FAIR OAKS FOOT AND ANKLE
3700 Joseph Siewick Drive, #200
Fairfax, Virginia 22033
(703) 264-0500
(703) 264-0501 FAX

WARRENTON FOOT AND ANKLE
400-D Hospital Drive
Warrenton, Virginia 20186
(540) 347-9393
(540) 347-9398 FAX

PATIENT INFORMATION

Patient's Full Name _____ Age _____ Today's Date _____

Home Address_____ City _____State_____

Zip _____ Home Phone _____ Cell Phone _____

Social Security Number_____ Date of Birth _____Sex _____

Email Address_____

Marital Status S M D W Sep Patient's Occupation _____

Employer _____ Address _____City,State,Zip _____

Primary Care Doctor _____ Phone Number _____ Date of last physical exam _____

Work Phone _____ Spouse's Name_____ Spouse's Work Phone _____

Spouse's Employer _____ Address _____

Full Name of Financially Responsible Person _____Date of Birth_____ Sex _____

Patient *Spouse* *Parent* *Other* Address if different from Patient _____

EMERGENCY CONTACT _____ Phone _____

How did you hear about us? _____

MAY WE LEAVE A MESSAGE REGARDING TEST RESULTS ON YOUR ANSWERING MACHINE? YES ☐ NO ☐

Fill out if patient is a minor

Parent's Name (if Patient is a minor) _____

Parent's Employer _____ Address _____

Parent's Occupation _____ Mother's Work Number_____ Father's Work Number_____

CHIEF CONCERN/PRESENT ILLNESS

Reason for Visit _____

How long have you been bothered by the above problem? _____

What have you done for your foot problem? _____

Is your foot problem a result of an accident? Yes ☐ No ☐ Date of Accident _____/_____/_____

Circumstances of Accident _____

MEDICAL HISTORY

Have you experienced any unusual or allergic reaction to any medications or latex (Such as Penicillin, Novocain, etc.)? Yes ☐ No ☐

If yes, which one (s)? _____

Do you smoke? Yes ☐ No ☐ **Do you drink alcohol?** Yes ☐ No ☐ **Pregnant or Currently Breastfeeding?** Yes ☐ No ☐

Check if you have ever been treated for:

☐Allergies	☐Blood Clots/DVT	☐GI/bowel problems	☐High Cholesterol	☐Rheumatoid Arthritis
☐Anemia	☐Broken Bones	☐Glaucoma	☐Kidney Disease	☐Thyroid Disease
☐Arthritis	☐Cancer	☐Gout	☐Liver Disease	☐Tuberculosis
☐Asthma	☐Diabetes	☐Heart Disease	☐Nervous Condition	☐Other: *please list*
☐Back Problems	☐Epilepsy	☐Hepatitis	☐Osteoporosis	
☐Bleeding Tendency	☐GERD	☐High Blood Pressure	☐Peripheral Arterial Disease	

Have you ever tested ***positive*** for HIV? **Yes** ☐ **No** ☐

VIRGINIA LAW requires us to inform you that your blood may be tested for the HIV (Aids) if any healthcare worker is accidentally exposed to your blood in a manner that could transmit HIV infection. Your consent is NOT required, but you will be informed if tested.

FAMILY HISTORY *Check if any blood relative has had:*

☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ Kidney Disease ☐ Overweight ☐ Similar foot problem

Have you ever had any surgery? Yes ☐ No ☐

Type of Surgery	Year

CURRENT MEDICATIONS

1.	5.
2.	6.
3.	7.
4.	8.

PHARMACY

Name _____ Phone Number _____

Address _____

PATIENT AUTHORIZATION

I hereby authorize Warrenton Foot & Ankle Center and/or Fair Oaks Foot & Ankle Center to release any medical information acquired in any examination or treatment.

_____ **Initial**

ASSIGNMENT OF BENEFITS

I hereby authorize Warrenton Foot & Ankle Center and/or Fair Oaks Foot & Ankle Center to apply for benefits on my behalf and that payments are made directly to Warrenton Foot & Ankle Center and/or Fair Oaks Foot & Ankle Center.

_____ **Initial**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Warrenton Foot & Ankle Center and/or Fair Oaks Foot & Ankle Center for services furnished me by physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its' agents any information needed to determine these benefits payable for related services. I fully understand that any services denied by Medicare Part-B as medically unnecessary or as services not covered by the Medicare program are my responsibility.

_____ **Initial**

I also understand that I (husband, wife, dependent) am fully responsible for my charges. Filing of claims on my behalf by the Warrenton Foot & Ankle Center and/or Fair Oaks Foot & Ankle Center is done **PURELY AS A COURTESY.**

_____ **Initial**

PLEASE NOTE THE FOLLOWING FEES:

A $25.00 FEE WILL BE CHARGED FOR ALL RETURNED CHECKS
I UNDERSTAND THAT A $25.00 FEE, PLUS ATTORNEY AND COURT COSTS, WILL BE ADDED TO MY ACCOUNT OR ANY UNPAID BALANCES THAT ARE SENT FOR COLLECTIONS.

Patient Signature _____ Date _____

Print Name _____

I acknowledge that I did not bring a referral as required by my Insurance company and/or do not have my Insurance card. I am electing to be seen today and agree to pay for the services rendered today since I do not have a valid referral or insurance card.

Signature _____ Date: _____

NOTICE OF PRIVACY PRACTICES

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

Our office is permitted to make uses and disclosures of protected health information of:

a. **Treatment-** i.e.; ordering and obtaining off site tests/results, writing prescriptions, etc.
b. **Payment-** i.e.; submitting insurance claims on your behalf for treatment rendered.
c. **Health Care Operation-** i.e.; internal business planning activities and quality of care evaluations.

We are permitted or required under specific circumstances, to use or disclose protected health information without the individuals written authorization, including, but not limited to:

a. **Disclosures required by law.**
b. **Disclosures to avert serious threats to health or safety.**
c. **Disclosures with references to workers compensation.**

Other uses and disclosures will be made only with the individual's written authorization, and the individual may revoke such authorization.

We may contact the individual to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual or patient. We will routinely contact patients via telephone at home and/or work and, unless otherwise requested, may leave messages on the appropriate voice mail or answering machine regarding appointments, test results, etc.

You have the following rights regarding your protected health information:

- The right to request restrictions on the use and disclosure of your protected health information. A written request should be submitted to the person listed below.
- 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 request an amendment 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 copy of this notice.

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the notice currently in effect.

We may change the terms of this Notice at any time. Any revised Notice will be effective for all health information that we maintain. The effective date of a revised Notice will be noted. A copy of the current Notice in effect will be posted. You may request a copy of the current Notice at any time.

If you would like to submit a comment or complaint about our privacy practices, or obtain additional information about our privacy practices, you may do so by sending a letter outlining your concerns to the person listed below. You will not be penalized or otherwise retaliated against for filing a complaint.

Privacy Officer
400-D Hospital Drive
Warrenton, Virginia 20186
(540)347-9393

This notice is first in effect on April 14, 2003.

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

_____
Patient Signature

_____
Parent or Authorized Representative (*if applicable*)

HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: _____

Relationship: _____

Contact information: _____

Health Information to be disclosed upon the request of the person named above. Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions)

(NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____

Patient Name (*please print*) Date

_____

Patient Signature

_____

Parent or Authorized Representative (*if applicable*)

HIPAA Authority for Right of Access: 45 C.F.R.