PATIENT REGISTRATION

Patient Information

Patient Name: Last	First	M.I.	☐ M ☐ F
By what name do you preferred to be addressed?			Single Married Widowed Other
Patient's Address:			
City	State	Zip	
Home Phone:	Work Phone:	Cell Phone:	
Social Security #:	Birth date:	Age:	Race:
Email:	Employer/Occupation:		
Emergency Contact:	Phone #:		

Insurance

Name of insured (if other than self): Birth Date:
Name of insured's employer: Work phone number:
Patient is: ☐ Subscriber ☐ Spouse ☐ Dependent/Child
We are required to have a copy of your insurance card(s) on file in order to bill your insurance for you. If we do not have this information on file, you will be billed directly and are solely responsible for all charges. Payment is due at the time of service. If you submit insurance card at a later date we will be glad to bill your insurance company and reimburse you when payment is received.

L&I Injury

Date of Injury: Type of Injury: ☐ Work ☐ Auto ☐ Other
Has a claim been filed? ☐ Yes ☐ No Claim#: Where was claim filed?
Cause of injury:

Referral

Referred By: ☐ Friend : _____ ☐ Doctor (name): _____ ☐ Other: _____ ☐ Web Search
Primary Care Physician: Phone #:
Preferred Pharmacy: Address & Phone#:

Signature

Release of Benefits Information: I authorize my insurance benefits to be paid directly to the doctor. I understand that the doctors office will bill my insurance as a courtesy and that I am responsible for all co-payments, deductibles and non-covered services. I authorize the release of information required to process my claims. (If not signed payment due at time of service.)

ALL CO-PAYMENTS AND BALANCES DUE ON DAY OF SERVICE.

Patient Signature: _____ Date: _____

PATIENT HEALTH RECORD

What is your present foot problem(s) or condition(s)? _____
_____
How long have you been bothered by the above? _____
What have you already done for your foot problem(s) or condition(s)? _____
_____

Medical History

Primary Care Physician _____ Phone# _____

Please **circle** if you have or have had any of following:

AIDS/HIV infection
Anemia
Artificial heart valves
Artificial joints/implants
Asthma
Back or neck problems
Bruise or bleed easily
Bulimia or anorexia
Cancer/tumor
Chemical dependency
Chest pain
Diabetes
Epilepsy or neurological problems
Fainting or dizzy spells
Glaucoma
Heart Disease
    Mitral valve proplapse
    Heart murmur
Gout
Hepatitis/Jaundice
Herpes
High or Low blood pressure
Hives or skin rashes
Kidney disease
Liver disease
MRSA
Pacemaker
Psychiatric treatment or Mental illness
Rheumatic fever
Seizures
Scarlet fever
Shortness of breath
Sickle cell anemia
Stomach ulcers
Stroke
Phlebitis
Thyroid disease
Tuberculosis
Ulcers

Do you have any other disease, condition, or problem not previously listed? _____

ALLERGIES:
Are you allergic to Penicillin ___ Codeine ___ Local anesthetics ___ Latex ___ Other: _____
or NO ALLERGIES ___

Please list all prescription drugs you are now taking (please include any herbal or OTC medications or vitamins)

_____

_____

Has your physician advised you to pre-medicate before dental treatment? _____
If female: Are you taking hormones or birth control? _____ Are you nursing? _____ Are you pregnant? _____
Do you use tobacco? _____ Have you had a recent weight loss/gain? _____ Do you use alcohol? _____
Have you had surgery? _____ If so, what type? _____ Year _____
type? _____ Year _____

Family History

Please **circle** if any blood relatives have had:
Arthritis Cancer Diabetes Heart Disease High blood pressure Kidney disease Obesity

I hereby give permission to the doctors to examine, diagnose and treat my feet and/or ankles medically or surgically and attest that the above information is accurate and true:

Patient (parent/guardian) Signature: _____ Date: _____

Financial and Office Policy

Thank you for choosing us as your podiatric physician. Utilizing a complete care management process, we are committed foremost to you, the patient, and your successful treatment. As an integral part of this process, we try to contain the cost of health care. Please carefully read the following outline of our financial and office policies so that we may better implement your complete care. Please ask any questions prior to signing at the space provided. A signature is required prior to treatment.

INSURANCE

In order to accurately submit a claim to your insurance company, we must have ***complete, accurate, and up-to-date insurance information***. We must also keep a copy of your insurance card. If your policy changes, you change insurance carriers or your coverage expires, you must notify our office immediately. Your insurance policy is a contract between you and your insurance company; therefore, you are responsible for payment whether or not your insurance company pays. ***It is your responsibility to contact your insurance company regarding authorizations, obtaining required referrals, second opinions, etc.*** If no referral/pre-authorization is received by your appointment date, we will request you either reschedule or pay for the visit.

CONTRACTED INSURANCE PLANS

We accept payment based on insurance companies' allowable fee structure and the contract your insurance group has with the carrier. Any allowable balances are the responsibility of the patient and are due in full upon receipt of statement.

NON-CONTRACTED and/or OUT OF NETWORK INSURANCE PLANS

We will do the billing from this office for your primary insurance as a courtesy. For instances where payment ***must*** be made to directly to you, we request payment at the time of service. Arrangements may be made for monthly payments of larger balances once your payment history has been established.

NO INSURANCE

Payment in full is expected at the time of service. In some instances, other payment arrangements, such as subrogation (3rd party), may be allowed; however, such arrangements ***must be*** made with our office prior to your visit. A letter from your medical insurance carrier to accept subrogation would be required. In most cases, we do not accept 3rd party claims.

MEDICARE

Medicare does not pay for routine foot/nail care or orthotics. ***We do NOT bill to Medicare for durable medical equipment.*** You must pay for these items upon receiving them and they cannot be returned to our office. Medicare can also limit the number of visits per diagnosis. It is your responsibility to educate yourself on this policy, to monitor the number of visits, and to pay for services not covered by Medicare.

PAYMENT

Payments for the balance due, co-payments, deductibles, etc. are due at the time of service and may be made by cash, check, or credit card. We reserve the right to refuse international or corporate cards. There will be a $35 charge for all returned checks. There will be a $35 fee for any credit card disputes that are found to be in our favor. Delinquent accounts will be referred for collection at the discretion of the office manager. If your account is forwarded to a collection agency for non-payment, an additional 35%-50% collection fee will be added to your balance due, plus any additional court costs and/or legal fees charged.

CO-PAYMENTS

Please be prepared to pay all co-payments at the time of service. We will ask to reschedule your appointment if you are not prepared to pay at the time of service.

DEDUCTIBLES

If you have an annual deductible that has not yet been paid in full at the time of the appointment, then ***any charges incurred up to that amount are to be paid in full at the time of service.***

PAYMENT ARRANGEMENTS

For larger balances, we may consider reasonable monthly payments with service charges applicable. However, this ***plan must be agreed to in writing prior to treatment being rendered.*** Verbal agreements will not be made by this office.

MINOR PATIENTS

The adult or the parent (custodial guardian) accompanying a minor is responsible for payment of services. For unaccompanied minors, non-emergency treatment will be denied unless prior written authorization from the parent or guardian has been made for the charges and treatment. Young adults (age 18 and over) are legally responsible for their accounts unless a parent or guardian accompanies them to the initial appointment and signs this financial agreement, regardless of insurance coverage.

MISSED APPOINTMENTS/SURGICAL APPOINTMENTS

Please help us serve you better by keeping scheduled appointments. If it is necessary to cancel an office appointment, please contact our office with a ***24 hour notice***. There will be a ***$50 charge for missed appointments within 24 hours.*** If it is necessary to cancel a scheduled surgical procedure, please contact our office within 3 business days from when you scheduled the surgery. After which time, there will be a ***$250 charge for missed or canceled surgical procedures.***

ORTHOTICS

Orthotics is a non-covered service by some insurance plans. As a courtesy, if we agree to file orthotics and/or any medical equipment to your insurance company and they determine that it is not covered you agree that you will be financially responsible for the full payment. Please check with your insurance company ***prior to the examination and casting*** for orthotics to determine your orthotics benefits. We require half of the total cost paid at the time of the examination and casting. Full payment is due when the orthotics are dispensed.

SUPPLIES/MISC.

For your convenience, we make some supplies available for purchase at our office. If you choose to purchase these items, **payment is due in full at the time of purchase and non-refundable**. We cannot bill for these items. We are unable to return or resale returned supplies and therefore **do not accept returns**. In light of this fact, we will afford you the opportunity to inspect items for use and fit during your visit. Once the item leaves our office, we must consider the item used and **non-returnable.**

Medical records/copies of x-rays must be requested in writing and are subject to a fee, which is to be paid at the time of the request (please allow up to 30 days for completion). Due to the increased demand of paperwork on our physicians there will be a fee for completion of forms such as disability, worker's compensation, employer/school form, FMLA, DMV form, etc.

Please refer to our posted Notice of Privacy regarding the use and disclosure of your private health information

I have read and understand this policy and acknowledge full responsibility for the payment of services rendered. This information provided by me is current, accurate, and complete to the best of my knowledge. I authorize all payments be made directly to Virginia Foot and Ankle Center or my provider on my behalf for any services or supplies furnished by my doctor or Virginia Foot and Ankle Center and for my doctor to act as my agent to help obtain payment. I authorize the release of medical information or documentation in their possession about me to all my insurance companies as well as to Medicare in order to determine the benefits of the benefits payable for related services, now or in the future.

Signature_____

Name (please print)_____ **Date**: _____

Phone # where you would like information/messages left regarding medical treatment. Please initial next to your preference:

Phone #: (_____) _____

1._____Please leave very little information

2._____Please leave specific details on the machine but not with someone who answers the phone

3._____Please leave specific details on the machine or with anyone who answers the phone