, Rheumatoid***	☐ ***Night Cramps***	☐ ***Weak Stomach***
☐ ***Blood Clots in legs***	☐ ***Kidney Problems or past Dialysis***	☐ ***Thyroid***	☐ ***Asthma/Bronchitis***

Social History:

Do you drink alcohol: ___yes ___no How often?___________ How much? _________

Do you use tobacco: ___yes ___no Amount per day? _________ How long? __________

Please state your Occupation, does it involve standing, running, climbing, sitting?:

____

Family Medical History: ____

To the best of my knowledge, I have answered the questions on these forms as accurately as possible. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor and/or the staff of any changes in my medical status. I hereby give my permission to Dr. William Stoll to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of the extremity condition. I also assign to the above named physician all benefits provided by my insurance company policy or policies for medical or surgical care. I understand that I am financially responsible for any balance due on my account.

Signature of Responsible Party ____________________________ Date: ____/___/_____

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Medical Appointment Cancellation Policy

Dear Patient:

We strive to render excellent medical care to you and the rest of our patients. In an attempt to be consistent with this, we have a Medical Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows:

We request that you please give our office a 24 hour notice in the event that you need to reschedule your appointment with the physician. This allows other patients to be scheduled into that appointment. It also makes it possible to reschedule you more efficiently. If a patient misses an appointment without contacting our office, this is considered a missed appointment ("No Show/No-Call."). A fee of $25.00 will be charged to you for a missed appointment. If a patient accumulates a total of three (3) missed appointments, the patient may not be rescheduled for future appointments and will be asked to leave the practice.

Additionally, if a patient is more than 15 minutes late to his/her appointment, the appointment may be cancelled.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you may have.

We thank you for your patronage.

I have read and understand the Medical Appointment Cancellation Policy of the practice and I agree to be bound by its term. I also understand and agree that such terms may be amended from time-to-time by the practice.

I, ____(print name), have received a copy of

Atlanta Foot Care Center's Medical Appointment Cancellation Policy.

___________________________________	_______________________________
Printed Name of Patient	**Relationship to Patient**
___________________________________	_______________________________
Signature of Patient or Responsible Party	**Date**

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- **All Co-Pays are due at the time of visit.**
- **You are ultimately responsible for payment of charges for services from our office.**
- **It is your responsibility to provide accurate insurance information and to present your insurance ID card at the time of your visit.**
- **If your plan requires a referral, it is your responsibility to obtain this prior to being seen by Atlanta Foot Care Center**
- **Cancellations for appointments and procedures must be received 24 hours prior to the scheduled appointment.**
- **Patients who fail to keep or cancel a scheduled appointment will be charged a $25.00 No-Show/No-Call fee.**
- **Cancellations for scheduled surgery must be received at least 72 hours prior to the scheduled surgery date and time.**
- **There is a $75.00 cancellation fee for scheduled surgeries that are cancelled less than 72 hours from the scheduled surgery date and time.**
- **Unpaid previous balances must be paid in full prior to any additional visits, unless arrangements have been made with the billing department.**
- **Returned check fee is $35.00**
- **Medical records requests must be received at least 48 hours prior to the date needed.**
- **Document reproduction starts at a nonrefundable $15.00 fee for document less than 100 pages. A $.25 per page fee applies for reproduction of each page over 100.**
- **X-rays will be released for a $35.00 fee, refundable upon return.**
- **Fees for medical records are set in accordance with allowable amounts as defined by the State of Georgia.**
- **Fees must be paid prior to mailing or pick up of medical records.**
- **WE DO NOT FAX MEDICAL RECORDS**
- **Administrative Services: There is a 35% fee for required Administrative Service for accounts turned over to collections.**

Please Initial __________

NOTICE OF PRIVACY PRACTICES

THIS PRIVACY NOTICE IS BEING PROVIDED TO YOU AS A REQUIREMENT BY FEDERAL LAW, THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA). IT IS EFFECTIVE APRIL 14, 2003.

THIS PRIVACY NOTICE DESCRIBES HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS AND FOR OTHER PURPOSES THAT ARE PERMITTED OR REQUIRED BY LAW.

IT ALSO DESCRIBES YOUR RIGHT TO ACCESS AND CONTROL YOUR PROTECTED HEALTH INFORMATION. YOUR "PROTECTED HEALTH INFORMATION" MEANS ANY WRITTEN OR ORAL INFORMATION ABOUT YOU, INCLUDING DEMOGRAPHIC DATA THAT CAN BE USED TO IDENTIFY YOU, CREATED OR RECEIVED BY YOUR HEALTH CARE PROVIDER, WHICH RELATES TO YOUR PAST, PRESENT, OR FUTURE PHYSICAL OR MENTAL HEALTH OR CONDITION.

How Your Protected Health Information Can Be Used:

Disclosures of your protected health information for the purposes described in this Privacy Notice may be made in writing, orally, or by electronic means.

1. **Treatment**. We will use and disclose your protected healthcare information to provide, coordinate, or manage your health care and related services, including coordination and management with third parties for treatment purposes. Here are some examples of how we may use or disclose your protected health information for treatment:

a) We may disclose your protected health information to a medical facility to order tests.

b) We may disclose your protected health information to other physicians who may be treating you or consulting with us regarding your care.

c) We may disclose your protected health information to those who may be involved in your care after you leave here, such as family members or your personal representative.

2. **Payment.** We will use your protected health information to obtain payment for the services we provide to you. We may also disclose your protected health information to another provider involved in your care for their payment activities. Here are some examples of how we may use or disclose your protected health information for payment:

a) We may communicate with your health insurance company to get approval for the services we render, to verify your health insurance coverage, to verify that particular services are covered under your insurance plan, and to demonstrate medical necessity.

b) We may disclose your protected health information to healthcare providers and/or medical facilities, which are involved in your care, so they can obtain payment for their services.

3. **Health Care Operations.** We may use and disclose your protected health information to facilitate our own health care operations and to provide quality care to all of our patients. Health care operations include such activities as: quality assessment and improvement; employee review activities; conduction or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance reviews; business planning and development; and business management and general administrative activities. In certain situations, we may also disclose your protected health information to another provider or health plan for their health care operations. Here are some examples of how we may use or disclose your protected health information for health care operations:

a) We may use your protected health information to review our treatment and services and to evaluate the performance of our staff in caring for you.

b) We may combine protected health information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective.

c) We may also disclose information to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes.

d) We may also use or disclose your protected health information in the course of maintenance and management of our electronic health information systems.

4. **Other Uses and Disclosures.** As part of the functions above, we may use or disclose your protected health information to provide you with appointment reminders, to inform you of treatment alternatives, or to provide you with information about other health-related benefits and services which may be of interest to you.

How Your Protected Health Information Can Be Used Without Your Authorization Or Your Opportunity To Object:

1. **When Required By Law**. We will disclose your protected health information when we are required to do so by federal, state, or local law.

2. **For Public Health Reasons.** We may disclose your protected health information as permitted or required by law for the following public health reasons:

   i) For the prevention, control, or reporting of disease, injury or disability;

   ii) For the reporting of vital events such as birth or death;

   iii) For public health surveillance, investigations, or interventions;

   iv) For purposes related to the quality, safety, or effectiveness of FDA-regulated products or activities, including:

   - Collection and reporting of adverse events, product defects or problems, or biological product deviations
   - Tracking of FDA-regulated products
   - Product recalls, repairs, or look-back,
   - Post-marketing surveillance

   v) To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease or condition;

   vi) Under certain limited circumstances, to report to an employer information about an individual who is a member of the employer's workforce.

3. **To Report Abuse, Neglect, or Domestic Violence.** We may notify government authorities if we believe a patient is a victim of abuse, neglect, or domestic violence. We will make this disclosure only when specifically authorized or required by law, or when the patient agrees to the disclosure.

4. **For Health Oversight Activities.** We may disclose your protected health information to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight.

5. **For Judicial or Administrative Proceedings.** We may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order. We may disclose your protected health information in response to a subpoena, discovery request, or other lawful process that is not accompanied by an order of a court of administrative tribunal if we have received satisfactory assurances that you have been notified of the request or that an effort has been made to secure a protective order.

6. **For Law Enforcement Purposes.** We may disclose your protected health information to a law enforcement official for law enforcement purposes, including:

   a. Wound or physical injury reporting, as required by law.

   b. In compliance with, and as limited by the relevant requirements of a court order or court-ordered warrant, a subpoena, summons, or similar process.

   c. Identification or location of a suspect, fugitive, material witness, or missing person.

   d. Under certain limited circumstances when you are the victim of a crime.

   e. Alerting law enforcement of the death of an individual where there is suspicion that the death may have resulted from criminal conduct.

   f. Reporting criminal conduct that occurred on the premises of the provider.

   g. In an emergency to report a crime.

7. **To Coroners, Medical Examiners, and Funeral Directors.** We may disclose protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. We may disclose protected health information to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent. In some cases such disclosures may occur prior to, and in reasonable anticipation of, the individual's death.

8. **For Organ or Tissue Donation.** We may use or disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating donation and transplant.
9. **For Research Purposes.** We may use or disclose your protected health information for research purposes when an institutional review board that has reviewed the research proposal and protocols to safeguard the privacy of your protected health information has approved such use or disclosure.
10. **To Avert a Serious Threat to Health or Safety.** We may, consistent with applicable law and standards of ethical conduct, use or disclose your protected health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health and safety or that of the public. 11. For Specialized Government Functions. We may use or disclose your protected health information, as authorized or required by law, to facilitate specified government functions related to military and veterans activities; national security and intelligence activities; protective services for the President and others; medical suitability determinations; correctional institutions and other law enforcement custodial situations.
12. **For Workers' Compensation.** We may use and disclose your protected heath information, as necessary, to comply with workers' compensation laws or similar programs.

How Your Protected Health Information Can Be Used Without Your Authorization, But With An Opportunity For You To Object:
We may use your protected health information to maintain a directory of patients in our facility. The information included in the directory will be limited to your name, your location in our facility, and your condition described in general terms.
We may disclose your protected health information to a friend or family member who is involved in your medical care or payment for care. In addition, if applicable, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.
You may object to these disclosures. If you do not object to these disclosures, or we determine in the exercise of our professional judgment that it is in your best interest for us to disclose information that is directly relevant to the person's involvement with your care, we may disclose your protected health information.

How Your Protected Health Information, Which You Authorize, Can Be Used:
Other than the uses and disclosures described above, we will not use or disclose your protected health information without your written authorization. Authorizations are for specific uses of your protected health information, and once you give us authorization, any disclosures we make will be limited to those consistent with the terms of the authorization. You may revoke your authorization, by submitting a revocation in writing, at any time, except to the extent that we have already taken action in reliance upon your authorization.

The Following Are Your Rights Regarding Your Protected Health Information:
1. **The Right to Request Restriction of Uses and Disclosures.** You have the right to request that we not use or disclose certain parts of your protected health information for the purposes of treatment, payment, or healthcare operations. You also have the right to request that we do not disclose your protected health information to friends or family members who may be involved in your care, or for notification purposes as described earlier in this notice. Your request must be made in writing and must state the specific restriction requested and the individuals to whom the restriction applies.
We are not required to agree to a restriction you may request. We will notify you if we do not agree to your restriction request. If we do agree to the restriction request, we will not use or disclose your protected health information in violation of the agreed upon restriction, unless necessary for the provision of emergency treatment.
We may terminate our agreement to a restriction if you agree to the termination in writing; if you agree to the termination orally and the oral agreement is documented, or if we notify you of termination of the agreement and the termination applies only to protected health information created or received by us after you receive the notice of termination of the restriction.
Request for restrictions must be made in writing to the Site Manager.
2. **The Right to Request Confidential Communications.** You have the right to make a special request of receiving communications of protected health information from us by alternative means or at alternative locations. We must accommodate reasonable requests of this nature. We may condition the provision of accommodation by requesting information from you describing how payment will be handled, or by requesting specification of an alternative address or alternative form of contact. Requests for alternative confidential communications must be made in writing.
3. **The Right to Inspect and Copy Protected Health Information.** You do have the right to inspect and obtain a copy of your protected health information that is maintained in a designated record set for as long as we maintain the protected health information. The designated record set is a collection of records maintained by us, which contains medical and billing information used in the course of your care, and any other information used to make decisions about you.
By law, you do not have a right to access psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative proceeding; and protected health information which is subject to a law which prohibits access to protected health information. However, you do have the right to request a review of denial to access this protected health information.

We may deny your request to inspect or copy your protected health information if, in our professional judgment, we determine that the access requested is likely to endanger you or another person, or is likely to cause substantial harm to another person referenced within the protected health information. You do have the right to request a review of denial to access.
If you request a copy of your information, we may charge you a fee for the costs of copying, mailing, or other costs incurred by us as a result of complying with your request.
Requests for access to your protected health information must be made in writing.
4. **The Right to Amend Protected Health Information.** You have the right to request that we amend your protected health information in a designated record set for as long as we maintain that information. In certain cases we may deny your request. If we deny your request you will be notified in writing, and you will have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement of disagreement, and if we do so, we will provide a copy of our rebuttal to you.
Requests for amendment of protected health information must be made in writing and must include a reason to support the requested amendments.
5. **The Right to Receive an Accounting of Disclosures of Protected Health Information.** You have the right to request an accounting of disclosures of your protected health information made by us. This right applies to disclosures made by us except for disclosures: to carry out treatment, payment, or health care operations as described in this Notice or incidental to such use; to you or your personal representatives; pursuant to your authorization; for our directory, or other notification purposes, or to persons involved in your care; or for certain other disclosures we are permitted to make without your authorization.
Requests for disclosure of accounting must specify a time period sought for the accounting, with the maximum time period being six years prior to the date of the request. We are not required to provide accounting for disclosures made before April 14, 2003. We will provide the first disclosure accounting you request during any 12-month period without charge. Subsequent disclosure accounting requests will be subject to a reasonable cost-based fee.
6. **The Right to Obtain a Paper Copy of this Notice.** Upon request, we will provide you with a paper copy of this notice.
7. **The Right to Express Complaints.** You have the right to express complaints to us and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated.
If you wish to complain to us, please do so in writing, and direct your complaint to the Compliance Officer/Site Manager. You will not be penalized for filing a complaint.

Our Requirements Regarding Your Protected Health Information

We are required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the Notice currently in effect. We reserve the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. If we change the Notice, we will provide a copy of the revised notice through in-person contact.

Patient’s with problems or questions pertaining to their health or financial privacy / HIPPA may contact:

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PH: 404-355-4522