KHUMALO FOOT AND ANKLE CLINIC, INC

LEGAL NAME (LAST, FIRST, M.I.) _____ PREV LAST NAME _____

NICKNAME _____ DATE OF BIRTH: ___/___/____ SSN: _____ MALE __ FEMALE __

ADDRESS, CITY, STATE, ZIP: _____

PO BOX/ SEC ADDRESS, CITY, STATE, ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL: _____ MAY WE SEND INFORMATION HERE: YES___ NO___

PREFERRED PHARMACY: _____ CITY: _____ STATE: _____

CONSENT TO REQUEST MEDICATION HISTORY FROM YOUR PHARMACY? YES_____ NO____

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER'S ADDRESS: _____

WORK PHONE: _____ MAY WE CONTACT YOU AT WORK? YES _____ NO _____

SPOUSE/PARTNER: _____ RELATION: _____

SSN: _____ THEIR EMPLOYER: _____

EMPLOYER'S ADDRESS, CITY, STATE, ZIP: _____

EMPLOYER'S PHONE: _____

IN CASE OF EMERGENCY, CONTACT: _____ RELATION: _____

HOME PHONE: _____ CELL PHONE: _____

1) PREFERRED LANGUAGE: ENGLISH ____ SPANISH ____ OTHER _____
2) RACE: WHITE ____ AFRICAN AMERICAN ____ ASIAN/PACIFIC ISLANDER ____
   NATIVE AMERICAN/ALASKAN _____ LATIN AMERICAN ___ DECLINE _____
3) ETHNICITY: HISPANIC/LATINO ___ NON-HISPANIC/LATINO ____ DECLINE _____

A COPY OF YOUR INSURANCE CARD IS REQUIRED; PLEASE PRESENT BOTH PRIMARY AND SECONDARY (IF APPLICABLE) CARDS TO THE RECEPTIONIST

INSURANCE COMPANY: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

SUBSCRIBER NAME: _____ DOB: ___/___/____ SSN: _____

RELATION TO THE PATIENT: _____ EMPLOYER: _____

DO YOU HAVE A SECONDARY INSURANCE? YES ____ NO ___

INSURANCE COMPANY: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

SUBSCRIBER NAME: _____ DOB: ___/___/____ SSN: _____

RELATIIONSHIP TO THE PATIENT: _____ EMPLOYER: _____

HOW DID YOU HEAR ABOUT OUR PRACTICE? RADIO NEWSPAPER FACEBOOK MOVIE THEATER WORD OF MOUTH

PATIENT NAME _____ DATE OF BIRTH _____

KHUMALO FOOT AND ANKLE CLINIC, INC

VERBAL COMMUNICATION AUTHORIZATION FORM

PATIENT NAME: _____ DATE OF BIRTH: _____

BY LAW, WE CANNOT RELEAE ANY INFORMATION REGARDING YOUR CARE TO ANYONE OTHER THAN YOURSELF WITHOUT YOUR EXPRESS, WRITTEN CONSENT.

PLEASE LIST ANY FAMILY MEMBERS OR OTHER INDIVIDUALS WHO MAY BE INVOLVED IN COORDINATING YOUR CARE, OR PAYMENT FOR CARE. PLEASE INDICATE WHAT TYPES OF IINFORMATION MAY BE SHARED WITH EACH INDIVIDUAL.

NAME	RELATIONSHIP TO PATIENT	TYPE OF INFORMATION (CIRCLE)			
		ALL	SCHEDULING	MEDICAL	BILLING
		ALL	SCHEDULING	MEDICAL	BILLING
		ALL	SCHEDULING	MEDICAL	BILLING
		ALL	SCHEDULING	MEDICAL	BILLING
		ALL	SCHEDULING	MEDICAL	BILLING
		ALL	SCHEDULING	MEDICAL	BILLING

____ **CHECK HERE IF NO ONE IS ALLOWED TO CALL ABOUT ANY OF YOUR INFORMATION**

SPECIFIC INSTRUCTIONS OR LIMITATIONS:

_____

_____

WE WILL RELY ON THE INFORMATION ON THIS FORM WHEN COMMUNICATING REGARDING YOUR CARE UNLESS YOU REQUEST CHANGES. PLEASE NOTIFY OUR OFFIE IF YOU WISH TO ALTER THE ABOVE DESIGNATIONS.

THIS AUTHORIZATION WILL BE CONSIDERED PERMAMENT UNLESS REVOKED BY YOU. TO REVOKE THIS AUTHORIZATION, PLEASE SEND A SIGNED, WRITTEN REQUEST TO: KHUMALO FOOT AND ANKLE CLINIC 1109 E REELFOOT AVE, STE D UNION CITY TN 38261

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE: _____

DATE: _____ RELATIONSHIP TO PATIENT: _____

PATIENT NAME _____ DATE OF BIRTH _____

KHUMALO FOOT AND ANKLE CLINIC, INC

CONSENT FOR MEDICAL TREATMENT

_____(initials) I authorize Dr. Bhekumuzi Khumalo and personnel of Khumalo Foot And Ankle Clinic, Inc to render medical treatment and evaluations as needed. I further authorize order of x-rays, injections, casting or other diagnostic tests and treatment as necessary.

CONSENT FOR FINANCIAL RESPONSIBILITY

_____ (initials) My insurance policy is a contract between myself and my insurance carrier. I am ultimately responsible for payment in full for all medical services provided to me. I acknowledge full financial responsibility for services rendered by Khumalo Foot And Ankle Clinic, Inc. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements are made prior to treatment. I agree to pay all collection and attorney fees, if applicable. In the event of default of payment of charges. I assign benefits to and authorize direct payment to Khumalo Foot And Ankle Clinic, Inc, of which it is entitled. This also includes proceeds and benefits accruing under any settlement structure or otherwise, or awarded in judgement for personal injuries caused by a third party for payment of services rendered by Khumalo Foot And Ankle Clinic, Inc, and/or any of its cellular numbers, which could result in charges to me I may also be contacted by text message or email, using only email addresses I provide.

PHOTO RELEASE FORM

_____ (initials) I, _____, hereby authorize Khumalo Foot And Ankle Clinic, Inc, the right to take pictures or videos of me. These picture and/or videos will go to your chart for documentation purposes as well as to show progress of healing. Pictures and/or videos may be used for research purposes or development of educational and promotional materials including but not limited to newsletters, flyers, posters, brochures, advertisements, fundraising letters, press kits or newsletters. Pictures and/or videos may also be submitted to journalist websites, social networking sites, or any other print and digital communications. There will be no compensation to patient for use of pictures and/or videos. This authorization extends to all languages, media formats and markets now known or hereafter devised. This authorization shall continue indefinitely unless I revoke said authorization in writing.

I understand and agree that these materials will be property of Khumalo Foot And Ankle Clinic, Inc.

I hereby hold harmless and release Khumalo Foot And Ankle Clinic, Inc from all liability, petitions and causes of action which I, my heirs, representative, executors, administrators, or any other person may make on my behalf or behalf of my estate.

I warrant that I am 18 years of age or older and that I am competent to contract in my own name. I have read this release before signing below and I fully understand the contents and meaning of this release.

SIGNATURE _____ DATE_____

WITNESS _____ DATE_____

PATIENT NAME _____ DATE OF BIRTH _____