



PATIENT REGISTRATION

Patient Information			
Patient's Name (Last, First, M.I.):			Date:
Home Address:		City, State, Zip:	
Home Phone:	Cell:	Business Phone:	
Email:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated		
Date of Birth:	Age:	SS #:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Employer:		Occupation:	
Spouse's Name (Last, First, M.I.):		Spouse's Date of Birth:	
Spouse's Email:		Spouse's Occupation:	
Spouse's Employer:		Spouse's Cell:	
If Patient is a Minor, Name of Parent or Guardian		Relationship to Patient	
Emergency Contact Person:		Contact Phone #:	
Health Insurance Information			
Do you have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please present insurance card(s) and photo ID to the receptionist for scanning.			
If the 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:	
Relationship to Patient:	Home Phone:	Cell:	
Insurance Subscriber's Name (Last, First, M.I.):		Date of Birth:	
Street Address:		City, State, Zip:	
Relationship to Patient:	Home Phone:	Cell:	
I assign directly to Virginia Foot & Ankle Surgical Associates all medical benefits. I authorize the use of my signature on all my insurance submissions. I hereby authorize the doctor and his staff to release all the information necessary to secure the payment of benefits.			
Primary Care Physician's Name:		Business Phone #:	
Were you referred by a Physician <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of physician:			
Medical Information Release			
I authorize the release of information including the diagnosis, records, medication; examination rendered to me and claims information.			
This information may be released to: <input type="checkbox"/> Spouse		Phone #	
<input type="checkbox"/> Children		Phone #	
<input type="checkbox"/> Other		Phone #	
<input type="checkbox"/> Information is not to be released to anyone.			
<input type="checkbox"/> Information is not to be released to:			
<input type="checkbox"/> Physicians and facilities participating in my health care for continuity of care.			
Social Drivers of Health			
Do you have trouble paying for your utilities? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you have trouble finding or paying for a ride? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you feel safe in your daily life? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you skip meals because you do not have money for food? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you homeless or worried that you could be soon? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you have enough money for your medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Patient/Guarantor Signature		Patient Name	Date

1. COINSURANCE, COPAYMENTS, DEDUCTIBLE, NONCOVERED SERVICES AND SUPPLIES

Copayments, noncovered services, and supplies are due at the time of service. We accept Visa, MasterCard, American Express, and Discover, checks or cash. Invoices are due upon receipt. 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 collection service or collection attorney. I understand that I am responsible for all deductibles, coinsurance, non-covered services and supplies. If my account balance 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, 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. The turnaround time for completion is 5-7 days.

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

2. UNINSURED PATIENTS

Payment in full is required at the time services are rendered and supplies dispensed. 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 collection service or collection attorney. If my account balance becomes delinquent, I agree to pay all costs related to collection fees, court costs, and attorney fees.

3. REFFERAL AUTHORIZATION

Your insurance carrier may require authorization from your primary care physician for our services. It is your responsibility to obtain all necessary referral authorizations prior to your visit. Contact your insurance company if you have questions.

4. PRACTICE REQUIREMENTS

- a. It 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 you 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 filing a complaint.

5. GENERAL CONSENT

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 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.

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 heath care worker associated with or working for Virginia Foot & Ankle is directly exposed to blood or body fluids of a patient, or if there is exposure to me in a way, 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 and understand that a blood sample may be drawn and tested for HIV or AIDS and/or Hepatitis B and C for the protection of all concerned. 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.

6. APPOINTMENT CANCELLATION

Please give our office 24-hour notice if your appointment needs to be cancelled or rescheduled to avoid a \$50.00 fee.

PATIENT/GUARANTOR

PATIENT NAME _____ **SIGNATURE** _____ **DATE** _____