Virginia Foot & Ankle Surgical Associates

Medicine • Trauma • Reconstructive 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 □Widowed □Divorced □Separated		Email Address:	
Date of Birth:	Age:	SS #: _____-_____- _____	□Male □Female
Employer:		Occupation:	
Business Street Address:			
Business City, State, Zip Code:			
Business Phone #:			
Spouse's Name (Last, First, M.I.):		DOB:	
Employer:		Occupation:	
Business Street Address:			
Business City, State, Zip Code:			
Business Phone #:		Email 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 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, MI.):			SS #: _____-_____- _____
Street Address:			
City, State, Zip Code:			
Home Phone #:		Business Phone #:	
Relationship to Patient:		Cell Phone #:	
Primary Care Physician:			
Street Address:			
City, State, Zip Code:		Business Phone #:	
Were you referred by a physician: □Yes □No If yes, by whom:			
How did you learn of our practice: □Friend □Patient □Relative □Newspaper □Magazine □Insurance Carrier			
□Internet □Other _			
Did you find our web site helpful: □Yes □No Did not use		Suggestions:	
Did you obtain these documents from our web site: □Yes □No			
Our office maintains compliance with the infection control standards mandated by the CDC and OSHA.			

Please turn to next page

Financial Policies, Consents and HIPPA Notifications

1. **Insurance Assignment and Release Authorization**
I, the undersigned, have health insurance coverage with (please enter name of your insurance) _____ 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.

2. **Coinsurance, Copayments, Deductibles, Noncovered Services and Supplies**
Copayments, noncovered services, and supplies are due at the same time of service. We accept Visa, MasterCard, American Express, and Discover, checks or cash. If you are unable to pay your copayment at the time of your appointment, there will be a $15.00 processing fee. All remaining balances are due upon receipt invoice. Balances over 30 days are subject to a monthly service charge. Balances over 60 days from the time of service are considered delinquent and will be turned over to an outside collections service. I understand that I am responsible for all deductibles, coinsurance, noncovered services, and supplies. In the event that my account balances becomes delinquent, I agree to pay all costs related to collection including collection fees, court costs, and attorney fees.

I understand that my insurance carrier may exclude/disallow coverage for certain services, treatment, medication, 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 only.

Our office charges $25.00 for all forms completed by our staff. There will be a 5-7 day turnaround time for the completion of these forms.

3. **Uninsured Patients**
Payment in full is required at the time services are rendered and supplies dispensed. Please ask our staff about the Care Credit Program offered by VFASA.

4. **Referral Authorization**
Your insurance carrier may require 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 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 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 examinations or treatment.

6. **Checks**
Checks presented for insufficient funds are subject to a $50.00 processing fee per check.

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

I consent to testing for blood borne pathogens, in specific circumstances. Whenever any health care worker associated with or working for Virginia Foot & Ankle Surgical Associates is directly exposed to body fluids of a patient manner which, according to the guidelines of the Center for Disease Control, may transmit human immunodeficiency virus (HIV or AIDS) 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 fluid 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 authorize Virginia Foot & Ankle Surgical Associates, PC to release my health information to physicians and facilities participating in my health care for continuity of care.

7. **Appointment Cancellations**
Please give our office a 24 hour notice if your appointment needs to be cancelled or rescheduled to avoid a $50.00 no-show fee.

8. **HIPPA Practice Requirements – Effective 4/15/03**
   a. The Practice: Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
   b. Is required to abide by the terms of this Privacy Note.
   c. Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
   d. Will not retaliate against you for filing a complaint.

By subscribing my name below, I acknowledge my understanding and agreement of all above terms and conditions.

Patient/Guarantor Signature_____ Patient Name_____ Date _____