REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____
City State Zip

Sex: ☐ M ☐ F Age _____ Birthday _____

Race: ☐ White ☐ Black ☐ Asian ☐ Indian ☐ Hawaiian

Ethnicity: ☐ Not Hispanic ☐ Hispanic

Patient SS# _____

Occupation _____

Employer _____

Spouse's/Parent's Name _____

Birthday _____ SS#_____

Occupation _____

Spouse's/Parent's Employer _____

How did you hear of us? _____

3 CONTACT INFORMATION

Home# _____Cell#_____

Work#_____ Ext_____

Email _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Phone number(s) _____

4 PODIATRIC HISTORY

What is the chief complaint for which you came to be treated?

_____

_____

_____

Please indicate which foot problems you now have or have had in the past.

Ankle Pain	☐ yes	☐ no	Heel Pain	☐ yes	☐ no
Athlete's Foot	☐ yes	☐ no	Ingrown Nails	☐ yes	☐ no
Bunions	☐ yes	☐ no	Warts	☐ yes	☐ no
Corns/Calluses	☐ yes	☐ no	Swelling	☐ yes	☐ no
Cramps	☐ yes	☐ no	Tired Feet	☐ yes	☐ no

Over

2 INSURANCE

Who is responsible for this account? _____

Relationship to patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ yes ☐ no

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with the above mentioned and assign directly to the doctors of the Foot and Ankle Clinic of the Virginias all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions, including Medicare and Medicaid.

_____
Responsible Party Signature

_____ _____
Relationship Date

5 MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins

_____

_____

_____

_____

_____

_____

Pharmacy Name _____

6 ALLERGIES

☐ Adhesive/Tape	☐ Local Anesthetics
☐ Aspirin	☐ Penicillin
☐ Codeine	☐ Sulfa
☐ Iodine/Betadine	☐ Anti-inflammatories

☐ Other _____

_____

7 MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Circulatory Problems	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Chemical Dependency	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Phlebitis	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Artificial Heart	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Valves or Joints			Heart Disease	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Bleed Disorders	☐ Yes	☐ No	Hepatitis A, B, C	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Varicose Veins	☐ Yes	☐ No

Hospitalization and surgeries you have had

_____

_____

_____

Family history: Diabetes ☐ Yes ☐ No Cancer ☐ Yes ☐ No Rheumatoid Arthritis ☐ Yes ☐ No Other: _____

Family physician _____ Last visit date _____

Phone number _____

Welcome and thank you for choosing our office for your foot care needs. In our continuing effort to provide personalized patient care in the most efficient and economical manner possible, we ask that you take a few moments to read our financial policy and fill out our medical history forms. Your clear understanding of our financial policy is important to our professional relationship. If you have any questions about our fees or your financial responsibilities for services rendered, please don't hesitate to ask us. We are a medical provider and are members of most insurance plans. It is **your** responsibility to make sure we are on **your insurance plan**. If your insurance requires a referral or prior authorization, it is your responsibility to make sure that this is in place prior to your appointment.

I understand and agree that all services rendered me, my dependents, or others assigned by me to my account are charged directly to me. I further understand I am personally responsible for payment. If I suspend or terminate care and treatment, any fees for services rendered will be immediately due and payable. Should the fees for the professional services not be paid in accordance with the provisions herein, reasonable attorney's fees, plus applicable finance changes and disbursements, allowances and costs provided by law shall be included in the computation of the amount due. Finance charges can be applied to all amounts that are at least 30 days past due at the rate of 1.5% per month (18% annual rate). **If the account is in default and turned over for collection, I acknowledge that I will be responsible for all reasonable costs associated with effecting collection.** If during the admission or application process I have provided a phone number; I acknowledge that I may be contacted at that number for account servicing matters, including but not limited to collecting on my account should it become delinquent.

If you are molded for a custom fabricated device (orthotics, brace) you are required to present to the office to ensure proper fit once the item is received by our office. You will be notified to set up an appointment for the fitting to occur. Failure to present in a timely manner will result in you being billed personally for the full cost of the device. These products are **non refundable.**

CONSENT

I certify that the above information is true and correct to the best of my knowledge and agree with the Financial Policy. I give my permission to the doctor and staff to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet and ankles.

Patient's/Parents' Signature_____ Date _____

Foot and Ankle Clinic of the Virginias

Notice Of Privacy Practices Acknowledgment

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain right to privacy regarding my protected health information. In understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operations and quality assessments and physician certifications

I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its' Notice of Privacy Practices at any time. I can contact the physician's office at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to abide by such restrictions.

Consent to Obtain Medication History

Our medical practice has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your "medication history." A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer.

An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions.

By signing this consent form you give us permission to collect, and give your pharmacy and your health plan permission to disclose, information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This information will become part of your medical record.

I give permission for you to obtain my medication history from my pharmacy, my health plans and my other healthcare providers.

SIGNATURE: _____