PATIENT DEMOGRAPHICS (Please complete all pages)

Date:	**SSN:**	
Full Name:	**D.O.B:**	☐ **MALE** ☐ **FEMALE**
Address:	**City/State/Zip:**	
Home Ph:	**Cell Ph:**	**Email:**
Reason for visit today?		
Referred By:	**Phone:**	
Employer Name:	**Occupation:**	

INSURANCE DETAILS

Primary Insurance:				**Subscriber (if not patient) D.O.B:**
Subscriber Name (if not patient):				**Subscriber (if not patient) SSN:**
Relationship to Patient:				**Copay:**
Statement Type:	☐ **Paperless (free)**	☐ **Paper Mail ($5)**	☐ **Charge to card**	**Card Holder Name:**

Credit Card#: _____Exp: _____ CCV:_____Zip code: _____

FINANCIALLY RESPONSIBLE INDIVIDUAL (If not Patient)

Full Name:	**D.O.B:**	**SSN:**
Address:	**City/State/Zip:**	
Email:	**Phone:**	**Relationship to Patient:**
Signature:	**Date:**	

EMERGENCY CONTACT

Name:	**Relationship to Patient:**	
Home Phone:	**Cell Phone:**	**Work Phone:**

ADDITIONAL INFORMATION

Shoe size:	**Height:**	**Weight:**	**Age:**	
Do you drink alcohol? Yes _____No_____		**How much?**		
Do you smoke? Yes _____No_____		**How much?**		

PHARMACY INFORMATION

Pharmacy Name:	**Phone:**
Address:	**City/state/Zip:**

MEDICAL HISTORY (Check which of the following you had or have at present)

☐ AIDS/HIV	☐ Cancer	☐ Hepatitis		
☐ Anemia	☐ Chest Pain	☐ High Blood Pressure	☐ Stomach Reflux/Heartburn	
☐ Ankle Pain	☐ Depression/Anxiety	☐ Kidney Disease	☐ Stroke	
☐ Asthma	☐ Diabetes	☐ Liver Disease	☐ Swelling legs/feet	Other:
☐ Allergies	☐ Fibromyalgia	☐ Lung Disease	☐ TB	
☐ Angina	☐ Foot Ulcers	☐ Osteoporosis	☐ Thyroid Disorder	
☐ Artificial Joints	☐ Glaucoma	☐ Pacemaker	☐ Varicose Veins	
☐ Broken Bones	☐ Gout	☐ Seizures		
☐ Bunions	☐ Heart Disease	☐ Sickle Cell Disease		

PREVIOUS SURGERIES, MAJOR INJURIES, OR HOSPITALIZATIONS (Include dates)

1.	3.
2.	4.

MEDICATIONS (List name and dose; including over the counter and vitamins)

1.	4.
2.	5.
3.	6.

ALLERGIES (Check known allergies and list any allergies or reactions to medications below)

☐ Penicillin	☐ Codeine	☐ Iodine	☐ Local Anesthetic	☐ Tape
☐ Sulfa	☐ Other:			

FAMILY MEDICAL HISTORY (Check if any blood relatives have had the following)

☐ Diabetes	☐ DVT
☐ Heart Disease	☐ Liver Disease

Other:

COMMUNICATION AUTHORIZATION (Optional)

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), APNA Podiatry will not release confidential health information, either in person or by telephone, email, or fax to any unauthorized people (excluding Insurance Provider). If you would like to authorize us to release medical information to someone other than yourself or to leave information on a recording device, please complete the following:

PRINT NAME: I, _____give my permission to APNA Podiatry LLC, Dr. Asifa Pathan or staff to speak to the following people about my medical care:

Name: _____Phone: _____Relationship: _____

Name: _____Phone: _____Relationship: _____

Leave message on answering service? **Ye**s _____**No**_____

SIGNATURE (Patient/Guardian): _____ DATE: _____

INSURANCE: We accept most commercial insurance plans including Medicare and Tricare. **A health insurance policy is a contract between you the Patient/Subscriber and your insurance carrier**. We will submit the claim to your insurance provider on your behalf if you have provided the necessary information such as photo ID, SSN, valid insurance card, referrals, and preauthorization. Failure to provide insurance requirements will result in payment responsibility by the Patient/Subscriber**. If for any reason the insurance carrier does not pay the claim, Patient/Subscriber is responsible for payment of the claim**.

NON-COVERED SERVICES: Please be aware that some, and perhaps all, of the services you receive may not be covered or deemed necessary by your Insurance Provider. You must pay for these services in full if your Insurance Provider does not cover services. Items such as **shoe inserts are not covered by insurance**.

PAYMENTS: Payment is expected at the time of service. **Patient/Subscriber** responsibility to ensure that their Insurance Provider has processed the claim and paid for our services. **All outstanding balance is due prior to seeing the doctor.**

NON-PAYMENT: Accounts Past Due **(30 days)** are subject to a **$35** rebilling **fee**. **Accounts** Past Due **(60 days)** are subject to a **$45** rebilling fee. If your account is more than 60 days past due, **it will be referred to a collection service**. If your account is forwarded to a collection service and/or an attorney, a fee of **40%** of the balance due will be added to your account to cover collection cost.

BILLING: Our office uses **paperless billing**. A bill will be sent to your email on file with a phone follow up. If you prefer a paper bill, a **$5 processing fee** is added to your bill. If you have a credit card on file, the balance will be charged to it.

IN OFFICE PRODUCTS: For your convenience, we make some products available for purchase in our office which are not covered by Insurance Providers. Products include non-custom shoe inserts, surgical shoes, and other products.

NON-TREATMENT RELATED FEES: **$20 (minimum)** fees for completion of forms (disability applications, handicap stickers, workman's comp etc.). **$10 - Detailed receipts of all claims/payments**. **$10- Personal copy of patient records. $15 - Copy of x-ray on disc**. Lost prescription scripts/orders $10. Returned checks fee is $50. (FEES SUBJECT TO CHANGE WITHOUT NOTICE)

APPOINTMENT POLICY: A **No-Show fee of $100** is charged if you fail to notify our office 24hrs prior to your scheduled appointment time.

AGREEMENT: I have read and agree to the terms set forth in this financial and office policy. I, the undersigned, certify that I (or my dependent) have insurance coverage that will pay for my medical care directly to APNA Podiatry. I understand that I am responsible for payment of deductibles, co-payments, co-insurance, and/or non-covered services. I hereby authorize the APNA Podiatry to release all information necessary to secure payment for services received. I authorize release of medical information to my insurance carrier or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

If applicable, I authorize APNA Podiatry to charge any remaining balance not covered by insurance to my credit card on file.

SIGNATURE: _____ **DATE:** _____

PRINTED NAME: _____

PRIVACY STATEMENT ACKNOWLEGEMENT

This is a summary of our Notice of Privacy Practices. The entire text detailing our privacy practices is available for your review, and we encourage you to read it and ask any questions you may have regarding our privacy practices. If you have any questions or would like to exercise any of your rights, please contact our Office. After reviewing the material, please sign in the space provided below.

PATIENT RIGHTS

As a patient, you have a right to inspect copy, amend, request a restriction, or revoke a prior restriction on the use and disclosure of your Protected Health Information (PHI). You may also request a copy of an accounting of disclosures, which will detail all disclosures made for reasons other than treatment, payment, or health care operational purposes. You may request that we communicate with you only in a specific manner (i.e., "only communicate with me at my work telephone number").

To obtain more information about your privacy rights of if you have questions, you want answered about your privacy rights (as provided for by Privacy Rule, Section 164.520(b)(vii)), you may contact the Practice's HIPAA Compliance Officer as follows:

Mail:	APNA Podiatry – 9001 Digges Road, Suite 201, Manassas VA 20110
Email:	foot@apnapod.com
Phone/Fax:	703-436-1037 – 703-436-8307
Web	https://apnapod.com/privacy-notice

PROVIDER RIGHTS

As your health care provider, we can use or disclose your PHI for treatment, payment, or health care operational purposes. Any other disclosure requires you to sign a specific authorization.

I acknowledge, I have reviewed a copy of the Privacy Statement.

SIGNATURE: _____ **DATE:** _____

PRINTED NAME: _____

_____

For Staff Use Only:

Written acknowledgement was not obtained for the following reasons:

_____

_____ _____

Staff Signature Date