

# **FOX MILL FOOT AND ANKLE CENTER, PLC**

**1860 Town Center Drive**

**Suite 220**

**Reston, VA 20190**

**Tel (703) 391-0211 Fax (703) 264-3983**

**<http://www.footdoctorva.com>**

**NEW PATIENT FORMS**

# **Fox Mill Foot & Ankle Center, PLC**

## **PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ Nickname (if used): \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_

Home Address: \_\_\_\_\_  
(Street) (City) (State, Zip Code)

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Marital Status: (Single) (Married) (Divorced) (Separated) Gender: (Male) (Female) Date of Birth: \_\_\_\_\_  
(Circle One Please) (Circle One Please) (Month/Day/Year)

Referred by: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
(Street) (City) (State, Zip Code)

Emergency Contact: \_\_\_\_\_  
(Name) (Relationship) (Phone)

Spouse's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_  
(Month/Day/Year)

Spouse's Employer: \_\_\_\_\_ Spouse's Work Phone: \_\_\_\_\_

Spouse's Employer Address: \_\_\_\_\_  
(Street) (City) (State, Zip Code)

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## **INSURANCE INFORMATION**

Primary Insurance: \_\_\_\_\_ Group No.: \_\_\_\_\_

Member ID No.: \_\_\_\_\_ Insurance Phone: \_\_\_\_\_

Insurance Address: \_\_\_\_\_  
(Street) (City) (State, Zip Code)

Name of Policyholder: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Policyholder Address: \_\_\_\_\_  
(Street) (City) (State, Zip Code)

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
(Pediatrician, If Minor)

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## **SECONDARY INSURANCE INFORMATION**

Primary Insurance: \_\_\_\_\_ Group No.: \_\_\_\_\_

Member ID No.: \_\_\_\_\_ Insurance Phone: \_\_\_\_\_

Insurance Address: \_\_\_\_\_  
(Street) (City) (State, Zip Code)

Name of Policyholder: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Policyholder Address: \_\_\_\_\_  
(Street) (City) (State, Zip Code)

**CHIEF CONCERN/PRESENT ILLNESS:**

What is your present foot problem? \_\_\_\_\_

How long have you been bothered by the above? \_\_\_\_\_

What have you done for your foot problem? \_\_\_\_\_

**PAST MEDICAL HISTORY:**

Family doctor's name \_\_\_\_\_

Doctor's Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you now or have you been under a physician's care during the past two years? (circle one) Yes No

Date of last complete physical exam: \_\_\_\_\_

Are you presently taking any medicine? (circle one) Yes No If yes, what? \_\_\_\_\_

Circle if you now have or were treated for (circle all that apply):

- |                         |                   |                     |                       |
|-------------------------|-------------------|---------------------|-----------------------|
| AIDS/ARC                | Bleeding tendency | Heart Disease       | Mitral Valve Prolapse |
| Allergies               | Cancer            | Heart Murmur        | Nervous Condition     |
| Anemia                  | Diabetes          | Hepatitis           | Rheumatic Fever       |
| Anesthesia Problems     | Epilepsy          | High Blood Pressure | Tuberculosis          |
| Arthritis               | Glaucoma          | Kidney Disease      | Ulcers                |
| Asthma                  | Gout              | Liver Trouble       |                       |
| Previous foot condition | Other _____       |                     |                       |

Have you ever experienced any unusual or allergic reactions to any medications (i.e., novacaine, penicillin, etc.)? (circle one) Yes No If yes, which one(s)? \_\_\_\_\_

Do you smoke? (circle one) Yes No

Have you had surgery? (circle one) Yes No

TYPE OF SURGERY	YEAR
_____	_____
_____	_____

**FAMILY HISTORY**

Circle if any blood relatives have had

- Arthritis   Cancer   Diabetes   Heart Disease   High Blood Pressure   Kidney Disease   Overweight

Foot problems similar to yours

Is there any other general or foot health information that should be known? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**THANK YOU FOR YOUR COOPERATION**

## **Financial Policy For Fox Mill Foot & Ankle Center, PLC**

- If our practice does not participate with or accept assignment from your health insurance company/carrier, payment in full will be due at time of service unless prior arrangements have been made.
- Office visit co-payments for our participating HMO/PPO insurances are due at the time of service. If we have to generate a billing statement to collect your co-payment there will be a minimum billing fee of \$5.00 added for the administrative costs of billing.
- If we participate with your primary health insurance or accept assignment, we will be happy to file a claim on your behalf. We allow 60 days for the balance to be paid by your insurance carrier. If the insurance carrier does not remit payment within 60 days, the balance will be due in full from you. If any payment is subsequently made by your insurance carrier in excess of the balance, we will refund the overpayment to you, providing, you do not have any outstanding accounts with our office.
- HMO/PPO claim denials due to no referral or authorization are the patient's responsibility. Office staff will notify and assist you in referral/pre-certification procedures, but final responsibility lies with the patient to comply with their specific insurance's requirements. All referrals must be presented to our business office before seeing the doctor.
- If we participate with your insurance or accept assignment, please present your insurance card each time you visit our office to insure proper information is on file. Otherwise, your visit may not be covered and you will be responsible for payment.
- There is a \$25.00 charge for all returned checks.
- All unpaid balances are subject to 1.5% interest per month (18% per annum A.P.R.) after 90 days.
- Please be on time for your appointment. If you need to reschedule your appointment, we request a minimum of 24 hours notice. If you miss a scheduled appointment without notifying our office a **\$25.00** charge may be added to your account.
- If your account must be forwarded to a collection service and/or an attorney because of non-payment, you will be responsible for all collection fees and/or attorney fees charged by these services.

### **ASSIGNMENT OF BENEFITS**

I, the undersigned, certify that I (or my dependent) have coverage with \_\_\_\_\_ and assign directly to **Fox Mill Foot & Ankle Center, PLC** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize **RELEASE OF MEDICAL INFORMATION TO MY INSURANCE CARRIER OR PHYSICIAN** to provide continuity of care. I authorize the use of my signature on all insurance submissions. By my signature I acknowledge review of this policy and hereby agree to its terms.

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

# FOX MILL FOOT AND ANKLE CENTER, PLC

## SUMMARY OF NOTICE OF PRIVACY PRACTICES

### A detailed Notice of our office Privacy Practices is available upon request.

The following summary outlines how our office will protect your health information, your rights as a patient and our common practices in dealing with your health information.

**Uses and Disclosures of Health Information.** We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

**Uses and Disclosures Based on Your Authorization.** Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

**Uses and Disclosures Not Requiring Your Authorization.** In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;

- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

**Patient Rights.** As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please submit your concerns in writing to:

**Dr. Seth Rubenstein**  
**1860 Town Center Drive, Suite 220**  
**Reston VA 20190.**  
**Telephone No. (703) 391- 0211.**

**FOX MILL FOOT AND ANKLE CENTER, PLC**  
1860 Town Center Drive  
Suite 220  
Reston, VA 20190

**ACKNOWLEDGMENT OF RECEIPT**

**OF**

**NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Authorized Representative (if applicable)

\_\_\_\_\_  
Signature