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 #: _____Preferred Pharmacy:_____

Primary Physician (Required): _____ Phone #:_____

HOW DID YOU HEAR ABOUT US?

REFERRED BY: Dr._____ City/State_____

☐ Internet Search: Google / Yahoo ☐ Facebook / Yelp / ZocDoc ☐ Previous Patient
☐ Other Patient ☐ Phone Book ☐ Newspaper **(list)**: _____
☐ Running Store ☐ One Life Fitness ☐ Insurance

Please indicate who can call for and/or receive your medical information and sign below:

Name: _____ Patient Signature _____ Date ____/____/_____

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: _____/_____/_____

SECONDARY INSURANCE INFORMATION (ONLY IF MEDICARE IS THE PRIMARY):

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.

There is a **$50.00 fee** for missed appointments and cancellations of less than 24-hours. 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. This will be your responsibility and will not be charged to your insurance.

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 ONLY**MEDICARE 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: _____/_____/_____

☐**Male** ☐**Female** ☐**New Patient** ☐**Former Patient (L.S.** ____/____/____**)** ☐**ref by Dr.**_____

Last Name : _____ **First Name**:_____ **Date**: _____/_____/_____

Chief Complaint : _____

Footwear: @Home_____ @Work _____

Location (what area(s) of foot and ankle?): _____

Quality: (describe pain) ☐Dull ☐Ache ☐Sharp ☐Throbbing ☐Numb ☐Electric ☐Stiff _____

Severity: (0 – no pain, 10- the worst) A.M. ◯___ P.M. ◯___

Duration: (how long have you had this issue?) ☐_____ (1,2,etc)days ☐_____weeks ☐_____months ☐_____years

Timing: ☐Constant ☐Intermittent ☐Flare-Ups ☐Other: _____

Context: (what causes or aggravates the pain?)_____

Current and Prior Treatment:_____

Diagnostic Testing already done: ☐X-rays ☐MRI ☐Ultrasound ☐Vascular Testing ☐Nerve Testing

Other Related Pain: (Is the pain spreading into other body parts?) ☐Back ☐Legs ☐Knees ☐Hips ☐_____

MEDICATIONS: (dosages or provide a list) _____

ALLERGIES (medications only): **NONE**◯LATEX, ADHESIVE, PENICILLIN, SULFA, NSAIDS, CODEIN,E IODINE DYE _____

_____

Past and Current Medical History **Weight**: _____lbs **Height**:____ft____in **Shoe Size**:_____

GI Problems: ☐Ulcers ☐Reflux ☐Hepatitis ☐NSAID-related ☐Other_____

Neurological: ☐Strokes ☐Seizures ☐Sciatica ☐CP ☐MS ☐Parkinson's ☐Peripheral Neuropathy ☐Herniated Disc ☐Other_____

Hematological: ☐Anemia ☐Lymphoma ☐DVT ☐Other_____

Respiratory: ☐Lung Problems ☐Asthma ☐Emphysema ☐Other_____

Muscle/Bone: ☐Arthritis ☐Rheumatoid Arthritis ☐Fractures ☐Sprains ☐Fibromyalgia ☐Knee Pain ☐Back Pain ☐Hip Pain ☐_____

Skin: ☐Psoriasis ☐Melanoma ☐Athlete's Feet ☐Warts ☐Skin Cancer ☐Other_____

Endocrine: ☐Diabetes – Type◯I/II◯(HBA1C____) ☐Hypothyroidism ☐Gout ☐Other_____

Cardiovascular: ☐Hypertension ☐PVD ☐Cardiac ☐Disease ☐Claudication ☐Aneurysm ☐Artery Block ☐Leg Stent

OBGYN: ☐Pregnant ☐Breast-feeding ☐Hysterectomy ☐Fibroid removal ☐Ovary removal ☐Other _____

Surgical History: (including foot) _____

Family History: ☐Arthritis ☐Asthma ☐Cancer ☐Cardiac ☐Diabetes ☐Kidney ☐Liver ☐Bunions ☐Hammertoes ☐Ingrown Nail ☐Neuroma ☐Heel Spurs ☐Other_____

Social History: Occupation (please specify how many hours you stand, walk, and sit.)_____

Tobacco Usage: ☐NONE ☐Never ☐Previous_____pk/day ☐Current_____pk/day

Alcohol Usage: ☐NONE ☐Never ☐Rarely ☐Occasional (please select one): ☐_____drinks/day ☐_____drinks/week

Marital Status: ☐Minor ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed # of children_____