

CENTER FOR FOOT AND ANKLE CARE, PC

PATIENT REGISTRATION *Please Print Clearly*

Patients Name	First	Middle	Last	Spouse	
Home Address	Street	City	State/Zip	Email Address	Home Phone
Employed by	Address			Work Phone	
Spouse/Parent Employed by	Address			Pt. Birth Date	Sex
Patient's Social Security #	Name, Address of Insurance Subscriber if Different From Patient				
His/Her Home Phone	His/Her Work Phone				
Referred By	Family Physician				
In Case of Emergency Contact	Relationship			Phone	

PRIMARY INSURANCE

Ins Co Name _____
 Address _____
 ID # _____
 Group # _____
 CODE _____
 Subscriber's Name _____
 Effective Date _____

SECONDARY INSURANCE

Ins. Co. Name _____
 Address _____
 ID # _____
 Group # _____
 CODE _____
 Subscriber's Name _____
 Effective Date _____

SUBSCRIBER INFORMATION	Name	Social Security #	Date of Birth	Relationship to Patient
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WORKERS COMP-INJURY ON JOB _____	ACCIDENT CASE _____
Date of Accident	Claim/File #
Insurance Carrier Name	

Insurance Carrier Address _____

Attorney's Name _____ Address _____ Phone _____

Patient Account # _____

MEDICAL INFORMATION

What is your chief foot complaint? _____

Have you been treated for this condition by another Podiatrist? Yes ___ No ___

Who? _____ When? _____

Have you had any injuries or operations on your feet or legs? Yes ___ No ___

Is excessive standing, walking, or lifting required on your job? Yes ___ No ___

Patient's Occupation	Age	Height	Weight	Check One: Single ___ Married ___ Div ___ Widowed ___ Sep ___
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Allergies: _____

Current Medications _____

	Yes	No
Are you in good health?	_____	_____
Are you now or have you ever been under a physicians care during The last 2 years?	_____	_____
Are you subject to prolonged bleeding?	_____	_____
Is there any personal or family history of diabetes?	_____	_____
Have you had any blood transfusions in the past 10 years?	_____	_____
Are you allergic to any medicines? If yes, which ones?	_____	_____
Have you ever been treated for heart trouble? Arthritis? Asthma? Epilepsy? Rheumatic Fever? Kidney or liver involvement? If yes, which ones?	_____	_____
Have you had any serious illness or operations?	_____	_____
Are you HIV positive or do you have any symptoms of AIDS?	_____	_____

PATIENT AUTHORIZATION

I, _____, hereby authorize Center for Foot and Ankle Care, PC to apply for benefits on my behalf for covered services rendered him. I authorize payment of medical benefits to be made directly to Center for Foot and Ankle Care, PC. I authorize any holder of medical information about me to release to my insurance carrier (Health Care Financing Administration and its agents, or other carrier) any information needed to determine these benefits or benefits payable for related services. I understand that I am financially responsible to Center for Foot and Ankle Care, PC for any balance not covered by this authorization. I am responsible for any deductible, co-insurance or non-covered services. In addition, I am fully responsible for all services if my insurance requires a referral and I do not have one.

SIGNATURE OF SUBSCRIBER OR BENEFICIARY _____

DATE _____

CENTER FOR FOOT AND ANKLE CARE, PC

LATE CANCELLATION / NO SHOW POLICY

Due to the increased demand for appointment times and having long waiting lists for cancellations, we have to implement a **Late Cancellation/No Show** policy. We regret that we have had to take this action. Our concern for seeing our patients in a timely manner has prompted us to take these steps. We ask for a 24 hour notice for all cancellations.

If a patient appointment has been confirmed and the patient fails to keep said appointment, there will be a fee assessed to the account depending on the type of appointment scheduled; i.e., routine follow up \$25 or procedure \$50.00.

I have read and fully understand my responsibility as a patient.

Signature

Date

FILING OF INSURANCE CLAIMS

We will gladly file your insurance claim accurately and promptly **once**. In order to do this properly, we need **Current, Correct** and **Complete** insurance information.

Please verify information routinely.

If payment is denied by the insurance company

The charges become due by the patient

We encourage you to call your insurance company, and resolve the problem. We no longer can wait indefinitely for payment. If the insurance company should pay us at a later date, we will gladly refund any money paid by the patient.

I have read the above and fully understand my responsibility as a patient.

Signature

Date

Center for Foot and Ankle Care, PC
3020 Hamaker Court
Suite 201
Fairfax, VA 22031
(703) 207-0073

**Notice of Privacy Practices
Patient Acknowledgement**

Patient Name _____ Date of Birth _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
 - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights has been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
 - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
 - The right to receive confidential communications of protected health information.
 - The right to inspect and copy protected health information
 - The right to amend protected health information.
 - The right to receive an accounting of disclosures of protected health information.
 - The right to obtain a paper policy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices upon request.

Signature _____ Date _____

Relationship to patient (if signed by a personal representative of patient) _____