PATIENT INFORMATION

Name (First)_____ **(Middle Initial)**_____ **(Last)** _____

Address:_____ **City/State:**_____ **Zip Code:**_____

Home Phone # (_____)_____ **Cell Phone** (____)_____ **Work Phone** (___)_____

Birth date_____ **Age**_____ **Sex**: Male / Female (Circle One) **Social Security #** _____

Marital Status: Single/Married/Divorced/Widow/Widower (Circle One) **Email Address:**_____
Employer:_____ **Occupation:**_____

Employer Address:_____ **City**_____ **State:**_____ **Zip** _____

ALLERGIES
Do you have any drug allergies or sensitivities? If so, please list them._____

_____

Pharmacy Name:_____

Pharmacy Location:_____

MEDICATIONS List all medications you are currently taking. Include over-the-counter products.

_____

_____

_____

IN CASE OF EMERGENCY CONTACT:

Name _____

Relationship _____ Phone _____

Who is your Primary Care Physician?

_____

Date of last visit? _____

Physician's Address or Location

_____

Phone _____

Are you under a doctor's care for any specific condition? If yes, describe briefly. _____

_____

How did you hear about us?___Friend __Physician

____Yellow Pages___Radio___TV___Other

INSURANCE

Primary Insurance Information

Name of Subscriber_____

Subscriber ID #:_____Group ID#_____

Relationship to Patient ____ Self ___Other

(If other, complete the following information)

Name of Insured _____

Insured's Date of Birth_____

Insured's Social Security # _____

Is this patient covered by additional insurance?

_____ Yes (Complete the following Information) _____No

Secondary Insurance Information

Name of Subscriber_____

Subscriber ID# _____ Group ID #_____

Insured's Name _____

Relationship to Patient ____ Self ___Other

(If other, complete the following information)

Insured's Employer _____

Insured's Social Security # _____

Insured's Date of Birth _____

FOOT HEALTH INFORMATION

What type of problem(s) are you currently experiencing?

_____

When did the problem(s) begin? _____

Have you received any treatments for this condition?

_____

Shoe Size _____ **Height** _____ **Weight**_____

Note: If additional space is needed for medication list, please alert staff.

Artineli Foot Care Solutions, PLLC

PATIENT NAME: _____ DOB: _____

Please list all types of previous surgeries and dates.

_____

_____

_____

MEDICAL HISTORY Please check Yes or No to indicate if you previously had or have any of the following conditions:

AIDS/HIV	Yes __ No __	Hepatitis	Yes __ No __
Arthritis	Yes __ No __	High Blood Pressure	Yes __ No __
Asthma	Yes __ No __	High Cholesterol	Yes __ No __
Back Problems	Yes __ No __	Kidney Problems	Yes __ No __
Blood Clots	Yes __ No __	Liver Problems	Yes __ No __
Cancer	Yes __ No __	Parkinson's disease	Yes __ No __
Diabetes	Yes __ No __	Psychiatric Problems	Yes __ No __
Epilepsy	Yes __ No __	Stomach Ulcers	Yes __ No __
Eye Problems	Yes __ No __	Stroke	Yes __ No __
Foot/Leg Cramps	Yes __ No __	Thyroid Problems	Yes __ No __
Gout	Yes __ No __	COPD/Emphysema	Yes__ No__
Heart Problems?	Yes __ No __	Lupus/Sickle Cell	Yes__ No__
Are you a current or past smoker?	**Circle:** Yes or No __	Do you drink alcohol?	Circle: Yes or No

When quit? _____ If so, how much? _____

How much do/did you smoke? _____

Consent for Care: I hereby give consent to Artineli Foot Care Solutions, PLLC and Dr. Shanta Griffin for treatment or services, which may include but are not limited to, laboratory procedures, examination, medical treatment and/or procedures that will be rendered to me or my dependent under the general and specific instructions of the physician.

Signature: _____ **Date:** _____

Patient / Parent or Guardian

Authorization to Obtain/Release Medical Records: I authorize Artineli Foot Care Solutions, PLLC, Dr. Shanta Griffin, or any representative of Artineli Foot Care, to obtain/release copies of my medical records from/to any physician or institution for the purpose of evaluation and/or comparison with examination and testing being performed on me or my dependent for the continuity of care.

Signature: _____ **Date:** _____

Patient / Parent or Guardian

Authorization to Pay Benefits to Physician: I hereby authorize payment to Artineli Foot Care Solutions, PLLC, and thus Dr. Shanta Griffin, for services rendered to me and/or my dependent. I also authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for any balance not covered by insurance and/or collection costs and legal fees incurred in any attempt to collect said balance.

Signature: _____ **Date:** _____

Patient / Parent or Guardian

Authorization to Leave Message: I hereby authorize Artineli Foot Care Solutions, PLLC, Dr. Shanta Griffin, and/or any representative of Artineli Foot Care to leave a message regarding pending appointments and/or scheduled tests at my residence. You may notify me of lab/test results readiness, as well as, matters relating to prescriptions and/or consults/referrals by an Artineli Foot Care representative leaving a message (check all that applies) ____on my answering machine/home voice mail; ____with my spouse; ____on my cellular phone voicemail; ____a family member (please specify name of the family member):_____. We will not disclose personal medical information in any message, other than general information relating to the topic of the call and the need for your return call to give you more specific details.

Signature: _____ **Date:** _____

Patient / Parent or Guardian

NOTICE OF PRIVACY PRACTICES AKNOWLEDGEMENT

ARTINELI FOOT CARE SOLUTIONS
1750 MADISON AVENUE, SUITE 260, MEMPHIS, TN 38104

I understand that, under the **Health Insurance Portability & Accountability Act of 1996 (HIPAA),** I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ☐ Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- ☐ Obtain payment from third-party payers.
- ☐ Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its ***Notice of Privacy Practices*** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the ***Notice of Privacy Practices***.

I understand that I may request, in writing, how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that Artineli Foot Care Solutions is not required to agree to my requested restrictions. However, if Artineli Foot Care Solutions does agree with my request, then you are bound to abide by such restrictions as detailed in Health Insurance Portability & Accountability Act of 1996.

If you would like to receive more information regarding HIPAA, please feel free to speak with someone in our office.

PATIENT NAME: _____ DATE: _____

PATIENT SIGNATURE: _____

ARTINELI FOOT CARE SOLUTIONS
FINANCIAL POLICY

1750 Madison Avenue, Ste 260, Memphis, TN 38104

ALL CHARGES ARE DUE AND PAYABLE WITHIN 45 DAYS OF THE BILLING DATE.

As a courtesy to the patient, Artineli Foot Care Solutions and/or Dr. Shanta Griffin, will bill your **primary** insurance company.

It is your responsibility as a patient to pay your co-insurance and/or co-pay for **each** visit **before** services are rendered. If you have a secondary insurance, the primary insurance co-pay must still be paid. If your annual deductible hasn't been met, then you must pay for all services in full at time of visit.

The patient (or guardian) is responsible for payment of the account within forty five (45) days as stated above. In the event, your insurance company denies payment, or no action is taken by the insurance company on the claim within 45 days, the patient will be billed for the balance due.

If you provide **incorrect** insurance information and your claim is denied, you are required to pay the balance due. It is then your personal responsibility to re-submit your claim directly to the appropriate insurance company.

The courtesy of a twenty-four (24) hour notice is expected should you need to cancel or reschedule an appointment. A fee of twenty-five dollars ($25.00) will be charged for each repeat failed appointment after the second (2^{nd}) offense. This fee must be paid at the next visit before services are rendered. If twenty-four hour notice is not given for cancellation of **SURGERY**, a fee of two hundred fifty dollars ($250.00) will be charged and will be due at the next visit before services are rendered.

All accounts referred to the attorney for collections will be charged applicable interest and the appropriate attorney fees.

I authorize the release of any medical information necessary to process my insurance claims. I authorize payment of medical benefits to Artineli Foot Care Solutions and/or Dr. Shanta Griffin. I understand that I am financially responsible to Artineli Foot Care Solutions and/or Dr. Shanta Griffin for charges not covered or paid by my insurance company.

I have read and understand the financial policy and agree to accept responsibility for full payment of my account.

_____ DATE

_____ PATIENT NAME (Print)

_____ PATIENT SIGNATURE