District Foot and Ankle | 4875 Eisenhower Ave #230 | Alexandria, VA 22304
Office Phone: (703) 832-9013 | Fax: (877) 843-1707 | www.districtfootankle.com

Chart No:_____

PATIENT REGISTRATION

FIRST NAME _____ LAST NAME_____

DATE OF BIRTH _____ Male | Female AGE: _____

□ Single □ Married □ Divorced □ Separated □ Widowed □ Partner □ Minor

ADDRESS_____

EMPLOYER _____OCCUPATION _____

HOME # _____ CELL # _____ WORK # _____

EMAIL _____ APPOINTMENT REMINDERS BY □ Email □ Phone □ Text

EMERGENCY CONTACT _____ EMERGENCY CONTACT #: _____

RELATIONSHIP _____ ADDRESS_____

RESPONSIBLE FOR PATIENT ACCOUNT (put n/a if same as above)

FIRST NAME _____ LAST NAME_____

ADDRESS_____

CELL # _____ HOME # _____ WORK # _____

INSURANCE: PRIMARY CARRIER INFORMATION

INSURED FIRST NAME _____ INSURED LAST NAME _____

INSURANCE CARRIER _____ SS#_____

POLICY # _____ GROUP # _____

EFFECTIVE DATE _____ PLAN □ HMO □ PPO □ OTHER

DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE CARRIER INFORMATION

INSURED FIRST NAME _____ INSURED LAST NAME _____

INSURANCE CARRIER _____ SS#_____

POLICY # _____ GROUP # _____

EFFECTIVE DATE _____ PLAN □ HMO □ PPO □ OTHER

DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

VISIT INFORMATION

WHO CAN WE THANK FOR YOUR REFERRAL? □ PHYSICIAN □ FRIEND □ OTHER □ INTERNET □ SOCIAL MEDIA
HOW DID YOU HEAR ABOUT US? _____

PRIMARY CARE PHYSICIAN & DATE OF LAST VISIT _____ PHONE _____

PHARMACY NAME: _____ PHARMACY PHONE #: _____

ARE YOU PREGNANT? □ YES □ NO ____NO. OF MONTHS IS THERE A CHANCE YOU ARE PREGNANT? □ YES □ NO

CHIEF COMPLAINT _____

REVIEW OF SYSTEMS

(Check the following symptoms if applicable)

CONSTITUTIONAL	○Chills ○Weakness	○Fever	○Weight Gain	○Weight Loss
CARDIOVASCULAR	○Chest Pain ○Heart Murmur ○Palpitations	○Cool Extremities ○Heart Valve ○Rheumatic Fever	○Cramps in Legs/Feet ○High Blood Pressure ○Varicose Veins	○Hair Loss on Legs ○Leg/Foot Ulcers ○Vascular Grafts
MUSCULOSKELETAL	○Ankle Sprain ○Broken Ankle ○Corns ○Childhood Foot Problems ○In-Toeing ○Knee Pain ○Neuroma	○Arch Pain ○Broken Foot Bone ○Flat Feet ○Gait (Walking) ○Problems ○Joint Implants ○Lower Back Pain ○Orthotic or Shoe Insert Use	○Arthritis ○Bunions ○Gout ○Hammer or Mallet Toes ○Joint Pain ○Muscle Cramps ○Paralysis	○Back Problems ○Calluses ○Heel Pain ○High Arch Feet ○Joint Stiffness ○Muscle Stiffness ○Weakness ○Toe Walking
DERMATOLOGICAL	○Athlete's Foot ○Hives ○Mole Changes	○Dryness ○Ingrown Nails ○Rash	○Eczema ○Itching ○Scars	○Fungal Nails ○Lumps ○Warts
NEUROLOGICAL	○Blackouts ○Neuromas ○Stroke	○Burning ○Numbness ○Tingling	○Charcot ○Neuroarthropathy ○Tremors	○Fainting ○Speech Problems ○Unsteady Gait (Walking)
ENDOCRINE	○Fatigue ○Weight Loss	○Goiter ○Weight Gain	○Thirst	○Thyroid
HEMATOLOGIC	○Anemia	○Bleed Easily	○Blood Clots	○Easy Bruisability

ALLERGIES: (Please also note any reactions if exposed)

_____

_____

_____

MEDICATION HISTORY: (Please include dosages)

_____

_____

_____

Please check if you consent to request previous prescription history from the pharmacy database. □ **Yes** □**No**

MEDICAL HISTORY

Anemia	Anxiety	Arthritis	Asthma
BPH	Back Problem	Breast Cancer	CAD
Congestive Heart Failure	Chronic Obstructive Pulmonary Disease	Cancer	High Cholesterol
Dementia	Depression	Dermatitis	Diabetes
Epilepsy	GERD	Glaucoma	Gout
HIV	Headache	Hepatitis	Hypertension
Myocardial Infarction	Migraine	Pneumonia	Kidney Stone
Stroke	Tuberculosis	Thyroid Disease	GI Ulcer

Please list any additional:

_____

_____

_____

FAMILY HISTORY: Please list any family history of medical problems:

_____

_____

_____

SOCIAL HISTORY: Mark all applicable:

	Date Last Used	Daily Usage	Years Smoking	Cessation Attempts
TOBACCO				

	Social	Occasional	Light	Heavy
ALCOHOL				

List any recreational drug use:

_____

SURGICAL HISTORY

AAA Repair	Aortic Aneurysm	Appendectomy	Breast Augmentation
Breast Reduction	CABG	Carotid Endarterectomy	Cataract Extract
Cesarean Section	Cholecystectomy	Colectomy	Duodenal Ulcer Repair
ESWL	Ectopic Pregnancy	Fracture Repair	Gallbladder Surgery
Gastric Banding	Heart Valve	Hernia Abdominal	Hip Fracture
Hip Surgery	Hysterectomy	Intestinal By-Pass	Knee Arthroscopy
Knee Surgery	LS Spine Surgery	Lasik	Mastectomy
Oophorectomy	PTCA	PVD Procedure	Pacemaker
Prior Surgeries	Prostate Biopsy	Prostatectomy Retro	Shoulder Arthroscopy
Shoulder Surgery	Sinusectomy (Nasal	Splenectomy	TURP
Thyroidectomy	Tonsillectomy	Tubal Ligation	Vasectomy

Please list any additional:

_____

_____

_____

VITALS

If Diabetic:
HbA1C% (most recent/date):_____Fasting Blood sugar (most recent/date):_____

Height:_____ Weight:_____ Shoe size:_____

IF INJURED ON THE JOB or MOTOR VEHICLE ACCIDENT, COMPLETE THIS PORTION

DATE OF INJURY _____ TYPE OF INJURY □ WORK □ AUTO □ OTHER

HAS CLAIM BEEN FILED? □ Yes □ No CLAIM NUMBER_____

WHERE WAS CLAIM FILED ?_____ CAUSE OF INJURY_____

ATTORNEY:_____ CONTACT:_____

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 questions about your policy, please call the phone number provided on the back of your insurance card. The patient or responsible party is responsible for their bill being paid in full. Please inform us at every visit of any changes to your insurance coverage.

Please initial each line indicating your understanding of our policies:

____**CO-PAYMENTS:** It is a requirement of your insurance company that we collect your co-pay. Payment is required before meeting with the doctor.

____**DEDUCTIBLES & CO-INSURANCE**: If you have a high deductible plan, we will collect a $125 deposit to apply towards your deductible and co-insurance. Any remaining balance after submission to your insurance company is your responsibility.

____**SELF-PAY:** Full payment is due at the time of service. A down payment will be required before seeing the doctor. At a minimum, an evaluation and management fee will be charged. Additional procedures/services may be recommended by the doctor but you will be informed of these charges before proceeding with treatment.

____**REFERRAL:** If your insurance plan requires a referral from your primary care doctor, this will be required at the time of your visit. Without a referral available, we will need to reschedule your appointment. It is the patient's responsibility to obtain a required referral.

____**NO SHOW:** 24 hours notice is required for cancellation of your appointment and failure to do so will incur a $50 fee. Failure to provide 24 hours notice of a procedural visit will incur a $100 fee.

____**SURGERY CANCELLATION:** Failure to provide 5 business days notice before surgery will incur a $300 fee.

____**BALANCES/COLLECTION FEES:** If balance is not collected within 30 days from the postmark date of a mailed statement, a $12 re-billing fee will be added to each additional statement due to an unpaid balance. Accounts due more than 90 days will be turned over to our collection agency and a $35 administrative fee will be added.

____**FMLA/DISABILITY/MEDICAL RECORDS:** There is a $25 charge for having the doctor complete these forms. There is a $10 fee to obtain a copy of your medical records.

I have read and understand these financial policies.

Patient Name (print):_____

Patient/Responsible Party Signature:_____
Date:_____

NOTICE OF PRIVATE PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSURES

Treatment: Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, the results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment to who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations: Your health information may be used as necessary to support the day-to-day activities and management of District Foot and Ankle. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires specific authorization However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information: Appointment reminders- your health information will be used by our staff to send you appointment reminders.

Information About Treatments: Your health information may be used to send you information that you may find interesting on the treatment or management of your medical condition. We may also send you information describing other health-related products and services that we believe may

interest you.

Individual Rights: You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

District Foot and Ankle's Duties: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information: You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your reports by contacting Lonny Nodelman, DPM. Your requests will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints: If you would like to submit a comment/complaint about our privacy practices, you can do so by sending a letter outlining your concerns to: Lonny Nodelman, DPM | District Foot and Ankle, PLLC | 4875 Eisenhower Avenue Suite #230 Alexandria, VA 22304

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint. Contact Person:

The name and address of the person you can contact for further information concerning our privacy practices: Lonny Nodelman, DPM | District Foot and Ankle, PLLC | 4875 Eisenhower Avenue Suite 230 | Alexandria, VA 22304

Patient Signature: _____ Date:_____

PRIMARY CARE DOCTOR NAME: _____

REFERRED FROM (circle below):

Primary Care Doctor

Online

Zocdoc

Insurance Directory

Friend/Family Member (name): _____

Other: _____

CREDIT CARD ON FILE AGREEMENT

Patient Name:_____

Date of Birth:_____

District Foot and Ankle, PLLC will securely save a credit card on file for any balance due. Once insurance benefits have been applied, a statement will be mailed to the patient. The credit card will be charged if after THIRTY days of the statement date, a balance remains.

The credit card information will be stored securely and cannot be viewed once entered into our system.

I agree to keep my credit card information on file with District Foot and Ankle, PLLC. As stated above, my credit card will be charged only if my balance is not paid within 30 days of the statement date.

Last 4 digits of credit card:_____

Expiration Date:_____

Cardholder Signature:_____

Date:_____