FOOT CARE CENTER, PLC

Patient Information

LAST_____ FIRST_____ MIDDLE_____

BIRTHDATE ____/____/____ SS#_____ MARITAL STATUS_____ SEX _____M _____F

ADDRESS_____ CITY_____ ST_____ ZIP_____

EMPLOYER_____ ADDRESS_____

HOME PHONE_____ EMAIL ADDRESS_____

WORK PHONE_____ CELL PHONE_____

PREFERENCE OF CONTACT: Home phone Cell phone Work Email

EMERGENCY CONTACT:_____ RELATIONSHIP_____ PHONE_____

Insurance Information

PRIMARY INSURANCE_____ ID#_____ GROUP#_____

NAME OF POLICY HOLDER_____ SSN#_____ BIRTHDATE__/____/_____

EMPLOYER INS PLAN? YES NO PATIENT RELATIONSHIP TO POLICYHOLDER_____

POLICYHODER ADDRESS_____

HOME PHONE_____ WORK PHONE_____

SECONDARY INSURANCE_____ ID#_____ GROUP#_____

NAME OF POLICY HOLDER_____ SSN#_____ BIRTHDATE__/____/_____

EMPLOYER INS PLAN? YES NO PATIENT RELATIONSHIP TO POLICYHOLDER_____

POLICYHODER ADDRESS_____

HOME PHONE_____ WORK PHONE_____

Authorization, Release, and Assignment of Benefits

I hereby assign Foot Care Center, PLC (James R. Arnold, DPM, Rhonda L. Davis, DPM, and Jessica Inthavongxay, DPM) all medical and surgical benefits due them for their professional services rendered to me and to my dependents. I also authorize and assign to release all information concerning my illness and treatment to my insurance carrier and any other physician said assignee who has consulted in my care. If it is necessary to obtain medical information from another party to assist in my care, I authorize release of medical records to Foot Care Center, PLC (James R. Arnold, DPM, Rhonda L. Davis, DPM, and Jessica Inthavongxay, DPM). This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment shall be considered as effective and valid as the original.

I understand that I am financially responsible for all charges, whether or not covered by insurance, and the full payment or copayment will be collected at the time of service, as required. An account balance over 90 days past due will be assessed a $15.00 late fee. In the event the account needs to be turned over to a collection agency, an additional 40% of the account balance shall be added to the outstanding balance to cover collection agency fees. I understand that failure to pay my account balance may result in the physicians being unable to provide additional treatment, except for medical/surgical emergencies, or where there is prepayment for additional services.

_____ _____

Signature of patient, insured or responsible party Date

Financial Arrangements

For your convenience, we offer the following payment methods: cash, personal check, MasterCard, Visa, American Express and Discover

FOOT CARE CENTER, PLC

DATE: _____ PATIENT HEALTH HISTORY

NAME: _____ DATE OF BIRTH: _____

PHARMACY/LOCATION: _____

ETHNICITY: _____ RACE: _____

PREFERRED LANGUAGE: English Spanish Other _____

MEDICAL CONDITIONS

Foot or Leg Injuries	Heart Attack/Disease	Pregnant	Gout
Foot or Leg Surgery	Irregular Heart Rate	Seizure Disorder	Cancer
Foot or Leg Cramps	High Blood Pressure	Stroke	Polio
Foot or Leg Numbness	High Cholesterol	Anxiety	Bursitis
Knee Pain	Emphysema	Depression	Varicose Veins
Unequal Leg Length	Asthma	Headaches	Prone to Infection
Weak Ankles	Stomach Ulcer	Arthritis	Rheumatic Fever
Bunions	Intestinal Disorder	Diabetes	Blood Disorder
Foot Skin Problems	Gastric Reflux	Thyroid Disorder	Kidney Disorder
Toe Nail Problems	Liver Disorder	Anemia	Low Back Pain

FAMILY HISTORY OF DIABETES Relation: _____
Additional family history:

_____

ALLERGIES None MANIFESTATION (i.e. rash, hives, etc.)

_____

_____

_____

MEDICATIONS None DOSE DIRECTIONS (i.e. ADMIN 1 TABLET 2 TIMES A DAY)

_____

_____

_____

_____

_____

_____

_____

_____

PREVIOUS SURGERIES: (List All)

_____

_____

May we contact your physician for your health records? Yes No
Have you had previous treatment by a Podiatrist? Yes No
When? _____ Why? _____

My chief foot complaint is: _____
This condition has existed for: _____Days _____Weeks _____Months _____Years

FOOT CARE CENTER, PLC

James R. Arnold D.P.M. - Rhonda L. Davis D.P.M. - Jessica Inthavongxay D.P.M.

RELEASE OF MEDICAL INFORMATION:
HIPAA FORM

Date: _____

I, _____, give my permission to **Foot Care Center, PLC** to Release my medical information to the following person (i.e. family member, legal guardian, friend, etc.)

_____

_____

_____

_____

Release of information: I authorize **Foot Care Center, PLC** to release to other physicians, medical facilities, my insurance company, or reimbursing agent all pertinent information, including a copy of my medical records that is required in connection with any care provided for determination of benefits or for continued medical care.

Financial Agreement: I authorize direct payment of medical benefits to my physician, or I am responsible for payment of the full fee, regardless of any insurance coverage which may be applied. I waive all claims as to proper venue for the hearing of this matter and agree that the City of Winchester shall be the proper venue for hearing any claim. I understand that I will be responsible for any interest or collection fees that could occur if I fail to pay my bill.

HIPPA Privacy: In 2003, a Federal Law was enacted that requires us to maintain the privacy of "Protected Health Information". Protected health information includes any identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you received or payment for your health care. The notice you will receive provides you with the information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information.

Notice of Deemed Consent: A law was enacted in Virginia in 1989 and amended in 1993 which authorizes healthcare providers to test their patients for HIV, Hepatitis B/C antibodies when the healthcare provider is exposed to the body fluids of a patient in a manner which may transmit those antibodies. Pursuant to this law, in the event to of such exposure, you will be deemed to have consented to such testing and to the release of the test results to the healthcare provider who may have been exposed. You will be informed if the test for HIV, Hepatitis B or C antibodies. The testing will be explained to you, and you will be given the opportunity to ask questions.

Sign:_____ **Date:**_____

Witness:_____ **Date:**_____

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