West End Foot and Ankle: Patient Registration Form

7650 Parham Rd, Suite 215 (MOB II) Richmond, VA 23294 804-346-1779

Patient Information

Last Name:_____ First:_____ MI:_____ Suffix:_____

SS#:_____ Male ☐ Female ☐

Address:_____ City:_____ ST:_____ Zip:_____

Date of Birth:_____ Marital Status:_____

Home:_____ Cell:_____ Work:_____

Email:_____

Who referred you to Dr. Weiss?_____ Work Status:_____

Insurance Policy Holder or Guarantor Information (if different than self):

Last Name:_____ First:_____ MI:_____ Suffix:_____

Address:_____ City:_____ ST:_____ Zip:_____

SS:_____ DOB:_____ M☐ F☐ Relationship:_____

Home:_____ Cell:_____ Work:_____

Emergency Contact Information:

Name:_____ Phone#:_____ Relationship:_____

Primary Care DR:_____ Phone#:_____
First and Last Name

Preferred Pharmacy:_____ Phone#:_____

Authorization to Disclose Patient Information (HIPAA)

I authorize West End Foot and Ankle to discuss my healthcare, treatment and billing with the following person(s):

Primary Care DR:_____

Name:_____ DOB:_____

Name:_____ DOB:_____

Name:_____ DOB:_____

I understand this authorization may be revoked by me at any time and must be done so in writing.
I acknowledge that I was provided a copy of the Notice of Privary Practices and that I have read (and had the opportunity to read) and understand the Notice.

X_____ Date:_____
Signature of Patient or Patient Representative

Relationship of Patient Representative:_____

Employee Signature:_____ Date:_____

ACCT#:_____

West End Foot & Ankle
Please Tell Us About Your Health

What are your foot/ankle complaints? _____
Are you having pain or discomfort at this time? Yes ☐ No ☐
Is yes is pain from an injury? Yes ☐ No ☐

Are you currently taking any medication? Yes ☐ No ☐
Please List Medications:

_____

_____

_____

Are you ALLERGIC or had adverse reactions to any medication or substance? Yes ☐ No ☐
Please List:

_____

_____

Have you been under the care of a medical doctor other than your PCP during the past 2 years? Yes ☐ No ☐
Name_____ Type_____

Have you been under the care of another podiatrist during the past 2 years?
Yes ☐ No ☐ Name:_____

Date of Last Physical Exam: _____
List surgeries (other than foot surgeries):

_____

_____

List any foot surgeries:

_____

Height_____ Weight_____

Check any of the following conditions you have had or currently have.

Diabetic ☐ Latest A1C_____ Name of Endocrinologist_____

☐ Heart Disease	☐ Artificial Heart Value	☐ Pacemaker
☐ Stroke	☐ High Blood Pressure	☐ Clotting Disorder/
☐ Asthma	☐ Arthritis	☐ Blood Clot History
☐ Liver Disease	☐ Hepatitis A B C	☐ Alcoholism/Addiction
☐ Psychiatric Treatment	☐ AIDS/HIV	☐ Ulcers
☐ Seizures/Dizzy Spells	☐ Cancer	☐ Kidney Trouble
☐ Thyroid Disease	☐ Gout	

Do you have any disease, condition or problem not listed above? Yes ☐ No ☐
Please explain:

_____

Family History of Diabetes: **Yes** ☐ **No** ☐
Family History of Blood Clots: Yes ☐ No ☐
Have you have any falls recently: Yes ☐ Date: _____ No ☐

Current Smoker ☐ Former Smoker ☐ Never Smoked ☐
Do you drink alcohol?_____ How long?_____How much per day_____

I have answered all questions truthfully and to the best of my knowledge.
Patient/Representative
Signature:_____Date_____

West End Foot and Ankle - Financial Policies

At West End Foot and Ankle (hereafter referred to as "WEFA"), we are committed to providing you with the best possible care and establishing a mutual understanding of this practice's financial policies. We need your assistance and knowledge of our policies and insurance to achieve these goals.

Insurance: Our office accepts most insurance plans. Your insurance company requires us to view your insurance card at EACH visit so we may correctly file your claim. If the insurance policy you present is expired or incorrect, please be aware that you will be responsible for any non-payment/denied claims by your insurance company. If your insurance company requires a referral, you must obtain a referral before your visit. If the insurance company notifies us after seeing the patient that a referral was needed but not requested by the patient, then we will bill you in full for the visit.

Not all services and supplies are covered benefits. Also, "convenience items" are not billable to insurance and are payable in full at the time of service. All bills from WEFA to the patient or patient representative are due in full upon receipt. WEFA only files to primary insurance. Payment for services not covered by your insurance company is the responsibility of the patient and is due in full at the time of service.

WEFA does not participate in or file with any Workman Compensation Policies.

Commercial Insurance Payments: Copayments are due at the time services are rendered. Once we are notified by your insurance company, bills will be mailed for any balance due.
We accept cash, checks, Mastercard, Visa, and Discover. The billing office will gladly discuss your treatment costs and any questions.

Affordable Care Act Patients: If you miss or only partially make a premium payment at any point in time, you will be responsible for paying WEFA in full for services that your health insurer will not cover due to non-payment of your health insurance premium.

Medicare: We will file your claim only if Medicare is your primary insurance. If Medicare does not automatically forward your claim to your secondary insurance, you are responsible for the balance on your claim after Medicare has paid WEFA.

If your account is turned over to a collection agency, WEFA, at the Doctor's discretion and under standard accepted medical practices, will no longer provide you with any medical or other service. Additionally, you are responsible for charges, interest, finance fees, court costs, legal fees, and collection fees.

Routine Foot Care: WEFA charges $75 for Routine Foot Care (Cutting of toenails and shaving off of non-infected corns and callouses). Medicare may not always cover routine foot care, as it has a very strict policy, and certain conditions must be met. If you have any questions regarding this, ask the Doctor.

Fees:

- There is a $50 fee for any appointment not canceled with at least 24 hours prior/ advance notice.
- There is a $100 fee for surgery not canceled with at least 48 hours prior/advance notice except when medically necessary.
- There is a $25 administrative fee for each claim that must be filed with the insurance company due to expired or incorrect insurance information, and WEFA must fill out the paperwork on behalf of the patient each time.

Please choose only ONE of the following:

__☐__ **FILE A CLAIM for me.** I authorize payment of medical benefits directly to West End Foot and Ankle / David Weiss DPM. I authorize the release of any medical information to the insurance company(ies) whose policy information I have supplied to process claims on my behalf. I authorize copies of this authorization to serve in place of an original.

__☐__ **SELF PAY.** Do NOT file a claim(s) for me. I am self-pay or will submit my claims to my insurance company or discount plan.

Please be advised that Healthcare is Not Free and that most people will have financial responsibility for services rendered by WEFA. Just as you, our patients, expect excellence in medical/surgical care, we expect them to honor the financial obligations that the Healthcare System places on them.

Signature of Patient or Legal Representative: **Date:**

_____ _____

Chart:_____