CENTER FOR FOOT AND ANKLE CARE, P.C.

LAST NAME	FIRST NAME	SEX MALE FEMALE	DATE OF BIRTH
ADDRESS	APT #	CITY	STATE	ZIP CODE
HOME #	WORK #	CELL #
E-MAIL ADDRESS	CONTACT PREFERENCE (CIRCLE ONE) HOME WORK MOBILE EMAIL
EMERGENCY CONTACT	RELATIONSHIP TO PATIENT	EMERGENCY #
PRIMARY INSURANCE	SUBSCRIBER NAME	SUBSCRIBER DATE OF BIRTH
SECONDARY INSURANCE	SUBSCRIBER NAME	SUBSCRIBER DATE OF BIRTH
PRIMARY CARE PHYSICIAN NAME	PRIMARY CARE PHYSICIAN PHONE NUMBER

PATIENT AUTHORIZATION

I, ______________________________, HEREBY AUTHORIZE THE CENTER FOR FOOT AND ANKLE CARE TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SERVICES RENDERED BY THE PHYSICIAN. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO BE MADE DIRECTLY TO THE CENTER FOR FOOT FOOT AND ANKLE CARE. 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 DETERMINET HESE BENEFITS OR BENEFITS PAYABLE FOR RELATED SERVICES. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE CENTER FOR FOOT AND ANKLE CARE 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

MEDICATION HISTORY AUTHORITY

OUR ELECTRONIC MEDICAL RECORDS (EMR) PROGRAM WILL AUTOMATICALLY IMPORT YOUR MEDICATION HISTORY FROM THIRD PARTY SOURCE (I.E. PHARMACIES). IN ORDER TO TRANSFER YOUR CURRENT AND PAST MEDICATIONS INTO OUR SYSTEM WE MUST HAVE YOUR AUTHORITY.

PHARMACY NAME	PHARMACY NUMBER

BY SIGNING BELOW I HEREBY CERTIFY CENTER FOR FOOT AND ANKLE CARE THE AUTHORITY TO TRANSFER MY MY MEDICATION HISTORY.

SIGNATURE OF PATIENT OR GUARDIAN

DATE

CENTER FOR FOOT AND ANKLE CARE, P.C.
3020 HAMAKER COURT, SUITE 201
FAIRFAX, VIRGINIA 22031
DR. BARRY SAFFRAN **DR. LONNY NODELMAN**

PATIENTS NAME:

OCCUPATION	HEIGHT	WEIGHT	AGE	SEX

CHECK ONE: SINGLE MARRIED DIVORCED WIDOW SEPARATED

PLEASE DESCRIBE WHAT BRINGS YOU HERE TODAY:

WHICH SIDE: RIGHT LEFT BOTH

HOW LONG HAVE YOU HAD THE PROBLEM:

WHAT MAKES IT BETTER:

WHAT MAKES IT WORSE:

PLEASE DESCRIBE THE TYPE OF PAIN YOU HAVE: (CHECK BOX OF ANY THAT APPLY)

SHARP	DULL	ACHING	CRAMPING	CONSTANT	STABBING
THROBBING	PINS AND NEEDLE	COMES AND GOES	SHOCKING	OTHER	

WAS THIS AN INJURY: YES NO | IF YES, WHEN DID IT HAPPEN:

HOW DID IT HAPPEN:

WHERE DID IT HAPPEN: HOME WORK SCHOOL AUTO

ON A SCALE FROM 0-10 (10 BEING THE WORSE) HOW SEVERE IS THE PAIN: 0 1 2 3 4 5 6 7 8 9 10

REVIEW OF SYSTEMS: PLEASE CHECK YES (Y) OR NO (N)

CHEST PAIN	Y N	EXCESSIVE URINATION	Y N	STOMACH PAIN OR BURNING	Y N
COUGH	Y N	BURNING URINATION	Y N	PALPATION OR FLUTTERING HEART	Y N
JOINT PAIN	Y N	DIFFICULTY SWALLOWING	Y N	FREQUENT LOSS OF STOOL	Y N
MUSCLE PAIN	Y N	DIFFICULTY SLEEPING	Y N	FREQUENT CONSTIPATION	Y N
BRUISE EASILY	Y N	FAINTING SPELLS	Y N	TROUBLED BY DEPRESSION	Y N
TROUBLE WALKING	Y N	EXTREMITY SWELLING	Y N	TROUBLED BY ANXIETY	Y N
USE A CANE	Y N	EXTREMITY WEAKNESS	Y N	SEVERE HEADACHES	Y N
LOSS OF SENSATION	Y N	SHORTNESS OF BREATH	Y N	WEAR HEARING AID	Y N
FREQUENT RASHES	Y N	WEAR GLASSES	Y N	OTHER:	

PAST MEDICAL HISTORY: PLEASE CHECK YES (Y) OR NO (N)

ASTHMA	Y N	HIGH BLOOD PRESSURE	Y N	BLOOD CLOTS	Y N
PSORIASIS	Y N	BLEEDING PROBLEM	Y N	VARICOSE VEINS	Y N
GOUT	Y N	HEART PROBLEM	Y N	PNEUMONIA	Y N
DIABETES	Y N	IRREGULAR HEARTBEATS	Y N	TUBERCULOSIS	Y N
EMPHYSEMA	Y N	MITRAL VALVE PROLAPSE	Y N	HIATAL HERNIA	Y N
COLITIS	Y N	RHEUMATOID ARTHRITIS	Y N	THYROID PROBLEMS	Y N
ULCERS	Y N	PSYCHIATIC PROBLEM	Y N	CANCER	Y N
SEIZURES	Y N	URINARY INFECTION	Y N	HIV/AIDS	Y N
STROKE	Y N	GALLBLADDER PROBLEM	Y N	OTHER:	

ORGAN TRANSPLANT YES NO | IF YES, PLEASE SPECIFY

PLEASE DESCRIBE ANY OF THE PROBLEMS YOU CHECKED FROM THE ABOVE LIST:

PLEASE DESCRIBE ANY PAST SURGERIES (PROVIDE YEAR)

Patient Signature:	Date:

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DR. BARRY SAFFRAN **DR. LONNY NODELMAN**

PATIENTS NAME:

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING, PRESCRIPTION OR OVER THE COUNTER		
NAME OF MEDICATION	STRENGTH/DOSAGE	HOW OFTEN DO YOU TAKE THIS MEDICATION

DO YOU HAVE ANY ALLERGIES (PLEASE LIST AND DESCRIBE REACTION)	
ALLERGIES:	REACTION

PAST FAMILY HISTORY:

(PLEASE CHECK ANY OF THE FOLLOWING MEDICAL PROBLEMS ANYONE IN YOUR IMMEDIATE FAMILY HAS OR HAD)

ARTHRITIS		MOTHER	FATHER	SISTER	BROTHER	GRANDPARENTS
DIABETES		MOTHER	FATHER	SISTER	BROTHER	GRANDPARENTS
HEART PROBLEM		MOTHER	FATHER	SISTER	BROTHER	GRANDPARENTS
BLEEDING PROBLEM		MOTHER	FATHER	SISTER	BROTHER	GRANDPARENTS
BLOOD CLOT		MOTHER	FATHER	SISTER	BROTHER	GRANDPARENTS
FOOT PROBLEMS		MOTHER	FATHER	SISTER	BROTHER	GRANDPARENTS
ANESTHESIA		MOTHER	FATHER	SISTER	BROTHER	GRANDPARENTS
OTHER:		MOTHER	FATHER	SISTER	BROTHER	GRANDPARENTS

SOCIAL HISTORY

DO YOU EXERCISE REGULARY:	YES	NO	WHAT TYPE AND HOW OFTEN:	
DO YOU DRINK ALCOHOL:	YES	NO	IF YES, HOW MANY DRINKS PER WEEK:	
DO YOU SMOKE:	YES	NO	IF YES, HOW MANY PACKS PER DAY:	HOW LONG:
DO YOU DRINK CAFFEINE:	YES	NO	IF YES, HOW MANY CUPS PER DAY:	
Patient Signature:			Date:	

CENTER FOR FOOT & ANKLE CARE, P.C.
FINANCIAL POLICIES

Patient Name: ______________________________

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, or your financial responsibility. The patient or responsible party is responsible for seeing that the entire bill is paid in full. Responsible parties will be responsible for any collection fees, interest, and other expenses necessary to collect on any account, including court costs, should legal action be necessary to collect.

We will ask to see your insurance card on your first visit and will scan your card into our system as needed to keep our information current. We will ask for this information at every visit, in order to ensure that no change in benefits or carrier has occurred. Please notify us if your insurance carrier or policy has changed. Billing of insurance is a courtesy we provide for patients and is not required by law.

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-INSURANCES:** 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 60 day.

___ **SELF-PAY/ UNINSURED:** Full payment is due at the 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 results in the patient's account being assessed a **$40.00** fee per check returned.

___ **MEDICAL RECORDS/ FORMS/PAPERWORK:** There is a **$20.00** 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. There is a **$15.00** fee for the copying of medical records and x-rays. **Any forms or medical records needed within 48 hours from the time it was given to our staff will need to pre-pay an additional $20.00 rush fee.**

___ **NO SHOW FEE:** Failure to cancel a routine office visit within 24 hours will result in a **$50.00** fee. Failure to cancel an in office procedure (ie: Nail excisions, wart removal, orthotic casting) within 24 hours will result in a **$100.00** fee.

___ **HOSPITAL SURGERY CANCELATION FEE:** Any surgeries cancelled, for non-medical reasons, within 5 business days of the date of surgery will incur a cancellation fee of **$300.00**

RESPONSIBLE PARTY SIGNATURE: ____DATE: __________
Patient Name (if different from Responsible Party): ____

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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 HEALTH AND HUMAN SERVICES IF I BELIEVE MY PRIVACY RIGHTS HAVE BEEN VIOLATED, AND NO RETALIATORY ACTION 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: ___________________________

RELATION TO PATIENT (IF SIGNED BY A PERSONAL REPRESENTATIVE OF PATIENT) _______________________________