

Prince William Foot & Ankle Center, P.C.

7430 Heritage Village Plaza, Suite 101
Gainesville, VA 20155
(703) 753-3338 office

South Riding Foot & Ankle Center

25055 Riding Plaza, Suite 220
South Riding, VA 20152
(703) 753-3338 office

PATIENT INFORMATION:

Date ____/____/____

Last Name: _____ First: _____ Middle: _____ Sex: Male Female

Street Address: _____ City/State: _____ ZIP Code: _____

Home Phone: _____ Cell Phone: _____ Social Security #: _____

Birth Date: ____/____/____ Marital Status (circle): Single / Married / Minor / Divorced / Separated / Widowed

Email: _____ Emergency Contact & Phone #: _____

Primary Physician: _____ Phone #: _____ Date last seen: _____

REFERRED BY: Dr. _____ City/State _____

How did you find us? Internet (circle): Google/ Facebook/ Yahoo/ _____ Phone Book
Other Patient Newspaper (circle): Observer / Heritage Horn
Running Store Physical Therapist other source _____ Insurance

PRIMARY INSURANCE INFORMATION:

Name of Company: _____ Policy # / Member ID: _____ Group #: _____

Relationship to Patient: _____ Copay: _____

POLICY HOLDER INFORMATION (if different from above):

Last Name: _____ First: _____ Middle: _____ Sex: Male Female

Street Address: _____ City/State: _____ ZIP Code: _____

Home Phone: _____ Cell Phone: _____ Social Security #: _____

Birth Date: ____/____/____ Marital Status (circle): Single / Married / Minor / Divorced / Separated / Widowed

SECONDARY INSURANCE INFORMATION:

Name of Company: _____ Policy # / Member ID: _____ Group #: _____

Relationship to Patient: _____ Copay: _____

SECONDARY POLICY HOLDER INFORMATION (if different from above):

Last Name: _____ First: _____ Middle: _____ Sex: Male Female

Street Address: _____ City: _____ ZIP Code: _____

Home Phone: _____ Cell Phone: _____ Social Security #: _____

Birth Date: ____/____/____ Marital Status (circle): Single / Married / Minor / Divorced / Separated / Widowed

Over→→→→

Prince William Foot & Ankle Center, P.C./ South Riding Foot & Ankle Center
Private Insurance Authorization for Assignment of Benefits

I, the undersigned, authorize payment of medical benefits to Prince William Foot & Ankle Center, PC for any services furnished to me by the physician. I understand I am financially responsible for any amount not covered by the contract. I also authorize you to release to my insurance company information concerning health care, advice treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administrating claim benefits. I permit a copy of this authorization to be used in place of the original.

Financial Policy

Payment or proof of valid insurance is due at the time services are rendered unless payment arrangements have been approved in advance by the Office Manager. **Full payment is due at the time of services, which may include deductibles, co-insurance, and co-payments.**

As a courtesy, we will submit your claim for all services to your insurance company. **Please remember your individual health insurance policy is a contract between you and your insurance company, and we are not a party of that contract. Be aware that some of our services may not be covered by your insurance policy. By presenting for care, you agree that you are responsible for all services and charges, regardless of your insurance status. Should any provided services not be covered by your insurance, we will not alter your claim, change your diagnosis, or report a different service than what was performed in order that your insurance will cover the charge. You will be responsible for the balance.**

A deposit of 50% is due on all Orthotics before ordering. Balance for the Orthotics is due upon receipt. Should your account become past due, you will be responsible for any finance charge or legal fees necessary to collect on this account. A Valid Collection Charge of 33% will be assessed if sent to Collections. A fee of \$50 will be assessed for all returned checks.

You may also be charged a fee if you do not show up for an appointment or cancel an appointment without giving 24 hours notice.

If your Insurance Company requires a referral it is your responsibility to submit a **valid** referral upon checking in with the front desk. If you do not have a valid referral you will be responsible for full payment of services rendered.

Acknowledgment of receipt of Notice of Privacy Practices (HIPPA)

I acknowledge that I was provided a copy of privacy practices and that I have read (or had the opportunity to read) and understand this policy.

I am also aware that a notice of privacy practices is posted in the reception area of Prince William Foot & Ankle Center, PC.

***Signature (EVERYONE):** _____ Date: ____/____/____

****MEDICARE ONLY**MEDICARE ONLY**MEDICARE ONLY**MEDICARE ONLY** MEDICARE ONLY**MEDICARE ONLY****

Medicare Lifetime Signature on File

I request that payment of authorized Medicare Benefits be made either to me or my behalf to Prince William Foot & Ankle Center, PC for any services furnished to me by the physician. I authorize any folder of medical information about me to be released to the Health Care Financing Administration and any agency information needed to determine these benefits or benefits payable for related services.

***Signature (MEDICARE ONLY):** _____ Date: ____/____/____

Name (last, first): _____ Date: __/__/____

Current Medications (please include dosages or provide a list): **NONE** _____

Allergies(medications): **NONE** LATEX/PENICILLIN/ SULFA/ NSAIDS/CODEINE/IODINE DYE
Other: _____

Weight: _____ lbs Height: _____ ft _____ in Shoe Size: _____

Past and current Medical History (please circle)

GI Problems: **NONE** ulcers/reflux/Hepatitis _____

Neurological: **NONE** strokes/seizures/sciatica/CP/MS/Parkinson's/Peripheral Neuropathy/ _____

Hematological: **NONE** Anemia/Lymphoma/ _____

Respiratory: **NONE** Lung Problems _____

Muscle/Bones: **NONE** Arthritis/Fractures/Sprains/Fibromyalgia _____

Skin: **NONE** Psoriasis/Melanoma/Athletes Feet/Warts/ _____

Endocrine: **NONE** Type I Diabetes/Type II Diabetes/Hypothyroidism/Gout _____

Cardiovascular: **NONE** PVD/DVT/Cardiac disease/Claudication/Aneurysm/Artery block _____

OB/GYN **NONE** Pregnant / Breastfeeding/ _____

OTHER Problems: _____

Surgical History: **NONE** _____

Family History: **NONE** Arthritis/Asthma//Cancer/Cardiac/Diabetes/Kidney/Liver/
Foot- Bunions/Hammertoes/Ingrown Nail/Neuroma/Heel Spurs

Social History: **Occupation** _____
Tobacco Usage: **NONE** Previous: __pk/day Current: __pk/day ___yrs
Alcohol Usage: **NONE** Occasional
Marital Status: Single Married Divorced _____children

REASON FOR VISIT: Nails Skin Orthopedic Injury Surgery Second opinion Laser Nail

Describe your symptoms briefly: _____

Onset: ___days ___months ___yrs **Problem is:** New/Reoccurrence/Stable/Worse/Improving/Daily/Intermittent

Pain Level: 0 (no pain) – 10 (unable to bear weight): ___/10 Mornings ___/10 Evenings Sharp/Achy/Throbbing

Treatments: _____

Please describe how much you walk/run/exercise per week(for orthopedic problems only):