



Last Name		First Name		M.I.	D.O.B.	SSN
Street Address		Apt. #	City	State	Zip Code	
Home Phone	Cell Phone		Email Address			
Marital Status M      S      Widow      Sep.      Div.			Spouse's Name			
Financially Responsible Person, If Different From Patient			Cell Phone		Work Phone	
Person, Other Than Spouse, to Contact in Case of An Emergency			Relationship		Contact's Phone	
Referring Physician's Name		Physician's Phone		Your Primary Physician's Name		Physician's Phone

**Insurance Coverage**

Primary Ins. Co.	Name of Policy Holder	Relationship	Policy Holder's DOB	Policy ID #	Group #
Secondary Ins. Co.	Name of Policy Holder	Relationship	Policy Holder's DOB	Policy ID #	Group #
Policy Holder's Employer			Employer's Phone #		

**MEDICARE LIFETIME SIGNATURE ON FILE**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Northern Virginia Foot and Ankle Associates/Laurel Foot and Ankle Center for any services furnished to me by the physician. I authorize any medical information about me to be released to the Health Care Financing Administration and any agent information needed to determine these benefits or benefits payable for related services.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

**PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE**

I, the undersigned, authorize payment of medical benefits to Northern Virginia Foot and Ankle Associates/Laurel Foot and Ankle Center for any services furnished to me by the physicians. I understand I am financially responsible for any amount not covered by my health insurance contract. I also authorize you to release to my insurance company any information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claim benefits, including worker comp claims. I permit a copy of this authorization to be used in place of the original.

Date: \_\_\_\_\_ Signate: \_\_\_\_\_

MEDICAL HISTORY

PATIENT'S NAME:

Reason for your visit: Date when symptoms began and a description of the symptoms

If problem is accident related, indicate date accident occurred and place of injury

Have you been treated by another physician for this problem? If yes, list physician's name and treatment

Past Medical History (check all that apply)

Table with 3 columns of medical conditions and 2 columns of Yes/No checkboxes. Conditions include AIDS/HIV, Anemia, Arthritis, Artificial Heart Valve/ Joints, Asthma, Back Problems, Bleeding Disorder, Cancer, Chemical Dependency, Chest Pain, Circulatory Problems, Diabetes, Epilepsy, Eye Problems, Gout, Headaches, Heart Disease, High Blood Pressure, Kidney Problems, Liver Disease, Low Blood Pressure, Nervous Problems, Psychiatric Care, Respiratory Disease, Rheumatic Fever, Shortness of Breath, Sinus Problems, Stroke, Tuberculosis, Ulcers, Varicose Veins, and Weight Loss, Unexplained.

Other Past Medical History:

Have you had any surgery? If yes, please list all past surgeries:

Form with three rows for listing surgeries, each row including a date field.

Are you currently taking any medications? If yes, please list them:

Form with 12 numbered rows for listing medications.

Do you have any medication allergies? If yes, please list and describe reaction:

Do you (circle): Drink Alcohol? Smoke Tobacco? If yes, how much?

Do you experience abnormal bleeding with surgery, cuts, extractions, or trauma? Yes No

Are you, or is there any chance you may be pregnant? Yes No

Put a check by any conditions below that any blood relatives have or had:

- List of conditions for blood relatives: Diabetes, Foot Problems, Heart Disease, Stroke, Gout, Arthritis, High Blood Pressure, Kidney Disease, TB, Cancer.

Other

Shoe Size Shoe Width Weight Height

## Policy for Payment of Medical Services and Products Agreement

Due to the vast amount of information, the daily changes in laws, regulations, and policies, we cannot guarantee that all services at all times will be covered by your insurance company. In order to achieve our goal of assuring that each patient receives the best possible care and to help our patient with their allowed medical benefits, we ask the assistance and attention of all our patients. It is important that each patient knows what their insurance plan offers for care, the services that their plan will pay for, and the changes that occur within their insurance plan. It is also important that each patient keeps us informed of current changes with their insurance, billing address changes, and that each patient provides us with proof of insurance, as well as a photo identification card. In the case where it is a requirement by an insurance company that a patient be seen with a referral and in the case where treatment plans must be submitted, it is the responsibility of the patient to see that these forms are obtained and given to the appropriate person in our office. In the case that the referral/treatment plan is not obtained and services are rendered the patient will be held financially responsible. As with any service, all charges are the responsibility of each patient from the date services rendered and payment in full is expected at the time of service is provided. To assist our patients, we accept Visa, MasterCard, American Express, Discover, Cash, and Checks as forms of payment.

### **PLEASE READ AND INITIAL EACH LINE BELOW ACKNOWLEDGING YOU HAVE READ ALL POLICIES.**

\_\_\_\_\_ **COPAYMENTS:** Your insurance **REQUIRES** that we collect your designated co-pay at the time of service. Please be prepared to pay the co-pay at each visit.

\_\_\_\_\_ **DEDUCTIBLES AND CO-INSURANCE:** We may collect your deductible and co-insurance at the time of service. We will bill your insurance company. Patient Responsibility portions of your bill are to be paid within 90 days.

\_\_\_\_\_ **SELF-PAY/UNINSURED:** Self-pay accounts shall exist if a patient has no insurance coverage or no evidence of insurance coverage. For new patients, a payment of **\$250.00** is required on the day of your appointment before being seen by the health care provider. If you are unable to pay the **\$250.00** please contact the billing office prior to your appointment. A discount off regular fees is offered for payment made at time of service.

\_\_\_\_\_ **REFERRALS:** If your insurance plan requires a referral from your primary care physician it is your responsibility to obtain it prior to your appointment and to have it with you at the time of the appointment. If you do not have your referral, **YOU MAY BE REQUIRED TO RESCHEDULE.**

\_\_\_\_\_ **RETURNED CHECK FEES:** Any returned check from the bank for non-payment (insufficient funds) shall result in the patient's account being assessed a **\$40.00** fee per check returned.

\_\_\_\_\_ **FORMS/PAPERWORK:** There is a **\$40.00 pre-payment** per form fee for the completion of paperwork or forms relating to disability, FMLA, etc. This fee is collected prior to completion of the paperwork, and for each time the paperwork is required. Allow seven working days for completion of forms. **Any forms needed within 48 hours from the time it was given to our staff will need to pre-pay an additional \$20.00 rush fee.**

\_\_\_\_\_ **DMV HANDICAP PARKING APPLICATIONS:** There is a \$10.00 fee for **ALL** DMV handicap parking applications.

\_\_\_\_\_ **NO SHOW FEE:** You will be charged a **\$35.00 fee** if you fail to cancel your appointment with 24 hours of your scheduled appointment or do not show for your scheduled appointment.

\_\_\_\_\_ **SURGERY CANCELTION FEE:** Any surgeries cancelled within 7 business days of the scheduled surgery date will incur a **cancellation fee of \$500.00. (Fee will be waived if surgery is canceled due to a death in the family, illness or if the patient is not cleared for surgery)**

Service charges are assessed for all accounts 30 days past due. Failure to pay outstanding balance promptly will result in actions being taken with our outside collection agency to achieve collection of fees. The patient is directly responsible for any laboratory expenses. Please sign below to acknowledge that you have read and understand our Policy of Payment Agreement for Medical Services and Products

**RESPONSIBLE PARTY SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Patient Name (if different from Responsible Party):** \_\_\_\_\_

**Patient statement: To the best of my knowledge, the information I will provide is accurate and complete.**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**I am aware of my HIPAA Rights (you can request a copy of your privacy rights at the front desk)**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

## How did you hear about us?

We would sincerely appreciate if you could take a few moments to complete the following questionnaire.

This information will be used to improve our outreach program.

Thank you for your time!

- A referring doctor

Name: \_\_\_\_\_

**\*\*\*If a doctor did not refer you to our practice, please check an option below:**

- A friend who is a current patient

Name: \_\_\_\_\_

- Magazine article or advertisement

Please specify: \_\_\_\_\_

- Google / Internet Search

- Insurance Carrier: \_\_\_\_\_

- Facebook

- Yelp!

- Other: \_\_\_\_\_

