Northern Virginia Foot & Ankle ASSOCIATES

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: _____ Signature: _____

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)

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

Other Past Medical History: _____

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

_____ Date:_____

_____ Date:_____

_____ Date:_____

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

1.	5.	9.
2.	6.	10.
3.	7.	11.
4.	8.	12.

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:

☐ 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 ACKNOWLEDING 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 CANCELATION 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: _____

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