Chart #:
Office Use Only

Virginia Foot & Ankle Surgical Associates™

Reconstructive, Revisional, & Trauma Surgery

Patient Registration

Patient Information

Patient's Name *(Last, First, M.I.)*: | Date:

Home Street Address:

City: | State: | ZIP Code:

Home Phone #:( ) | Cell Phone #:( )

Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ | Number of Children:

Date of Birth: | Age: | SS#: | ☐ Male ☐ Female

Employer: | Occupation:

Business Street Address:

Business City: | State: | ZIP Code:

Business Phone #: ( ) | E-Mail Address:

Spouse's Name *(Last, First, M.I.)*: | Nickname:

Employer: | Occupation:

Business Street Address:

Business City: | State: | ZIP Code:

Business Phone #: ( ) | E-Mail Address:

If Patient is a Minor, Name of Parent or Guardian:

Emergency Contact Person:

Relationship to Patient: | Contact Phone #:( )

Health Insurance Information

Do you have health insurance: ☐ Yes ☐ No (If yes, please present your insurance card(s) and photo ID to the receptionist for copying.)

If patient is not the financially responsible party, please complete the section below.

Financially Responsible Party *(Last, First, M.I.)*: | SS#: _____

Street Address:

City: | State: | ZIP Code:

Home Phone #:( ) | Business Phone #:( )

Relationship to Patient: | Cell Phone #:( )

Primary Care Physician: | Business Phone #:( )

Street address:

City: | State: | ZIP Code:

Were you referred by a physician? ☐ Yes ☐ No If yes, by whom:

How did you learn of our practice: ☐ Friend ☐ Patient ☐ Relative ☐ Insurance Carrier ☐ Magazine ☐ Newspaper

☐ Internet ☐ Other _____

Did you find our web site helpful? ☐ Yes ☐ No ☐ Did not use | Suggestions:

Did you obtain these documents from our website? ☐ Yes ☐ No

Our office maintains compliance with the infection control standards mandated by the CDC and OSHA.

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Financial Policies and Consents

1. Insurance Assignment and Release Authorization

I, the undersigned, have health insurance coverage with ______________________________________ and assign directly to Virginia Foot & Ankle Surgical Associates all medical benefits. I authorize the use of this signature on all my insurance submissions. If any, otherwise payable to me for services rendered to me or my dependents. I hereby authorize the doctor and his staff to release all information necessary to secure the payment of benefits.

I understand that my insurance carrier may pay less than the actual bill for services or supplies. I agree to be financially responsible for all charges whether or not paid by insurance.

2. Coinsurance, Copayments, Deductibles, Noncovered Services, and Supplies

Copayments, noncovered services, and supplies are due at the time of service. All remaining balances are due upon receipt of invoice. Balances over 30 days are subject to a monthly service charge. Balances over 60 days from time of service are considered delinquent and will be turned over to an outside collection service. I understand that I am responsible for all deductibles, coinsurance, noncovered services, and supplies. In the event that my account becomes delinquent, I agree to pay all costs related to collection fees, court costs, and attorney fees.

I understand that my insurance carrier may exclude/disallow coverage for certain services, treatments, medications, appliances, orthotics, or other durable medical equipment that the physician may prescribe or recommend, and that I will be financially responsible for these noncovered charges, Furthermore, I understand that I cannot return such items for a refund because such items are considered single patient use.

3. Uninsured Patients

Payment in full is required at the time services are rendered and supplies dispensed.

4. Referral Authorization

Your insurance carrier may require a referral authorization from your primary care physician for our services. Please be aware that it is your responsibility to obtain all necessary referral authorizations prior to your visit. Contact your insurance carrier if you have any questions in regards to this issue.

5. General Consents

I voluntarily consent to medical and/or surgical treatment at Virginia Foot & Ankle Surgical Associates or affiliated facilities which may include examinations, diagnostic tests, photographs, x-rays, and treatments by the doctor and staff. I understand that the general nature, purpose, risks, and alternatives associated with a any procedure or treatment will be explained to me by the doctor, and in the case of other services, by healthcare staff. I understand that I will have an opportunity at that time to ask for more information and to ask questions. I further understand that medical care and treatment is not an exact science. No promises or guarantees have been made to me as to the results of examination or treatment.

I give permission for photography to be used in scientific publications, presentations, and office use. The identity of these photographs shall remain confidential.

I consent to testing for bloodbourne pathogens, in specific circumstances. Whenever any health care worker associated with or working for Virginia Foot & Ankle Associates is directly exposed to body fluids of a patient in a manner which, according to the guidelines of the Center for Disease Control, may transmit human immunodeficiency virus (HIV or SIDS) and/or Hepatitis B and C. In these circumstances, I understand that I will be deemed to consent to such appropriate testing. Virginia Foot & Ankle Surgical Associates will provide the results of these tests to the patient through his or her primary care physician and to the health care worker(s) who was/were exposed.

If there is a blood or body fluids exposure to me from a healthcare worker, or to a healthcare worker from me, I consent and understand that a blood sample may be drawn and tested for HIV(AIDS) and/or Hepatitis B and C for the protection of all concerned.

I certify that I have read and accept all of the above mentioned terms and conditions.

X____ Date:_________________________________

(Signature of patient/guardian)

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