Virginia Foot & Ankle Surgical Associates

*Medicine • Trauma • Reconstructive Surgery*

# MEDICAL HISTORY

## Reason for Today's Visit

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

Please describe current problem:

Which lower extremity: ☐Left ☐Right | How long has this problem troubled you:

Have you undergone previous treatment for this problem: ☐Yes ☐No If yes, please describe:

Is your problem a result of injury: ☐Yes ☐No If yes, date of injury: | Did injury occur while at work: ☐Yes ☐No

## Medications (prescription and nonprescription medications)

| Medication Name | Dosage | Frequency | Medication Name | Dosage | Frequency |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## Allergies

Please indicate: ☐No known allergies ☐Yes, please list below (medication, food, materials etc.)

| | |
|---|---|
| | |
| | |
| | |
| | |

## Medical History (please check all that apply)

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Arthritis/Bone-Joint Problems | ☐ | ☐ | Eye Problems | ☐ | ☐ |
| Anemia | ☐ | ☐ | Gout | ☐ | ☐ |
| Asthma/Breathing/Lung Problems | ☐ | ☐ | Gynecological Problems (Females) | ☐ | ☐ |
| Back Problems | ☐ | ☐ | Head and Neck Problems | ☐ | ☐ |
| Bleeding Problems | ☐ | ☐ | Heart Attack Date _____ | ☐ | ☐ |
| Blood or Blood Product Transfusion | ☐ | ☐ | Hepatitis/Jaundice/Liver Disease | ☐ | ☐ |
| Blood Clots | ☐ | ☐ | High Blood Pressure | ☐ | ☐ |
| Cancer | ☐ | ☐ | High Cholesterol | ☐ | ☐ |
| Chemotherapy | ☐ | ☐ | Injury/Trauma Kidney Problems | ☐ | ☐ |
| Chest Pain/Heart Problems | ☐ | ☐ | Kidney Dialysis (Circle Days) M T W T F S S | ☐ | ☐ |
| Circulatory Problems | ☐ | ☐ | Lower Extremity Wounds | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Lyme Disease | ☐ | ☐ |
| Dropfoot | ☐ | ☐ | Neuromuscular Disease | ☐ | ☐ |
| Ear/Nose/Throat Problems | ☐ | ☐ | | | |

## Medical History (Please check all that apply)

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Numbness or Weakness | ☐ | ☐ | Seizures/Epilepsy | ☐ | ☐ |
| Other Serious Illnesses | ☐ | ☐ | Sickle Cell Disease or Trait | ☐ | ☐ |
| Pacemaker | ☐ | ☐ | Skin Problems | ☐ | ☐ |
| Polio | ☐ | ☐ | Stroke Date: _____ | ☐ | ☐ |
| Positive Culture for MRSA/VRE | ☐ | ☐ | Stomach/Intestinal Problems/Ulcers | ☐ | ☐ |
| Positive Test for HIV | ☐ | ☐ | Tetanus Immunization Date:_____ | ☐ | ☐ |
| Previous Diabetic Foot Wounds | ☐ | ☐ | Thyroid Problems | ☐ | ☐ |
| Prostate Problems (Males) | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Psychiatric/Emotional Disorder | ☐ | ☐ | Urinary Tract Problems | ☐ | ☐ |
| Recent Weight Gain/Loss | ☐ | ☐ | Venereal Disease | ☐ | ☐ |

## Family History

Father: Living ☐ Deceased ☐ Mother: Living ☐ Deceased ☐ Siblings: indicate # of siblings _____

Does or did anyone in your immediate family have any of the previously mentioned medical problems: ☐Yes ☐No

If yes, please describe:

## Surgical History

Previous foot or ankle surgery: ☐Yes ☐No If yes, please describe: ☐Right ☐Left

Previous surgery other than foot or ankle: ☐Yes ☐No If yes, please describe:

Have you ever had any anesthetic agents: ☐Yes ☐No If yes, please indicate: ☐ General ☐ Spinal ☐ Epidural

☐ Sedation ☐ Local ☐ Regional | Please describe any complications:

Do you have any internal metal, vascular or other implants (pins, grafts, screws, plates, clips, joints, etc.): ☐Yes ☐No

If yes, please describe:

## Personal History

Do you smoke: ☐Yes ☐No If yes, how much:

Do you drink alcohol: ☐Yes ☐No If yes, how often:

Are you pregnant or breast feeding (females): ☐Yes ☐No If no, are you trying to become pregnant: ☐Yes ☐No

Do you participate in physical fitness activities: ☐Yes ☐No If yes, please describe:

Are you: ☐Right handed ☐Left handed ☐Both | Weight: _____ | Height: _____

Do you use: ☐ Cane ☐ Walker ☐ Brace ☐ Crutches ☐ Wheelchair ☐ Prosthesis

Shoe size:_____ Shoe width:_____ What type of shoes do you wear: _____

If there is additional information that you think the doctor should know, please describe below.

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# 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 a minimum of $35.00 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 _____

## PRACTICE REQUIREMENTS

a. Is required by federal law to maintain the privacy of your Protected Health Information (PHI) and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

b. Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.

c. Is required to abide by the terms of this Privacy Notice.

d. Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all your PHI that it maintains.

e. Will distribute any revised Privacy Notice to you prior to implementation.

f. Will not retaliate against you for filling a complaint.

## EFFECTIVE DATE/PATIENT ACKNOWLEDGMENT

This Notice is in effect as of today.

By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

_____ _____

Patient Name Patient Signature

_____

Date

## Medical Information Release Form

Name: _____ Date of Birth: _____/____/_____

### Release of Information

☐ I authorize the release of information including the diagnosis, records, medication; examination rendered to me and claims information. This information may be released to:

☐ Spouse_____ Phone#_____

☐ Child(ren)_____ Phone#_____

☐ Other_____ Phone#_____

☐ Information is not to be released to:

_____

_____

☐ Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____

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## PATIENT REQUEST FOR MEDICAL RECORDS OR OTHER PROTECTED HEALTH INFORMATION (PHI) TO BE RELEASED TO OUR OFFICE

To: _____ Fax: _____
(Name of facility/physician to release the information)

Patient Name: _____ Pt #: _____
Address: _____ Date of Birth: _____
City/State/Zip: _____ Home Phone: _____
Work Phone: _____

**I hereby request that a copy of my medical records or other recorded Protected Health Information (PHI) as designated below be released to Virginia Foot & Ankle Surgical Associates.**

☐ Office Notes
☐ X-rays
☐ Diagnostic Test Results
☐ Other _____

**My requested mode of delivery of this documentation is**:

☐ Fax to (434) 977-8083
☐ I will pick up the documentation

_____ _____
Signature of Patient of Legal Representative Date

**This information was faxed to the above facility by**:

_____ VFASA _____
Staff Member Date

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## WELCOME

The staff and surgeons at Virginia Foot & Ankle Surgical Associates would like to cordially welcome you to our practice. Our practice has been providing foot and ankle care to the residents of the central Virginia are since 1994. Since our beginning we have developed a reputation for providing high quality compassionate care to our patients. We value your decision when choosing our practice to manager your foot and ankle problems.

It is our mission to provide a relaxed environment and caring staff to help meet your medical needs. Your first visit to our office stablishes a vital foundation to our relationship. During your first visit, we make sure to obtain important information, such as a detailed account of your current complaint and medical history. We encourage you to bring a list of all the questions that you would like to discuss with your doctor.

***Thank you for allowing us to participate in your healthcare we look forward to seeing you.***

## VFASA OF CHARLOTTESVILLE

103 South Pantops Dr. Suite #201, Charlottesville, VA 22911
(434) 977-8040

From Madison or the Ruckersville area

Take 29 South to Hydraulic Road. Left on Hydraulic Road.
Follow Hydraulic Road to 250 bypass. Left on 250 bypass.
Follow 250/East Richmond Road, you will go past McIntire Road & past the exit for Park Street and over Free Bridge.
At the next traffic light turn Right onto Riverbend Drive at the Express Carwash.
At the next traffic light turn Left onto South Pantops Drive (Food Lion Shopping Center will be on Right.)
Take first Left on Spotnap Road (this will be second turn on left but first named road.)
Once, on Spotnap, take the first Left into a parking lot. You will then see our building, the door is Suite #201 slightly in front of you to the left.

From the Shadwell exit on 64

Take 250 Bypass heading west. You will pass Peter Jefferson Parkway on your left. Continue until you come to a large intersection near the bottom of the hill just before the bridge.
Turn Left onto Riverbend Drive at the Express Carwash.
At the next traffic light turn Left onto South Pantops Drive (Food Lion Shopping Center will be on Right.)
Take first Left on Spotnap Road (this will be the second turn on left but first named road.)
Once on Spotnap, take the first Left into parking lot. You will then see our building, the door is **Suite #201** slightly in front of you to the left.