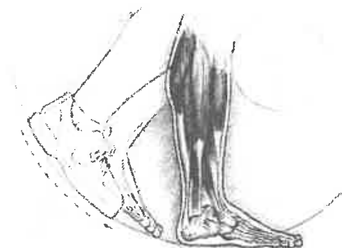


AUGUSTA PODIATRY ASSOCIATES, P.C.

Medicine and Surgery of the Foot and Ankle

Henry G. Bryant, III, D.P.M., FACFAS
Diplomate, American Board of Foot and Ankle Surgery
Fellow, American College of Foot and Ankle Surgeons
Member, American Academy of Podiatric Sports Medicine
Board Certified Foot and Ankle Surgeon

Billing & Insurance Policy Patient Consent Form

Financial responsibility for services rendered rests with the patient/guarantor, regardless of any insurance coverage. Drs. Bryant & Hamilton file insurance claims as a courtesy, however, your insurance is ultimately your responsibility and this courtesy filing in no way reduces your financial responsibility for the services rendered.

We participate with many HMOs, insurance companies, as well as other medical plans and will direct bill your insurance under these plans. We will bill these plans for whom we have an arrangement and will only require our patients to pay the authorized copayments, deductible, coinsurance, and fees for services which are non-covered under their policy. It is our office policy to collect all copayments on the day of the appointment. Again, in the event that the patient's health plan deems a service to be "non-covered', the patient will be responsible for the entire charge for that non-covered service. Payment will be due upon receipt of a statement from our office.

If your insurance coverage is with a plan with which we do not participate, we will be happy to send in a claim form for you as a courtesy. However, all charges will be the responsibility of the patient/guarantor. We cannot accept responsibility for negotiating claims with your insurance companies.

We will bill the patient's health plan for physician services in the hospital. The same financial responsibilities apply.

Prior Authorization/Pre-Certification:

Many HMO plans and insurance companies require you to obtain authorization for your services from your primary care provider (Internist, Family Practitioner, Pediatrician, etc.). It is your responsibility to obtain authorization from your primary care provider (PCP). This is required by your insurance before you visit our office, even when the visit is for an urgent problem. Contact your insurer if you have questions, or contact the office of your PCP. Obtaining this referral/prior authorization is your responsibility and failure to do so will result in non-coverage of our services by your insurance carrier. By signing this form you accept responsibility for payment of any and all fees not covered by your insurance company/HMO due to failure to obtain pre-certification/prior authorization.

Signature:______________________________ Patient/Guarantor Date:_______________

PLEASE TURN OVER AND SIGN THE BACK. THANK YOU.

University Hospital Medical Center/Evans
4321 University Parkway
Suite 103, Building #2
Evans, GA 30809
(706) 854-2050

www.augustapodiatry.com

Medicare:

We are participating providers under Medicare. This means that we accept the fees set by Medicare for medical services covered by the Medicare program and rendered to a Medicare recipient, including surgery. Medicare patients will be responsible only for coinsurance payments, deductible and non-covered services, such as preventive and routine services.

Acknowledgment of Non-Coverage of Services by Insurance Carrier:

By signing below you are acknowledging that you assume full financial responsibility for today's services should your insurance carrier deny any or all of our charges. Regardless of our participation with your insurance carrier/HMO you agree that you will pay all expenses should your carrier deny our services for any reason.

I fully understand that Dr. Bryant will be filing my insurance claim for me as a courtesy. This courtesy filing in no way reduces my financial responsibility for these services.

My signature below indicates that I have read this form in its entirety and any questions that I may have had regarding any of these policies have been answered to my satisfaction.

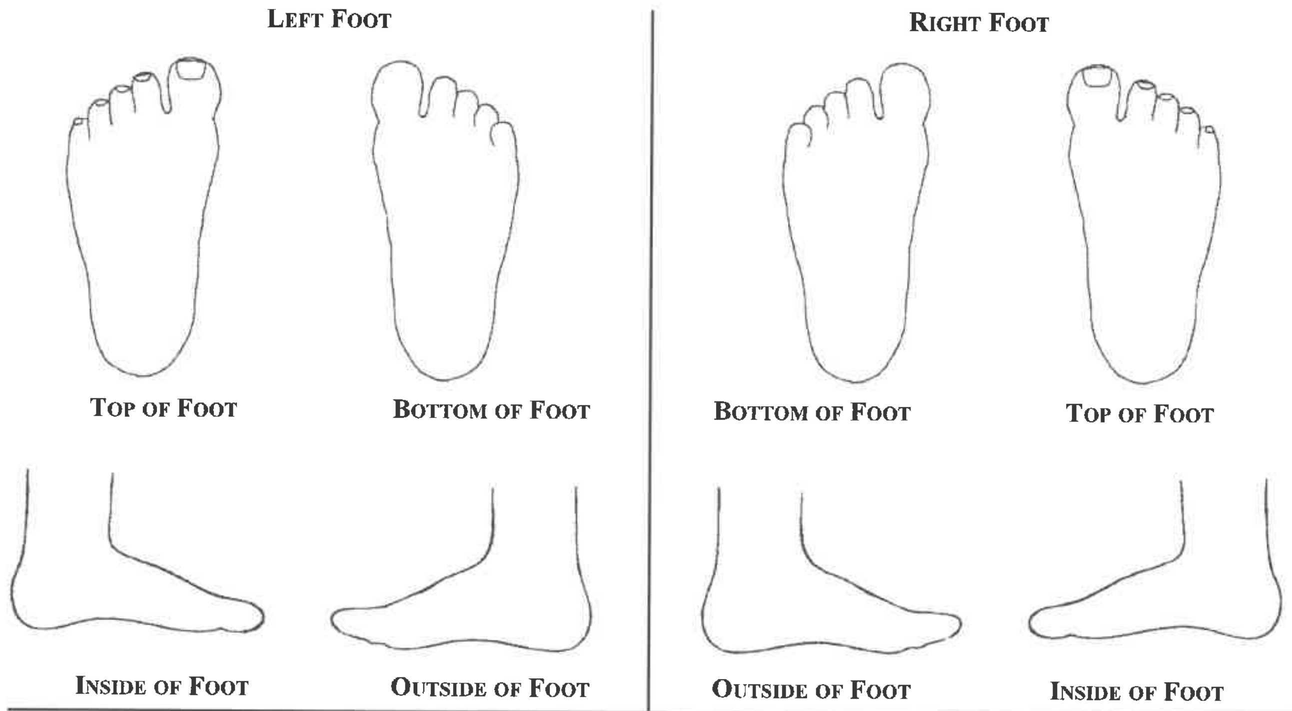
Signature: ______________________________ Patient/Guarantor

Date: ______________________________

Current Problem

What specific problem brings you to our office today? ____________________

Where is the pain/problem located? Please mark on the pictures below.



How long ago did this problem first start? ________ Days / Weeks / Months / Years

Did your pain or problem: ☐ Begin all of a sudden ☐ Gradually develop over time

How would you describe your pain? ☐ No pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Radiating ☐ Itching ☐ Stabbing ☐ Other ____________

Since the time your pain or problem began, has it: ☐ Stayed the same ☐ Became worse ☐ Improved

What makes your pain or problem feel worse? ☐ Walking ☐ Standing ☐ Daily Activities ☐ Resting ☐ Dress shoes ☐ High heels ☐ Flat shoes ☐ Any closed toe shoe ☐ Running ☐ Other ____________________

What makes your pain or problem feel better? ____________________

What treatments have you had for this problem? ____________________

How has this problem affected your lifestyle or ability to work? ____________________

Was this problem caused by an injury? ☐ Yes (describe) ____________________ ☐ No

If yes, was it a work-related injury? ☐ Yes ☐ No

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in medical status.

____
Print name of patient, parent or guardian

____
Signature of doctor

____
If other than parent, relationship to patient

____
Date

____
Signature

____
Date

AUGUSTA PODIATRY ASSOCIATES, PC

Henry G. Bryant III, DPM, FACFAS
www.augustapodiatry.com

New Patient Information Form

Full Name:				Date of Birth:	Age
Address:		City:		State:	Zip:
Sex:	SSN:	Home Phone:		Marital Status: M/S/D/W	
Place of Employment:		Work Phone:		Alternate Phone:	
Spouse's Name:		Spouse DOB:		Spouse SSN:	
Parent's Name (if patient is a minor)		Parent's SSN:		Height:	Weight:
Insurance #1 Name:			Insurance #1 ID#:		
Insurance #2 Name:			Insurance #2 ID#:		

Problem History

In your own words, please describe the problem you are having:

____

____

How much pain are you having (please circle)?

MILD PAIN — SEVERE PAIN

NONE (0) 1 2 3 4 5 6 7 8 9 10

Who is your regular doctor? ______________________

Who referred you to us? ______________________

Social History

Do you smoke? YES/NO How much?______________

Do you drink alcohol? YES/NO How much? ______________

Occupation: ______________________

Medical History

Are you allergic to any medicines (please circle)?

Penicillin Sulfa Codeine Aspirin Adhesive Iodine

Other: ______________________

Please list any (& all) allergies other than medication:

____

Please list all current medications (& dose) and supplements:

______________________ ______________________

______________________ ______________________

______________________ ______________________

Please list all previous surgeries and hospitalizations:

______________________ ______________________

______________________ ______________________

______________________ ______________________

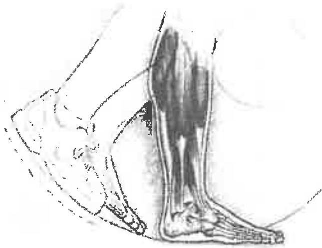
Medical Review of Systems

Please check (√) if you or a family member have or have had any of the following:

Condition	Patient	Family
Diabetes		
High Blood Pressure/Hypertension		
Heart Attack/Heart Disease		
High Cholesterol		
Poor Circulation		
Stomach Ulcer/Frequent Heartburn		
Cancer		
Frequent Headaches		
Frequent Blurred or Double Vision		
Epilepsy		
Bleeding from the ears or nose		
Thyroid Problems		
Chest Pain/Angina		
Anemia/Low Blood		
Excessive Bleeding		
Difficulty Breathing/Wheezing/Asthma		
Tuberculosis		
Rheumatic Fever		
Pneumonia		
Colon Disease		
Gallbladder Disease		
Kidney Problems		
Liver Disease or Jaundice		
Hepatitis		
Bone or Joint Disease (Arthritis)		
Bursitis/Sciatica		
Phlebitis or Vein Problems		
Leg or Night Cramps		
Tested positive for HIV		

Please list any other medical problems:

Shoe Size: ____________ Signature: ______________________________ Date: ______________



Augusta Podiatry Associates, P.C.

Medicine and Surgery of the Foot and Ankle

Henry G. Bryant, III, D.P.M., FACFAS
Diplomate, American Board of Foot and Ankle Surgery
Fellow, American College of Foot and Ankle Surgeons
Member, American Academy of Podiatric Sports Medicine
Board Certified Foot and Ankle Surgeon

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU: The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.
For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.
For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students or other personnel who are involved in taking care of you at the practice or the hospital. For example, we may disclose medical information about you to people outside the practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.
For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.
WHO WILL FOLLOW THIS NOTICE: This notice describes our practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other practice personnel.
POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION: We create a record of the care and services you receive at the practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the practice, whether made by practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected health care information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors, health oversight activities, inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

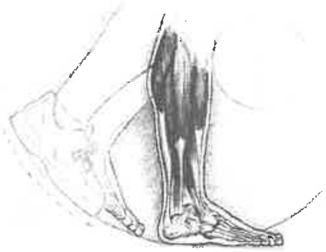
You have the following rights regarding medical information we maintain about you:
Right to an Accounting of Disclosures. You have a right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.
Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for amendment.
Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.
Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.
Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.
Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we disclose about you for treatment, payment or health care operations. You have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.
CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the practice's waiting room.
COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact Jeana Rice, Office Manager, (706) 738-1925. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**
OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

➢Patient or Patient's Personal Representative ______________________________ **Date** ____________

University Hospital Medical Center/Evans
4321 University Parkway
Suite 103, Building #2
Evans, GA 30809
(706) 854-2050
www.augustapodiatry.com



AUGUSTA PODIATRY ASSOCIATES, P.C.

Medicine and Surgery of the Foot and Ankle

Henry G. Bryant, III, D.P.M., FACFAS
Diplomate, American Board of Foot and Ankle Surgery
Fellow, American College of Foot and Ankle Surgeons
Member, American Academy of Podiatric Sports Medicine
Board Certified Foot and Ankle Surgeon

Payments and Collections

Payments of all copays, deductibles, and/or coinsurance are due at the time of service. As a service to you, our office will bill your insurance company. Being a participating provider with most insurance companies, the insurance companies require that we collect these fees, as they are terms of your health care contract. Additionally, patients are ultimately responsible for all balances.

For your convenience, we accept credit cards Including Visa, MasterCard, Discover, AMEX and cash or check.

Due to the constant changes In health insurance it is your responsibility to know your health coverage. If you should have any questions regarding if a certain procedure is covered, it is to your advantage to call your insurance company and find out exactly what your contract covers. Their customer service representatives will be happy to assist you.

In the event that part or all of your account is turned over to a collection agency for non-payment, you will be charged a 35% collection fee. The collection fee Is 50% if it goes legal.

***We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment.

If an appointment is not cancelled at least 24 hours in advance you will be charged a NO SHOW FEE.

1st No show • $50.00 fee * 2nd No show • $75.00 fee * 3rd No show - $75.00 fee and termination from the practice

Signature ______________________________ Date ____________________

University Hospital Medical Center/Evans
4321 University Parkway
Suite 103, Building #2
Evans, GA 30809
(706) 854-2050

www.augustapodiatry.com