14349 Justice Rd,
Midlothian VA 23113
Phone: 804.837.4144
Fax: 823.9335

SYNERGYHEALTH FOOT AND ANKLE

2610-A Gaskins Rd,
Henrico, VA 23238
Phone: 804.433.3233
Fax: 804.823.9335

Patient Registration Form

Name (Last, First, Middle): _____ Nickname: _____

If the patient is a minor, Name of Guardian: _____ Relationship to patient: _____

Sex: ☐ Male ☐ Female SSN: _____ DOB: _____ Age: _____

Address: _____ City: _____ State: _____ ZIP: _____

Home phone: _____ Mobile phone: _____ Work phone: _____

Email address: _____ Preferred method of contact: ☐ Home ☐ Mobile ☐ Text ☐ Email

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Occupation: _____ Are you a student? ☐ Yes ☐ No If yes, ☐ Full time ☐ Part time

Employer or school: _____ Location _____

Emergency Contact Information

Name: _____ Relationship to patient: _____

Emergency contact number: _____

Medical Insurance Information

Are you insured? ☐ Yes ☐ No Primary: _____ Secondary: _____

Relationship to insurance policy holder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

If your insurance coverage is not under your own name, please specify the following:

Name of policy holder: _____ Policy holder DOB: _____

Policy holder's employer: _____

Government Question

The government expects healthcare practitioners to ask the questions below. However, a response is **optional**.

Race (optional): ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ American Indian/Native Alaskan ☐ Native Hawaiian/Pacific Islander Ethnicity (optional): ☐ Hispanic ☐ Not Hispanic

Primary Care Physician

Name of family doctor/PCP: _____ Date of last PCP visit: _____

PCP address: _____ PCP phone: _____

Referral

How did you hear about us? _____

Pharmacy Information

Name of Pharmacy: _____ Address: _____

Phone: _____ May we E-prescribe? (See below): ☐ Yes ☐ No

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy from the point of care. By signing this consent form, you are agreeing that we may electronically transmit your prescriptions directly to your pharmacy. E-Prescribing is an optional service and you may choose to decline. Please note that consenting to E-Prescribing also permits the use of your prescription medication history from other healthcare providers and/or third-party benefit payers (i.e., your insurance company) for treatment purposes only. I hereby provide informed consent to SynergyHealth Foot & Ankle Associates, PLLC to enroll me in the E-Prescribe Program.

Patient/Guardian Signature: _____ **Date:** _____

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What is the reason for your visit today? _____

How long has this bothered you? (Please circle): 1 2 3 4 5 6 Days Weeks Months Years

What treatment have you tried, and what has worked in the past? _____

_____

On a scale of 1 to 10 (1 being no pain and 10 being the worst), what is your pain level? _____/ 10

Past Medical History

Medication List (doctor prescribed and over the counter): _____

_____

_____

_____

Are you diabetic? ☐ Yes ☐ No If yes, are you ☐ Type 1 ☐ Type 2? A1C_____ Date of last A1C_____

Please indicate if you have a problem with any of the following:

☐ High blood pressure ☐ High Cholesterol ☐ Heart Disease ☐ Kidney Disease ☐ Circulation problems

☐ Alcoholism ☐ Anxiety ☐ Arthritis (specify) _____ ☐ Asthma ☐ Blood clotting/DVT/PE

☐ Blood disorders ☐ Breathing problems ☐ Cancer (specify) _____ ☐ Depression ☐ Gout

☐ Heart attacks ☐ Heart murmurs ☐ Hepatitis ☐ Liver problems ☐ Mental Illness ☐ Musculoskeletal

☐ Neurological (specify) _____ ☐ Neuropathy ☐ Seasonal Allergies ☐ Sleep Apnea ☐ Stroke

☐ Skin disorders (specify) _____ ☐ Stomach/bowel ☐ Thyroid (specify) _____

☐ Other (specify) _____

Are you pregnant? Y / N **Are you nursing?** Y / N

Allergies ☐ Yes ☐ No

If YES, please list all allergies: _____

Surgical History

Please list all previous surgeries: _____
Do you have any artificial heart valves? ☐ Yes ☐ No
Do you have any artificial joints? ☐ Yes ☐ No If YES, where? _____

Social History

Do you smoke? ☐ Yes ☐ No If yes, how frequently? ☐ ½ ppd ☐ 1 ppd ☐ 1 ½ ppd ☐ 2 ppd

Did you smoke in the past? ☐ Yes ☐ No If YES, for how long and how many PPD? _____

Do you drink? ☐ Yes ☐ No If YES, how many drinks per week? _____

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Family History

- ☐ Alzheimer's
- ☐ Arthritis
- ☐ Bleeding disorder
- ☐ Blood clot/DVT/PE
- ☐ Bunion
- ☐ Flatfoot
- ☐ Cancer
- ☐ Cataract
- ☐ Circulation problems
- ☐ Depression
- ☐ Diabetes
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Neurologic
- ☐ Stroke
- ☐ Other: _____ _____ _____

Review of System

Please check the box if you currently have any of these symptoms or check "NONE

Cardiovascular
- ☐ leg pain when walking
- ☐ fever
- ☐ chest pain/pressure
- ☐ leg swelling
- ☐ cold hands/feet
- ☐ fainting palpitation
- ☐ vascular disease
- ☐ valve problem
- ☐ **NONE**

Respiratory
- ☐ chest pain
- ☐ wheezing
- ☐ COPD
- ☐ Coughing
- ☐ Snoring
- ☐ Shortness of breath
- ☐ Emphysema
- ☐ **NONE**

Gastrointestinal
- ☐ abdominal pain
- ☐ heartburn
- ☐ blood in stool
- ☐ vomiting
- ☐ stomach ulcers
- ☐ diarrhea
- ☐ trouble swallowing
- ☐ decrease appetite
- ☐ increase appetite
- ☐ constipation
- ☐ **NONE**

Integumentary
- ☐ athletes' foot
- ☐ nail abnormalities
- ☐ keloids
- ☐ itchiness
- ☐ dry scaly skin
- ☐ **NONE**

Hematologic
- ☐ lower leg ulcers
- ☐ sickle cell disease
- ☐ anemia
- ☐ blood thinners
- ☐ clotting disorders
- ☐ **NONE**

Genitourinary
- ☐ blood in urine
- ☐ hesitancy
- ☐ incontinence
- ☐ increase urgency
- ☐ decrease frequency
- ☐ excessive urination
- ☐ kidney disease
- ☐ kidney stone
- ☐ **NONE**

Musculoskeletal
- ☐ Back pain
- ☐ muscle weakness
- ☐ muscle pain
- ☐ neck pain
- ☐ sciatica
- ☐ joint stiffness
- ☐ joint pain
- ☐ joint instability
- ☐ arthritis
- ☐ **NONE**

Neurological
- ☐ tingling
- ☐ weakness
- ☐ seizures
- ☐ numbness
- ☐ headaches
- ☐ tremor
- ☐ paralysis
- ☐ **NONE**

Assignment or Benefits & Authorization to Release Information

If I am entitled to benefits under the Medicare or any insurance policy or other health benefit plan (covering me or anyone legally responsible for me) in consideration for services provided to me by SynergyHealth Foot & Ankle, I assign, transfer, and convey the benefits payable under such program, policy, or plan for services rendered to me. I authorize payment of benefits directly to SynergyHealth Foot & Ankle, with such benefits to be applied to my bill. **I understand and acknowledge that this assignment does not relieve me of financial responsibility for charges incurred by me or anyone on my behalf, and I hereby acknowledge responsibility for and agree to pay charges not paid under the assignment, including any coinsurance amounts, deductibles, Durable Medical Equipment, and any charges for services deemed to be non-covered, not pre-certified, or not pre-authorized by my insurance.**

_____ (*Initial*) I give my consent for examination and treatment by SynergyHealth Foot and Ankle.

Responsible Party Signature: _____

Relationship: _____ Date: _____

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Patient HIPAA Acknowledgement and Designation

I. Acknowledgment of Practice's *Notice of Privacy Practices (NPP)*:
By subscribing my name below, I acknowledge that a copy of the Notice of Privacy Practices (NPP) was made available at my request, and that I have read (or had the opportunity to read if I so chose) and understand the notice of Privacy Practices (NPP) and agree to its terms.

Name of Patient: _____ Signature _____

II. Designation of certain relatives, Close Friends and other Caregivers as my Personal Representative:
I agree that the practice may disclose certain pieces of my health information to a personal Representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In the case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my healthcare.

Name: _____ Relationship:_____ Phone #: _____

Name: _____ Relationship:_____ Phone #: _____

Name: _____ Relationship:_____ Phone #: _____

Name: _____ Relationship:_____ Phone #: _____

III. Request to Receive Confidential Communication by Alternative Means:
As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communication to me by the alternative means that I have listed below

OK to leave voice messages with detailed information ☐ Cell ☐ Home ☐ Both
OK to leave voice messages with call back number **only** ☐ Cell ☐ Home ☐ Both
OK to mail to address listed above ☐ Yes ☐ No
OK to text message with detailed information ☐ Yes ☐ No

IV. The preceding Authorization are voluntary and I can refuse to agree to their terms without affecting any of my rights to receive healthcare at the Practice
V. These Authorizations may be revoked at any time by notifying the Practice in writing at the Practice mailing address marked to the attention of "HIPPA Compliance Officer."
VI. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of the any revocation
VII. I may see the copy of the information described in this form, if I ask for it, and I will get a copy of this for after I sign it.
VIII. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction. I fully understand this authorization form, and have received an executed copy if one was requested.
IX. This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked.
X. I have read all

_____

Print Name of Patient | Signature of Patient | Date

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Financial Policy Agreement

We at SynergyHealth Foot & Ankle are committed to providing you with the best possible care. If you have medical insurance, we are eager to help you receive your maximum allowable benefits. In the event you are uninsured, we are still committed to providing quality care for all patients. In order to achieve these goals, we need your assistance, understanding and agreement of our payment policy.

Unless insurance arrangements have been approved in advance by our staff, payment for services is due at the time services are rendered. We accept cash payments, checks, MasterCard, Visa, American Express and Discover.

Returned checks and balances older than 30 days are subject to additional collection fees and interest of 1.5% per month. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize that:

- Insurance is a contract between you and your insurance company. You are responsible to uphold its terms.
- Our fee generally falls within the acceptable range by most insurance companies and therefore is covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of the "usual, customary, and reasonable" (U.C.R.) fee for this region. Thus, our fees are considered usual, customary, and reasonable by most companies. This does not apply to companies who reimburse based on arbitrary "schedules" or fees, which bears no relationship to the current standard of fees and cost of care in this geographic region. Not all services are a covered benefit in all contracts; some insurance companies arbitrarily refuse to cover certain services. We will gladly give you the information needed for you to check with your insurance company if a service is covered or not.
- MEDICARE PATIENTS: We would like you to understand that accepting assignment means that you are responsible for the yearly deductible and for the 20% (co-insurance) of what Medicare allows. You are also responsible for services that your supplemental/secondary insurance does not cover. If your supplemental/ secondary insurance does not pay this amount, YOU are responsible for the balance.
- We will file your insurance claim as a courtesy that we have always extended to our patients. However, all charges are your responsibility, not your insurance company's. We will make our best effort to collect from them, but if despite our best efforts we are not successful, you are responsible for the unpaid balance.
- We realize that temporary financial problems may affect timely payment of your account. We don't want any financial problems to get in the way of our good relationship with you. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

  If you have any questions about the above information or any uncertainty, please don't hesitate to ask us.
  We are here to help you!

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1. All co-payments are due at the time of visit. Postdated checks are not accepted.
2. Co-insurance and unmet deductibles are due prior to scheduled surgeries and procedures. Once benefits are verified and your estimated financial responsibility is calculated you will be notified of the payment amount and due date.
3. You are ultimately responsible for payment of charges for services you receive from our office.
4. In accordance with your insurance member handbook, it is your responsibility to provide accurate insurance information and to present for your care; you will be responsible for payment at the time of service. We will provide you with a copy of the insurance claim so that you can obtain reimbursement from your insurance company.
5. It is your responsibility to ensure that we are participating providers with your insurance.
6. If you plan requires a referral it is your responsibility to obtain this prior to being seen by our provider.
7. Cancellations for appointments and procedures must be received at least 24 hours prior to the scheduled appointment. Patients who fail to cancel a scheduled appointment will be subject to a cancellation fee.
8. Payment is due for rendered services 30 days from the date of your billing statement. Unpaid previous balances must be paid in full prior to any additional visits, unless arrangements have been made with our financial counselor. Any returned checks will be subject to a $35.00 fee.
9. Medical record requests are to be received in writing at least 72 hours prior to the date needed. Fees for medical records are set in accordance with allowable amounts as defined by the state of Virginia. Payment must be received prior to record delivery. No more than 5 pages may be faxed.
10. Administrative Services: There is $25.00 charge for each administrative service payable prior to service completion. This Administrative Service fee covers specific administrative services including any and all paperwork pertaining to disability, work leave for **non-operative** medical conditions, any revisions needing to be made on previously requested and completed paperwork for information that was not specified prior to completion, and any other administrative item that not covered by insurance.
11. All sales are final with any over the counter (OTC) or durable medical equipment (DME) items.
12. Patient Refunds: Please allow 60 days from the time your insurance company responds to a claim for your refund to be processed. Refunds will be issued in the form of a paper check that will be mailed to your home address on file.
13. Collections Fees: You will be sent up to three notices for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notices your account will be forwarded to our collection's agency. If your account is sent to a collection's agency, a 35% fee will be added to your account. You bear complete financial responsibility for any fee(s) incurred.
14. If you are uninsured, compliance with our financial agreement is still required in full. An outline of our self-pay patient agreement is available to review upon request.

I have received, read, and understand the financial policy of SynergyHealth Foot and Ankle Associates, PLLC and agree to its terms.

Signature of Patient/Guardian _____ Date _____