NEW PATIENT INFORMATION

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CENTRAL VIRGINIA Foot & Ankle LASER CENTER FEATURING NOVONAIL®

ENTIRE FRONT PAGE IS REQUIRED

Patient Name_____
First Middle Last Name you wish to be called

Billing Address_____ Responsible Party_____
Street City State Zip If Minor

[ ] Land Line Phone (____)____-_____

[ ] Mobile Phone (_____)_____-_____ [ ] Voice [ ] Text

[ ] Email_____

Please let us know how it is you heard about us: Google Facebook Radio Other_____

Date of Birth_____/_____/_____ Age_____ Sex (circle): Female/Male SSN#_____

Marital Status (circle): Single Married Widowed Separated Divorced

Emergency Contact_____ Relation to Patient_____ Phone (_____) _____-_____

*Primary Care Physician_____ Date of last visit_____

*Preferred Pharmacy (Name & Location) _____

Employer_____ Work Phone (_____) _____-_____ Position/Occupation_____

Race/Ethnicity: American Indian or Alaskan Native Asian Black or African American

Native Hawaiian or Pacific Islander White or Caucasian Hispanic or Latino

Primary Language_____ Secondary Language_____ Height __ft. ___in. Weight _____ lbs.

Reason for Visit? _____ Is it associated with an injury? YES NO

Circle all that apply: Left Foot Right Foot Left Ankle Right Ankle Toes Nails

Length of symptoms? _____What makes it better? _____ What makes it Worse? _____

Problem Status (circle): Problem getting worse Problem staying the same Problems improving

www.cvillefootankle .com

INSURANCE AUTHORIZATION

Name of Insurance Subscriber (*if different than patient. Exp. spouse, parent or guardian that the insurance*)

_____ Relationship to patient _____
First Last

Date of Birth (of insured) ____/____/_____ SSN#_____ Phone (_____) _____-_____

AUTHORIZATION FOR TREATMENT, ASSIGNMENT AND RELEASE

I hereby give Christopher B. Stewart, DPM, PC and his staff member's permission to treat my feet and/or ankle disorders. I the undersigned, have insurance coverage with_____ and assign directly to Christopher B. Stewart, DPM, PC all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment benefits. I authorize the use of this signature on all my insurance submissions.

X_____ **_____/_____/_____**
Signature of Insured/Guardian **Date**

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made to Christopher B. Stewart, DPM, PC, for any services furnished me by the physician. I understand my signature request that payment be made and authorize the release of medical information, necessary to apply the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claims forms or electronically submitted claim, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

X_____ **_____/_____/_____**
Beneficiary Signature/Guardian **Date**

Please include any notes regarding a caretaker and/or care facility that may be relevant to contacting the patient and/or patient care.

_____
_____
_____

MEDICAL HISTORY Continued

We welcome you to the practice. Completion of this questionnaire regarding your medical history and present condition will assist us in the diagnosis and treatment of your feet and/or ankle condition. All information will be part of your confidential medical record.

REVIEW OF SYMPTOMS (Please check chronic symptoms you have had in the past year)

__Abdominal Pain
__Ankle Pain/Swelling
__Poor Appetite
__Arm Pain
__Back Pain
__Bloating/Gas
__Bleeding Gums
__Blurred Vision
__Bloody Urine
__Bruising
__Bowel Changes
__Chest Pain
__Chills
__Constipation
__Cough
__Depression
__Diarrhea
__Difficulty Swallowing
__Earache
__Fever
__Foot Pain
__Forgetfulness
__Hand Pain
__Hay Fever
__Headache
__Hearing Loss
__Hemorrhoids
__Hip Pain
__Hot Flashes
__Indigestion
__Irregular Heartbeat
__Itching, Keloids (Scar Tissue)
__Knee Pain
__Leg Pain
__Nausea
__Numbness (Legs/Feet)
__Rash
__Ringing in Ears
__Shortness of Breath
__Shoulder & Neck Pain
__Sinus Problems
__Sleep Loss
__Sweats
__Tingling
__Urinate frequently
__Vomiting
__Weight Gain
__Weight Loss

MEDICAL HISTORY (Please check conditions you have or have had in the past)

__AIDS/HIV
__Asthma
__Bleeding Disorder
__Blood Clot(s)
__Cancer (Type_____)
__Cataracts
__ COVID-19/exposure or any other highly contagious virus
__Diabetes
__Emphysema
__Glaucoma
__Gout
__Heart Disease
__Hepatitis
__Herpes Simplex
__High Cholesterol
__High Blood Pressure (Hypertension)
__Liver Disease
__Mental Illness (Type_____)
__Multiple Sclerosis
__Osteoarthritis
__Pacemaker/Defibrillator
__PVD (Peripheral Vascular Disease)
__Rheumatoid Arthritis
__Sickle Cell
__Stroke/TIA
__Varicose Veins
__Other _____

FAMILY MEDICAL HISTORY (To the best of your knowledge, please specify family member(s) –Mother, Father, Sister, Brother, Maternal Grandmother or Grandfather and Paternal Grandmother or Grandfather)

_____Alcoholism
_____Anemia
_____Anxiety
_____Asthma
_____Birth Defects
_____CAD
_____Cardiovascular Disease
_____CHF
_____Cancer (type: _____)
_____Congenital Anomaly
_____COPD
_____Crohn's Disease
_____Depression
_____Diabetes
_____Epilepsy
_____GERD
_____Hypercholesterolemia
_____Hyperlipidemia
_____Hypertension
_____Hypothyroidism
_____Kidney Disease
_____Liver Disease
_____Multiple Births
_____Osteoarthritis
_____Osteoporosis
_____Pulmonary Disease
_____Stroke
_____Substance Abuse

We welcome you to the practice. Completion of this questionnaire regarding your medical history and present condition will assist us in the diagnosis and treatment of your feet and/or ankle condition. All information will be part of your confidential medical record.

SURGICAL HISTORY (Clearly list surgeries you have had *and* approximate year)

_____ _____
Surgery Name and/or Description Year

_____ _____
Surgery Name and/or Description Year

_____ _____
Surgery Name and/or Description Year

_____ _____
Surgery Name and/or Description Year

MEDICATIONS (List *all* meds AND dosages – YOU MAY BRING YOUR MED LIST INSTEAD OF LISTING below)

Rx_____ Rx_____

Rx_____ Rx_____

Rx_____ Rx_____

Rx_____ Rx_____

Circle all that Apply: Gold Therapy Chemotherapy Accutane Corticosteroids (Ex: Prednisone)

ALLERGIES (List *all* Allergies including food)

__Aspirin __Codeine __Iodine _____
__Novocain __Penicillin __Other_____ _____
__Tape/Adhesive __Latex __None _____ _____
__Local Anesthetics __Sulfa Drugs _____ _____

SOCIAL HISTORY (Circle what applies)

Tobacco/Nicotine: Never Current Smoker Occasional Smoker Former Smoker
When did you stop smoking? _____
How long did you smoke for? _____

Alcohol: Never None Occasional Social Moderate Heavy

Caffeine per Day: 0 1 2 3 4+

Welcome to Our Office

FINANCIAL POLICIES

Thank you for choosing us as your Podiatric Physician. We are committed to your treatment being successful, as you, the patient, are our first and foremost concern. As part of our service, we try to contain the cost of health care. In an effort to do this, we have implemented a Financial Policy.

INSURANCE: If your Doctor is a participating provider with your insurance plan, we will submit your claims to your insurance company for any podiatry issues you are being treated for. To do this we must have complete and accurate insurance information and a copy of your identification card. Your insurance policy is a contract between you and your insurance company; therefore, you are responsible for payment whether your insurance company pays. It is your responsibility to contact your insurance company regarding obtaining required referrals, second opinions, etc. Failure to do so may reduce the number of benefits paid by your insurance, and the balance will then become your responsibility to pay. All co-payments must be paid at the time of service. If you have an annual **deductible** which has not yet been paid in full then any charges incurred up to that amount are **due at the time of your visit.**

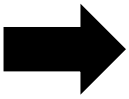
NO INSURANCE: If you do not have insurance or the doctor is not a participating provider with your insurance plan, please be prepared to fully cover the fees for each visit at the time of treatment.

PAYMENTS: Payments for the balance due, co-payments, deductible, non-covered supplies, etc., are due at the time of service and may be made by cash, check or credit card (**Visa, MasterCard, Discover, AMX and Debit**). There will be a $35.00 charge for returned checks. Delinquent accounts will be referred for collection at the discretion of the office manager.

REFERRALS: Some insurance companies require subscribers to have a referral from a primary care physician prior to being seen by a specialist. It is your responsibility to contact your PCP if a referral is needed, no services will be rendered until the referral has been received or the patient pays for the services at the time they are rendered.

NON-PAYMENT/PAST DUE ACCOUNTS: Please be aware that if a balance remains unpaid for 60 days, we will not see you until you are in good standing and we may refer your account to a collection agency, and your account will be charged an additional $50 for all collection expenses and court costs. Partial payments are only accepted if negotiated in advance with the office manager.

MISSED APPOINTMENTS/NO SHOWS: In an effort to meet the demands for patient appointments, please call our office 24 hours in advance if you are unable to keep your scheduled appointment, this allows us to accommodate our other patients. It is our policy to charge a $50.00 fee for missed appointments not canceled within 24 hours prior to the scheduled appointment. We understand that 24-hour notice is not always possible, and we will take these on a case-by-case basis. If you must miss an appointment, please call us as soon as you know you cannot make it. Patients who habitually do



not show and do not contact us, take time away from other patients and will be asked to find another provider. Our policy is to charge a fee of $250.00 when patients cancel surgery less than 2 weeks before the scheduled surgery date.

FORM COMPLETION: We reserve the right to charge a reasonable fee of $5.00 for form completion. i.e. Disability forms, Family medical leave forms etc.

ORTHOTICS: Orthotics is a non-covered service by most insurance plans. Please check with your insurance company prior to the examination and casting for orthotics to determine your orthotics benefits. A deposit of $249 is requested at the time of the examination and the casting and remaining balance is due when the orthotics are dispensed.

SUPPLIES: For your convenience, we make some supplies available for purchase in the office. If you choose to purchase these items, payment is due at the time of purchase. These are non-covered items, and we cannot bill insurance for these items. All retail items are final sale. No refunds will be given unless the product is defective, in this case an exchange will be made.

I, the undersigned, have read, understand and agree to the policies described above, and understand that Christopher Stewart, DPM, PC, The Podiatry Group will render services in consideration of and reliance on my authority to agree and my agreement to abide by the terms/guidelines above. I further understand and agree that a photocopy or facsimile of this agreement should be as valid as the original and that any attempted modification of the above terms should be void and without effort.

X_____ ____/____/_____

Patients Signature (or Legal Guardian) **Date**

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

In compliance with federal privacy law and regulations, all patients must, on their initial date of registration and thereafter request, sign and date this Written Acknowledgement Form. If you would like a copy, we are happy to provide one at any time upon request.

I HEREBY ACKNOWLEDGE THAT I UNDERSTAND AND I CAN REQUEST A COPY, AT ANY TIME, OF THE PRIVACY POLICIES AND FULLY AGREE TO THE TERMS OF THE POLICY.

X_____ ____/____/_____

Patient Signature/Guardian **Date**