THE ANKLE & FOOT CLINIC
OF NORTHERN VIRGINIA, PLLC

Welcome to our office!

This form will become a part of your medical record.
Please fill out as accurately as possible

Patient Information

Name: _____ DOB: ____/____/____
First Last M.I. MM/DD/YYY

Address: _____

Phone: _____ ☐ Mobile ☐ Home

Email: _____ Occupation: _____ ☐ Retired

Gender at birth: ☐ Male / Female ☐ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Primary Care Doctor: _____ Date of last visit: _____

Current Medications ☐ None

Please list all prescription, over the counter, supplements, with dosing:

_____
_____
_____
_____
_____

Allergies ☐ None

Please list any medication allergies with reaction:

_____
_____
_____

☐ Adhesive/tape ☐ Local anesthetic ☐ Egg
☐ Sulfa ☐ Sea Food ☐ Iodine ☐ Latex

Medical History (check all that apply) ☐ None

☐ Diabetes (Type 1 / Type 2) ☐ Heart Disease / Heart Attack ☐ High Blood Pressure ☐ Neuropathy
☐ High Cholesterol ☐ Blood Clots /DVT ☐ Peripheral Vascular Disease ☐ Arthritis ☐ Thyroid Disease
Other: _____

Social History

Tobacco: ☐ Former – year quit _____ ☐ Current - packs per day _____ ☐ Never
Alcohol: ☐ Yes ☐ No
Exercise? ☐ No ☐ Yes – activity type: _____
Who lives with you? _____

Surgical History ☐ None

Please list any previous operations and year of surgery:

_____
_____
_____
_____
_____

Family History ☐ None

Diabetes	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Heart disease	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
High Blood Pressure	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Bleeding Disorder	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Blood Clot/DVT	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Stroke	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent

Other _____

Preferred Pharmacy: _____
Address (or road): _____
Phone #: _____

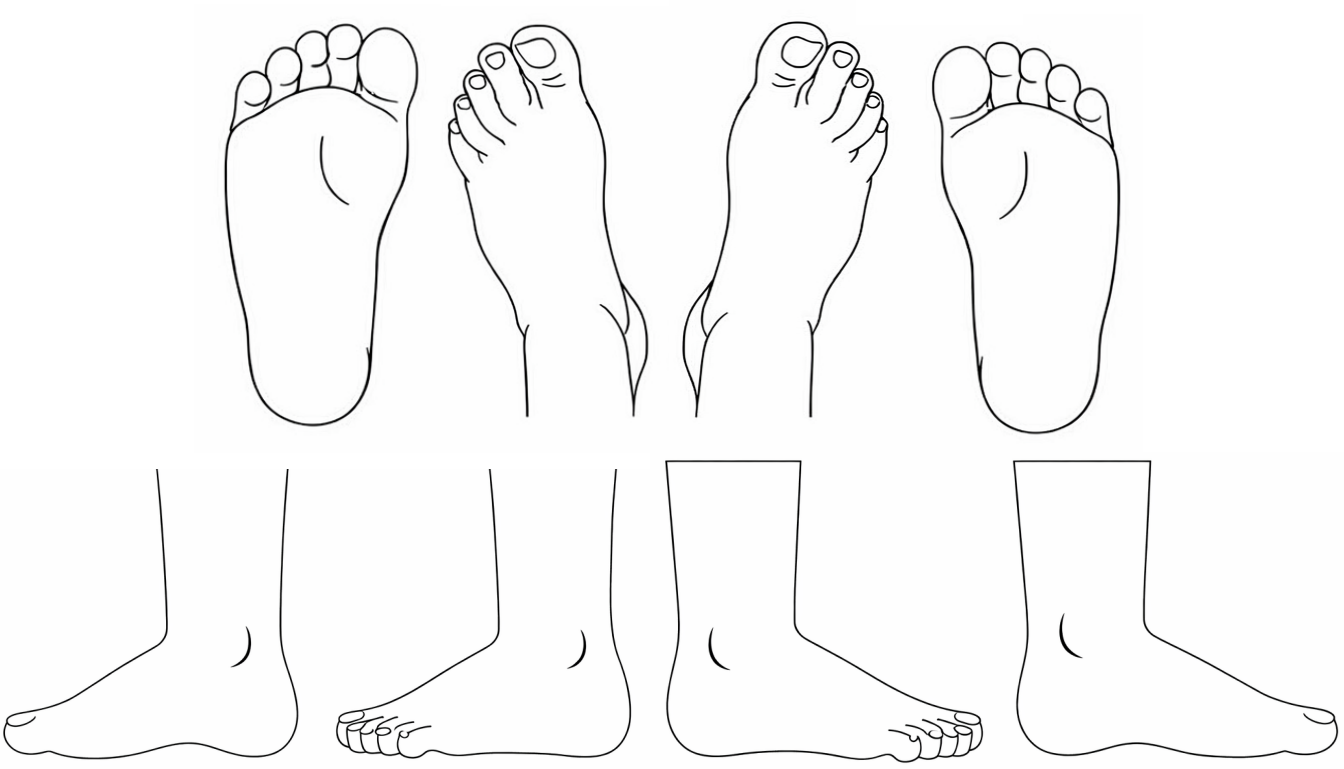
Emergency Contact: _____
Relationship: _____
Phone #: _____

Lower Extremity Medical History

Reason for visit today: _____

_____

Left Right



Location: ☐ Right ☐ Left ☐ Both

When did this problem start? _____

Pain type:
☐ Sharp ☐ Dull ☐ Burning ☐ Tingling ☐ Throbbing ☐ Shooting ☐ Other: _____

Severity: ☐ Mild ☐ Moderate ☐ Severe

Associated: ☐ Swelling ☐ Bruising ☐ Redness ☐ Skin temperature change

Since it started it has gotten: ☐ Better ☐ Worse ☐ Stayed the same

Injury/Trauma? _____ Date: _____

Prior treatment: _____

Seen by another provider? ☐ No ☐ Yes: Please explain _____

THE ANKLE & FOOT CLINIC
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Welcome to The Ankle and Foot Clinic of Northern Virginia, PLLC. We are excited about your decision to visit our practice. Our goal is to provide you with comprehensive medical care and quality services. Please carefully review the following policies: a copy can be provided at your request.

Office Policies and Procedures

Appointments:

- Cancellations/No Shows: We require **24 hours advanced notice** if you need to cancel or reschedule an appointment. Failure to contact us may result in a **$50.00 fee**. No further services will be rendered until this fee is paid. Also, we reserve the right to terminate the doctor/patient relationship after two missed appointments, without notifying us within 24 hours.
- Late arrivals: Patients **more than 10 minutes late may need to reschedule**, unless we have an available opening.

Health Insurance:

- All patients are required to bring a valid insurance card and identification to every visit. If insurance information is not provided at the time of service, you will be responsible for all charges as an out-of-pocket expense.
- Your insurance policy is a contract that exists between **you and your insurance company**. Our relationship is with you, the patient, and not the insurance company. If you have specific questions about your policy, please call the phone number provided on the back of your insurance card. It is your responsibility to know your insurance benefits.
- We bill all participating insurance companies (including secondary insurance) as a courtesy to you; however, if your insurance denies payment of a claim, you will be responsible for all charges. By signing below, you agree to allow The Ankle and Foot Clinic of Northern Virginia, PLLC to submit insurance claims on your behalf. Also, you also agree to authorize the release of pertinent medical information to your insurance companies so that proper reimbursement can be made directly to The Ankle and Foot Clinic of Northern Virginia, PLLC.
- Some services you receive may be considered non-covered or not medically necessary by your health insurance plan. This is dictated by your health insurance policy. You will be financially responsible for these charges. This includes routine foot care services such as nail and/or callus care, unless there is a medically qualifying diagnosis as indicated by your insurance policy.
- We will submit your claims and assist in any way we can to help get claims paid. At times however, your insurance may require additional information from the patient and/or the subscriber. Failure to provide additional information may result in the outstanding balance becoming your personal responsibility.

Payments

- **All co-payments, deductibles, and co-insurance payments are due at the time of your visit.** Payment for non-covered services is also due at the time of visit.
- Outstanding balances will be collected prior to rendering of additional services.
- Patient balances **must be paid within fourteen days** of your statement date. A **$10.00 surcharge** will be added to your account if additional statements must be sent. Account balances over **60 days** will be sent to our collection agency and will be subject to a monthly finance charge. In addition, if legal action is taken and we win a judgment, you agree to reimburse all cost and expenses for attorney fees incurred in collecting any amounts past due.

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- If a check is returned on your account, you will be responsible for a $50.00 returned check fee in addition to the original fees for service.
- In the event of an overpayment, the credit may be applied towards future visits, or the credit will be refunded to the patient. Refund checks will be mailed to the address we have on file; please update our office if your address changes. If you misplace your refund check, a new check can be reissued with a fee of $30 for stopping payment of the original check.

Forms & Records:

Typically, we do not charge for completing brief forms. However, for complex or lengthy forms, or multiple signed copies of the same form, there will be a fee of $25. Some complex forms may involve an office visit to ensure that the information provided on the form is correct.

- We require up to 5 business days for completion of any requested forms.

Medication Refill Requests:

- Please allow 1-2 business days for a response on all refill requests. Please plan ahead if a refill is required near the weekend and note all requests are required to be made by Thursday at 4:30 pm.

Referrals:

- Often, our office does not require a referral, though **if your insurance plan requires a referral from your primary care doctor, it will be required prior to your appointment.** Without a referral, you might be subject to out-of-pocket expenses due to non-coverage by your insurance company.

Returns:

- All non-custom durable medical equipment items or other items dispensed in office may be returned to the office within 7 days, if items have not been used.
- Unused over the counter items may be returned if unopened and in original packaging within 7 days.

By signing here, I acknowledge I have read, fully understand, accept, and agree to comply with the office and financial policies of The Ankle and Foot Clinic of Northern Virginia, PLLC. I understand that I can request a copy of these policies at any time. You also permit a copy of this to be used in place of the original. This authorization form will expire 3 years from date of signature.

_____ _____

Signature of Patient (Parent/Guardian if patient is a minor or unable to sign) Date

_____

Printed Name

THE ANKLE & FOOT CLINIC
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HIPAA Acknowledgement of receipt of Notice of Privacy Practices

I have been offered a copy of the Notice of Privacy Practices for The Ankle and Foot Clinic of Northern Virginia, PLLC. Be advised that we will not sell or solicit your name unless authorized.

_____ _____
Signature of Patient (Parent/Guardian if patient is a minor or unable to sign) Date

During the duration of my care, I give permission for my medical information to be released to:

_____ _____ _____
Name Relationship Phone

Email Communication Consent

I have been offered a copy of the email communication information from The Ankle and Foot Clinic of Northern Virginia, PLLC.

I acknowledge that I have read and fully understand the email communication information. I understand the inherent risks associated with the communication of health information via unencrypted email between the office and me, and consent to receive such communications despite those risks **as well as any other instructions that the office may impose to communicate with patients by email. Any questions I may have had were answered. I understand that this consent is valid until I revoke the consent as outlined above.** By signing, you agree to hold The Ankle and Foot Clinic of Northern Virginia harmless for unauthorized use, disclosure, or access of your protected health information sent to the email address you provide.

Email Address: _____

Phone Messages

Excluding our reminder calls, may we leave messages regarding medical information on your answering machine? ☐ Yes ☐ No

Acknowledgement and Consent of Voice Recording

Please be advised that our office uses HIPAA compliant voice recording and artificial intelligence (A.I.) during your visit as a part of our clinical practice to assist with the generation of your medical record. This voice recording and A.I. adheres to the Health Insurance Portability and Accountability Act (HIPAA) guidelines to ensure your data is secured and protected. Your voice recording data is stored for a maximum of 30 days. Only the healthcare professionals involved in your care will have access. Due to the integration of this technology within our office, without your consent we will not be able to provide medical care. By signing here, I acknowledge and consent to voice recording and use of A.I. during my clinical encounters. This consent is valid unless revoked in writing.

_____ _____
Signature of Patient (Parent/Guardian if patient is a minor or unable to sign) Date

_____
Printed Name