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_____

Circle 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 & Ankle, LLC: Financial Policy Information Agreement

Welcome to West End Foot and Ankle (WEFA). We are committed to providing you the best possible care and to establishing a mutual understanding regarding the financial policies of this practice. In order to achieve those goals, we need your assistance and understanding of our policies as well as those of your insurance policy.

Our office accepts most insurance plans. We are required by your insurance company 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 plan requires a referral, it is your responsibility to obtain a referral before your visit. If we are notified by the insurance company after seeing the patient that a referral was required but was not requested by the patient, then we will bill you in full for the visit. Not all services and supplies are a covered benefit. Also "convenience items" are NOT billable to insurance and payable in full at the time of service. All bills from WEFA to the patient/patient representative are due in full upon receipt. WEFA only files to primary insurance. WEFA does not participate nor file with any Workman Compensation Policies.

Commercial Insurance Patients: Copayments are due at the time services are rendered. We accept cash, checks and Master Card/Visa/Discover. Bills will be mailed for any balance due once we are notified by your insurance company. The billing office will gladly discuss your treatment costs and any questions you may have.

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

Medicare: We will file your claim for you only if Medicare is your primary insurance company. 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, West End Foot & Ankle, at the doctor's discretion and in accordance with standard accepted medical practices, will no longer provide medical or any other services to you. Additionally, you are responsible for any and all charges, interest, finance fees, court costs, legal fees and collection fees.

There is a $25 fee for appointment not cancelled with at least 24 hours prior/advance notice.
There is a $50 fee for surgery not cancelled with at least 48 hours prior/advance notice except when medically necessary.
There is a $25 administrative fee for each claim that requires refiling to the insurance company due to expired or incorrect insurance information.

Please choose only one of the following:

_____FILE A CLAIM for me. I authorize payment of medical benefits directly to West End Foot & Ankle/David T. Weiss DPM. I hereby authorize the release of any medical information to the insurance company (ies) whose policy I have supplied in order to process my claim.

_____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.

Healthcare is NOT FREE. Please understand that MOST people will have a financial responsibility for services at our clinic. Just as you, our patient, expect excellence in medical/surgical care, we expect our patients to honor their financial responsibilities that the Healthcare System places on them.

Signature of Patient or Legal Representative: Date:

_____