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: ______________________________ MI: ____ Sex: M F

Street Address: _____________________________________ City/State: ______________________ ZIP Code: ________

Home Phone: ____________________ Cell Phone: ____________________ Social Security # _____________________

Birth Date: ______/______/______ Marital Status: ○ Single ○ Married ○ Minor ○ Divorced ○ Separated ○ Widowed ○ Other

EMAIL: ____

Emergency Contact & Phone #: ____

Primary Physician (Required): _______________________________ Phone #:__________________________________

HOW DID YOU HEAR ABOUT US?

REFERRED BY: Dr.____________________________________ City/State_________________________________

Internet (circle): Google / Facebook / Yahoo / __________ Other Patient

Newspaper (circle): Observer / Heritage Horn Phone Book

Running Store Physical Therapist Insurance

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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: M F

Street Address: _____________________________________ City/State: ______________________ ZIP Code: _______

Home Phone: ____________________ Cell Phone: ____________________ Social Security # ____________________

Birth Date: ______/______/________

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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: M F

Street Address: _____________________________________ City: ______________________ ZIP Code: ____________

Home Phone: ____________________ Cell Phone: ____________________ Social Security #: ____________________

Birth Date: ______/______/________

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.

Please read and initial that you acknowledge the following statements (1 – 4):

1. ________ ***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.

2. ________ 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.**

3. ________ 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.**

4. ________ **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.**

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.

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 $35 will be assessed for all returned checks.

The first time you are unable to call or make your scheduled appointment, there will **not** be a charge. However, subsequent missed appointments **without the minimum 24 hours' notice** will result in a **$50.00** charge that will not be billed to your insurance company and will be your responsibility. ***Patients will be charged a fee of $200.00 for any surgical No-Show or a cancellation not made at least 72 hours from the surgery time.***

Please note that three late cancellations or no-shows, in a rolling 12 month period, may result in your discharge from Prince William Foot & Ankle Center.

Any patient that is more than 15 minutes late for an appointment may have that appointment cancelled by our office in order to keep other patients on schedule.

Acknowledgment of Receipt of Notice of Privacy Practices (HIPAA)

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 ONLYMEDICARE ONLY** **Medicare Lifetime Signature on File** **MEDICARE ONLY**MEDICARE ONLY**

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: _____/_____/___________

Last Name: ______________________________First:______________________________ Date: ___/____/_______

Current Medications (please include dosages or provide a list): NONE____

____

Allergies (medications): O NONE O LATEX O PENICILLIN O SULFA O NSAIDS O CODEINE O IODINE DYE
Other: ____

Weight: ___________ lbs Height: _______ft ___________in Shoe Size:_________

Past and Current Medical History (please circle)

GI Problems: O NONE O Ulcers O Reflux O Hepatitis ___________________________________

Neurological: O NONE O Strokes O Seizures O Sciatica O CP O MS O Parkinson's
O Peripheral Neuropathy_____________________________________

Hematological: O NONE O Anemia O Lymphoma_______________________________________

Respiratory: O NONE O Lung Problems____

Muscle / Bones: O NONE O Arthritis O Rheumatoid Arthritis O Fractures O Sprains O Fibromyalgia
____

Skin: O NONE O Psoriasis O Melanoma O Athletes Feet O Warts___________________
____

Endocrine: O NONE O Type I Diabetes O Type II Diabetes O Hypothyroidism O Gout
____

Cardiovascular: O NONE O Hypertension O PVD O DVT O Card Disease O Claudication
O Aneurysm O Artery Block____________________________________

OB/GYN O NONE O Pregnant O Breastfeeding ____________________________________

OTHER Problems: ____

Surgical History: O NONE ____

____

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

Social History: Occupation ____

Tobacco Usage: O NONE O Previous: __pk/day O Current: __pk/day ___yrs

Alcohol Usage: O NONE O Occasional

Marital Status: O Single O Married O Minor O Divorced O Widowed # of Children_______

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

Describe your symptoms briefly: ____

____

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

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

Treatments: ____

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

____