Atlanta Center for Foot & Ankle Surgery, LLC
218 Sandy Springs Place, Sandy Springs, GA 30328
Telephone: 404-257-0611 Fax: 404-207-1159

Patient Information

Patient Name: _____

Preferred Name to be called: _____ Date of Birth: _____

Phone: Home: _____ Cell: _____

Email: _____

Address: _____

City: _____ County _____ State: ____ Zip: _____

Social Security: _____ Sex: Female Race: _____ Marital Status: single

Employer: _____ Job Title: _____

Employer Address: _____ Work Phone: _____

Person to Contact in Case of Emergency: Name: _____

Address: _____ Phone: _____

Spouse or Responsible Party Information

Name: _____ Address: _____

Relation to Patient: _____ Date of Birth: _____ Social Security: _____

Employer: _____ Address: _____ Work Phone: _____

Insurance Information

Do you have Medicare? ◯ NO ◯ YES Do you have Medicaid? ◯ NO ◯ YES

Was this an on the job injury? ◯ NO ◯ YES If yes, complete the workers compensation section.

Motor Vehicle Accident? ◯ NO ◯ YES If yes, please give date of accident: _____

Primary Insurance: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Policyholder: _____

Policy Number: _____

Group # / Adjuster: _____

Secondary Insurance: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Policyholder: _____

Policy Number: _____

Group # / Adjuster: _____

For Worker's Compensation Only

Worker's Comp Carrier: _____ Date of Injury: _____

Adjuster's Name: _____ Phone: _____

Mail Claims To: _____

Atlanta Center for Reconstructive Foot & Ankle Surgery, LLC

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Patient Name:_____ Date:_____

Explanation of Surgical fees and charges:

Ambulatory Surgical Center Fee: Represents the charges submitted by the surgical facility and includes operating time, recovery room, surgical supplies, medications, and any other special instrumentation. Fee is due at time of service.

Anesthesia Service Fee: This is submitted by the anesthesiologist and / or nurse anesthetist and covers those costs involving IV sedation. This is based on time, so it is filed with your insurance carrier after your surgery. You will receive a bill after your claim is filed.

Doctor / Surgeon Fee: This is submitted by the surgeon and covers the actual surgeon's fee and normal postoperative treatments. This fee is collected at your Surgeon's office either before or after your surgery.

Pathology Fee: This fee can occur if your doctor requests a specimen to be sent to pathology for further testing. You may receive a bill from the pathology service provider after your surgery.

Financial Responsibility

I have requested professional services from Surgery Center and the Anesthesia Provider on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that if my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I agree to endorse the check, if made out to me, and mail it directly to the correct Provider. If I deposit the check, I am responsible for reimbursing my provider the amount of the payment.

I am fully aware that having health insurance is not a guaranteed form of payment and it is my responsibility to ensure that my bills for professional services from all Providers are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, that any Provider's Third-Party Billing Service for the claims assigned hereunder, to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan and assigned hereunder to Provider; and (2) the right and ability to act as my Authorized Representative to pursue any such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, appeals, and any other applicable remedy, including fines.

A photocopy of this Assignment of Benefits / ERISA Authorization shall be as effective and valid as the original.

_____ _____

Patient Signature Date

ATLANTA CENTER FOR FOOT & ANKLE SURGERY, LLC

NOT A REVOCATION OF ADVANCED DIRECTIVE OR MEDICAL POWER OF ATTORNEY

PATIENT NAME: _____ **SURGERY DATE:** _____

All patients have the right to participate in their own health care decision and to make *Advance Directives or to Execute Power Of Attorney* that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. Atlanta Center for Foot & Ankle Surgery respects and upholds those rights.

However, unlike an acute care hospital setting, the Atlanta Center for Foot & Ankle Surgery does not routinely perform "high risk" procedures. Most procedures preformed in the facility are considered to be of low to moderate risk; however no surgery is without risk. You will discuss the specifics of your procedure with your physician who can answer questions as to its risk, expected recovery and care after surgery.

Therefore, it is our policy to suspend a Do Not Resuscitate (DNR) request if received at the Atlanta Center for Foot & Ankle Surgery. If an adverse event occurs during your treatment at this facility, we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatment or withdrawal of treatment measures already begun will be ordered in accordance with that hospital's policy. Your signature below does not revoke or invalidate any current *Advanced Directive or Medical Power Of Attorney.*

If you do not agree with this policy, we will assist you in rescheduling the procedure.

Please check the appropriate box below to answer these questions;
Have you executed an *Advance Directive, Living Will, or a Power Of Attorney* that authorizes someone to make healthcare decisions for you?

- ☐ Yes, I have an *Advance Directive, Living Will, or Medical Power of Attorney*
- ☐ No, I do not have any of the above
- ☐ I would like a copy of the State of Georgia Advanced Directive
- ☐ I would like more information on *Advance Directives,* ***go to website; www.ors.dhr.georgia.gov in the search box type in Georgia Advance Directive***

If you checked the first box "yes" to the question above, please provide us with a copy of that document so that it may be made a part of your medical records.

By signing this document, I acknowledged that I have read and understand its contents and agree to the policy as directed. If I have indicated that I would like additional information, I acknowledge receipt of that information.

Patient's Signature: _____ Date: _____

Witness: _____ Date: _____

If consent to the procedure is provided by anyone other than the patient, the person providing the consent or authorization must sign below. I acknowledge that I have read and understand its content and agree to the policy as described.

Signature: _____ Date: _____

☐ Guardian ☐ Health Care Agent ☐ Attorney ☐ Other: _____

ATLANTA CENTER FOR FOOT & ANKLE SURGERY, LLC

The following Physicians providing care own or have financial interests in Atlanta Center for Foot & Ankle Surgery Center; Doctors: Beach, Camasta, Carter, Cass, Cohen, Cutsuries, Filiatrault, Greenbaum, John, Julien, Lay, Light, Monday, Peebles, Pierre, Richardson, Schancupp, Sharif, Todd, Ulett, Verlezza, Warner, and Weiskopf.

In recognition of our responsibility in rendering patient care, we affirm these Patient Rights & Responsibilities

THE PATIENT HAS THE RIGHT TO:

1. Receive services without regard to age, race, color, sexual orientation, religion, marital status, sex, national origin, or sponsor (for example, legal representative if patient has been adjudged incompetent);
2. Be treated with consideration, respect, and dignity including privacy;
3. Receive treatment in a safe and secure setting;
4. Be free from all forms of abuse, neglect, or harassment;
5. Seek consultation with the physician(s) of his/her choice;
6. Contract with his/her physician(s) on mutually agreeable terms;
7. Privacy and confidentiality of information and records pertaining to the patient's treatment;
8. Be fully informed about his / her medical condition, the risks and benefits of treatment, possible alternate treatment and prognosis, in terms that the patient can be reasonably expected to understand;
9. Receive from his/her physician information necessary to give informed consent prior to start of any non-emergency procedure and / or treatment, the reasonably foreseeable risks involved, and any alternative for care or treatment in a manner of disclosure that permits the patient to make a knowledgeable decision;
10. Receive information necessary to decline or execute an advance directive for healthcare;
11. Refuse medical treatment even if it is recommended by his/her physician and to be fully informed of the consequences;
12. Refuse to participate in experimental research;
13. Express complaints or grievances about the care and services provided and to have the center investigate such complaints. The center is responsible for providing the patient or designee with a written response within 30 days indicating the findings of the investigation if requested by the patient.

THE PATIENT HAS THE RESPONSIBILITY FOR:

1. Providing the center and physician, to the best of his/her knowledge, accurate and complete information about present complaints past illness, hospitalization, prescribed and over the counter medication, allergies to medications, foods, or environment, and other matters related to his/her health;
2. Reporting unexpected changes in his/her condition to the center and physician;
3. Reporting to the center whether he/she understands the contemplated course of action, treatment, procedure and what is expected of him/her;
4. Following the treatment plan recommended by the center and physician;
5. Keeping appointments and notifying the center when unable to do so for any reason;
6. His / her actions if he/she refuses treatment or does not follow the center's or physician's instructions;
7. Following facility rules and regulation affecting care and conduct;
8. Consideration and respect of the facility staff and property;
9. Asking what to expect regarding pain and pain management;
10. Assuring that financial obligations of his/her health care are fulfilled as promptly as possible.

TO FILE A COMPLAINT:

If you feel you have been treated unfairly, your patient rights or privacy rights have been compromised by staff at the surgery center you may file a complaint with us by notifying our Clinic Manager of your complaint. All complaints will be investigated and reviewed by the Clinic Manager and appropriate action taken.

The Atlanta Center for Foot & Ankle Surgery, will work to resolve your complaint in the timely manner. Once a complaint is filed we will respond back to you within 5 days of receiving your notice of complaint. The response will be in writing and we may need to contact your for additional information. All complaints will receive a final resolution within three weeks of receiving; this will allow time for the surgery center staff to thoroughly investigate your complaint and resolve the issue.

Atlanta Center for Foot & Ankle Surgery Center
218 Sandy Springs Place, Sandy Springs, Georgia 30328
404-257-0611 extension 224 or fax 404-574-2408
Attention: Kendra Ford, Administrator
Email: kford@acrfas.net

State of Georgia Department of Community Health
Health Care Regulation Division Complaint
2 Peachtree St. NW Atlanta, GA 30303
Intake:
1-800-878-6442 Please leave contact information for a return call
Fax: 404-657-5731

Medicare Beneficiary
Telephone: 1-800-MEDICARE OR 1-800-633-4227
https://www.medicare.gov/forms-help-resources/contact-medicare

Pre-Anesthesia Questionnaire / Evaluation

Patient Name: _____ **Age**: _____ **Height:** _____**Weight:** _____
Best Contact Phone number:_____**Doctor:**_____ **Surgery Date**: _____
List All Current Medications (both prescription and over the counter): _____

_____

List all prior surgeries: _____
List All Allergies: _____

Please Circle YES or NO, If YES Circle Disorder

YES☐ NO☐ Have you ever had problems with anesthesia? Specify _____
YES☐ NO☐ Do you have a difficult airway?
YES☐ NO☐ Do you have any allergies to latex, soy, egg, or peanut products?
YES☐ NO☐ Do you have any metal allergies?
YES☐ NO☐ Have you or any family member ever had malignant hyperthermia (i.e.a high fever associated with anesthesia)?
YES☐ NO☐ Do you have any heart problems: High Blood Pressure, Mital Valve Prolapse, Heart disease, Heart Attack, Angina, Atrial Fib?
YES☐ NO☐ Do you have Aortic Stenosis?
YES☐ NO☐ Do you have an abnormal heartbeat?
YES☐ NO☐ Congestive Heart Failure or Cardiomyopathy?
YES☐ NO☐ Do you have a pacemaker or internal defibrillator?
YES☐ NO☐ Do you see a Cardiologist routinely? If Yes How Often? _____

Stress Test: YES☐ NO☐ Date: _____ Normal/Passed ☐ Abnormal ☐
Heart Cath YES☐ NO☐ Normal Mild blockages ☐ Angioplasty/Stent ☐

Are you on any of the following Blood Thinners or Heart medications?

YES☐	NO☐	Coumadin	YES☐	NO☐	Eliquis	YES☐	NO☐	Brilinta
YES☐	NO☐	Plavix	YES☐	NO☐	Effient	YES☐	NO☐	Pletal
YES☐	NO☐	Aggrenox	YES☐	NO☐	Pradaxa	YES☐	NO☐	Aspirin 81mg
YES☐	NO☐	Nitroglycerin	YES☐	NO☐	Xarelto	YES☐	NO☐	Aspirin 325

YES☐ NO☐ Do you have any gastrointestinal problems including: Hepatitis, Heartburn, Hiatal Hernia, Ulcers, Gallstones?
YES☐ NO☐ Do you have any skin problems including: Herpes, Rashes, Eczema?
YES☐ NO☐ Do you have any blood disorders including: Sickle Cell, Anemia, Mono, Clotting Disorder, Deep Vein Thrombosis?
YES☐ NO☐ Do you have Diabetes? Do you take insulin? _____
YES☐ NO☐ Do you have a Thyroid Disorder?
YES☐ NO☐ Do you have any Neurological disorders?
YES☐ NO☐ Have you ever had a Seizure, Stroke, or Aneurysm?
YES☐ NO☐ Epilepsy/Seizures, Are you controlled with medications? no
YES☐ NO☐ Do you have any breathing problems including: Asthma, COPD, or Emphysema, Sleep Apnea?
YES☐ NO☐ Do you use a CPAP machine or Bipap?
YES☐ NO☐ After climbing a flight of stairs, are you short of breath?
YES☐ NO☐ Do you have any kidney problems including: Renal Failure, Urinary Tract Infections, Kidney Stones?
YES☐ NO☐ Do you have any limitations on the use of any joints, especially the neck and jaw?
YES☐ NO☐ Do you have Arthritis?
YES☐ NO☐ Do you have any fractures?
YES☐ NO☐ Do you have Cancer?
YES☐ NO☐ Do you have any infectious diseases or are you a carrier of any infectious diseases?
YES☐ NO☐ Have you ever had a HIV test? If yes, was it positive or negative? _____
If YES to any of the above questions please explain: _____

_____

Have you had or do you have any other medical conditions not covered above? _____
YES☐ NO☐ Do you smoke? Packs per day? _____ How many years? _____If quit, how long ago? _____
YES☐ NO☐ Do you use alcohol? If yes, how much? _____
YES☐ NO☐ Do you wear contact lens?
YES☐ NO☐ Do you have dentures, partials, etc.? _____
YES☐ NO☐ Do you have an emotional condition? If yes, please explain: _____

Female Patients Only:
When was your last period? _____Could you be pregnant? YES☐ NO☐ Are you post menopausal? YES☐NO☐
Have you had a Hysterectomy? YES☐NO☐ Have you had a Tubal Ligation? YES☐ NO☐

_____ _____
Patient Signature Date

Concordia Anesthesia

PRE AND POST ANESTHESIA INSTRUCTIONS

Pre- Anesthesia Instructions:

A licensed Anesthesia Professional will administer your anesthesia care. You will receive a call from an Anesthesia staff member 48 hours prior to your surgery. This is to discuss your anesthesia care. Please inform anesthesia of your medical history, allergies, and any pervious surgery you may have had. If you become ill or develop a fever, be sure to call your surgeon's office as early as possible since the surgery may need to be rescheduled.

- Do not eat or drink anything **after 11 pm the night before surgery**, unless otherwise instructed by the anesthesia staff. This will include gum, candy, and breathe mints.

- Check with your physician regarding the administration of your routine medications before surgery and we will discuss this again during your pre-anesthesia call. If instructed take meds two (2) hours prior to arrival.

- Patients with Diabetes must contact their doctor for instructions how to take their insulin the day of their surgery.

- Make arrangements for someone to drive you home after surgery.

Post-Anesthesia Instructions:

- You will remain at the surgery center until you are adequately alert to be discharged.

- Do not operate complex or dangerous machinery, including an automobile, for 24 hours.

- Do not drink alcohol for 24 hours.

- Follow your physician's orders regarding diet, rest and pain medication.

- Do not take pain medication or antibiotic on an empty stomach, unless instructed otherwise. Doing so may make you nauseated.

Financial Arrangements:

Charges for your anesthesia care are separate from your surgical charges. We will file a claim as a service to you. Please be aware of the provisions and any limitations in you policy, since pre-verification is not a guarantee of payment.

Atlanta Center for Foot and Ankle Surgery, LLC
Pre-Operative Instructions

Surgery Date: _____ **Surgery Time:** _____

Now that you have scheduled your foot surgery, there are several things you need to do to ensure that everything goes as planned.

1. Do not eat or drink ANYTHING after 11 pm the night before surgery unless otherwise instructed by the Anesthesia staff. This includes gum, candy, lozenges, mints, etc. If you brush your teeth, please do not swallow. If you've been told to take any medications by anesthesiologist, take them with small sips of water.

2. Make arrangements for an adult to bring you to the surgery center and stay for the duration of your surgery. You will not be permitted to drive yourself home

3. Arrive at least one (1) hour prior to your schedule surgery time. It takes approximately one (1) hour to prep a patient for surgery. If running late, please call 404-257-0611 extension 0; as soon as possible.

4. Arrange for someone to assist you for the first 24 hours after surgery.

5. Bring a photo I.D. and insurance cards, and any form of payment to pay coinsurance / copay to surgery center.

6. You may wear loose fitting clothes such as shorts with elastic in the waist (no metal zippers, snaps, and buttons). Women may want to wear a sports bra with no metal hooks or underwire. Sweat pants may also be worn. Please do not wear restricting clothing, this is very important.

7. Do not bring any valuables. All jewelry must be removed; this also includes wedding rings, watches and all piercing (including navel, tongue and any other body parts pierced). If all jewelry is not removed you could be at risk for being burned.

8. Do not wear contact lenses, make-up, nail polish, or lotion.

9. Notify your doctor of any cuts, scrapes, or infected insect bites, which develop on your foot or leg the week prior to surgery.

10. Do not cut your toenails three days prior to surgery. Remove all nail polish. Do not shave hair off legs, feet, or toes 24 hours prior to surgery.

11. Should you develop any signs or symptoms of illness before your surgery, please notify your doctor. The doctor should be aware of any sore throat, ear ache, abdominal illness, or fever which may occur in the week before surgery.

12. Do not plan on traveling far from home after surgery (unless you have previously discussed this with your doctor). Discuss with your doctor any plans with regards to anticipated activity following your surgery.

13. Wash feet thoroughly the evening prior to surgery with an antibacterial soap, ie. Dial

14. Make sure to bring the blue surgical folder with you the day of surgery.

15. If the doctor gave you a **Surgical Shoe** or **Boot**, please bring it with you to the surgery center.

16. If you need assistance getting into the building, please have someone notify the front desk.

It is important that you understand the necessary steps, which will be needed to insure the best possible results, are obtained. If you have any questions or concerns, call your doctor or call the surgery center at 404-257-0611.

The above pre-surgical instructions have been reviewed with or by me and I fully understand the instructions.

_____ _____

Signature Date

Atlanta Center for Foot & Ankle Surgery, LLC
Post-Operative Instructions for Foot Surgery

Patient Name: _____

It is important that these instructions are followed to insure proper healing and to obtain the best results:

1. Keep your foot elevated above the level of your heart during transportation home and for the first 48 hours. Elevate the foot by supporting foot and legs with pillows. The knee should be slightly bent.
2. Apply an ice bag to the foot for 30 minutes every hour for the first few days. It is not necessary to apply ice when sleeping. Wrap ice pack with a towel. **Do not place ice pack directly on bare skin.**
3. **Keep walking to a minimum - bathroom and for meals only.** Always wear your surgical shoe when walking. It is not necessary to wear the shoe when sitting or sleeping.
4. **DO NOT REMOVE THE DRESSINGS.** This will be done at the first follow-up appointment. **NO SHOWERS!!!** Keep the dressing/cast **CLEAN and DRY. Sponge bathing is recommended.**
5. **Medications** – Eat prior to taking your medications. Make sure you take your medications as directed on the label. If you have any side effects, **call your doctor immediately.**
6. If your doctor ordered crutches, please continue to use until your doctors tells you otherwise.
7. **Avoid the use of tobacco and DO NOT CONSUME ANY ALCOHOLIC BEVERAGES!**
8. Exercise your legs frequently by bending your knees to stimulate circulation and to prevent swelling of the legs.
9. If you have any of the following problems, **call your doctor**. He/she has arranged 24 hour coverage:
    - Your operative foot should change color significantly
    - The bandages become overly stained
    - If pain is intolerable with no relief from pain medication
    - You bump or injure the surgical site
    - You develop a fever greater than 100 F
    - You get the dressing wet
    - Be sure to call your doctors office for your follow-up appointment.

Always follow Physicians instructions if different from above.

The above instructions have been read and reviewed with me and I fully understand them.

_____ _____

Patient Signature/Responsible Adult RN Signature/ Medical Assistant

_____ _____

Date Date