RESTON PODIATRY ASSOCIATES, LTD.

Patient's FIRST_____M.I. _____LAST_____SEX:_____

Home Address _____ City _____

State _____Zip _____-_____Home Phone: _____ Cell Phone:_____

E-MAIL :_____SSN:_____ AGE: _____ DOB: _____

Race: Other

Ethnicity: Hispanic or Latino

Marital Status: (Single) Patient's occupation _____

Employer _____ Work Phone _____

Address_____ City/State/Zip _____

Name of Financially Responsible Person _____

Relationship to Patient: Other Responsible Person's DOB:_____ SSN:_____

Address (If different from patient) _____

Parent's name (If patient is minor) _____

Parent's Employer _____ Parent's Occupation _____

Mother's Work Phone _____Father's Work Phone _____

Name of nearest relative not living with you _____

Address _____ City/State/Zip _____

Home Phone _____ Work Phone _____

Referred to Our Office By: _____

MEDICAL INSURANCE INFORMATION

WE INVITE YOU TO DISCUSS ANY QUESTIONS REGARDING OUR SERVICES OR OUR FEES.

THANK YOU.

REVISED 07/26/2017

Patient's Name_____ DOB_____

CHIEF CONCERN/PRESENT ILLNESS:

What is your current foot/ankle problem_____

Is your current foot/ankle problem: Left ☐ Right ☐ Both ☐

How long have you been bothered by the above_____

What have you done for your foot/ankle problem_____

Was your foot/ankle problem a result of an accident No . If so, date of accident _____

Circumstances of accident _____

MEDICAL HISTORY:

Family Doctor's Name _____Address _____ Phone:_____

Are you now or have you been under a physician's care during the past 2 years: Yes ☐ No ☐

Date of Last Physical exam _____ Are you presently taking any medication Yes ☐ No ☐

If yes, name of medication(s):_____

_____

Have you ever tested **positive** for Human Immunodeficiency Virus (HIV) Yes ☐ No ☐

Have you ever tested **positive** for a communicable disease (e.g. Hepatitis, Tuberculosis, Syphilis,Gonorrhea, Chlamydia, Herpes Simplex) Yes ☐ No ☐ Name of condition _____

Do you have a history of Alcoholism or Drug Dependency? Yes ☐ No ☐

Are you Pregnant? Yes ☐ No ☐

Do you use tobacco? Yes ☐ No ☐ If yes, what type/how often _____

Check if you have been treated for:

☐ Allergies	☐ Asthma	☐ Epilepsy	☐ Kidney Disease
☐ Anemia	☐ Bleeding tend.	☐ Glaucoma	☐ Liver Trouble
☐ Anxiety	☐ Blood Clot (DVT)	☐ Gout	☐ Nervous Condition
☐ Arthritis (Osteo)	☐ Broken Bones	☐ Heart disease	☐ Reflux (GERD)
☐ Arthritis (Rheum)	☐ Cancer	☐ Hepatitis	☐ Stroke (CVA)
☐ Arthritis (Other)	☐ Depression	☐ High Blood Pressure	☐ Thyroid
	☐ Diabetes	☐ High Cholesterol	☐ Ulcers

Other_____

Have you ever experienced any unusual or allergic reactions to **LATEX/ADHESIVE** or **ANY**

Medications (such as) Novocaine, Penicillin, Sulfa, etc: **If yes**, which one(s)_____

_____

Have you had surgery?:Type: _____ year

_____ year_____

_____ year _____

Patient's Name_____ DOB_____

FAMILY HISTORY:

Have any of your blood relatives had:

☐ Anesthesia Problems	☐ Cancer	☐ High Blood Pressure
☐ Arthritis	☐ Diabetes	☐ Kidney Disease
☐ Blood Clot (DVT)	☐ Heart Disease	☐ Obesity

Foot problems similar to yours _____

Is there any other general or foot health information that should be known? _____

_____

- Virginia Law requires us to inform you that your blood may be tested for the HIV (AIDS) virus if any health care worker is accidentally exposed to your blood in a manner that could transmit HIV infection. Your consent is **NOT** needed, but you **will be** informed if tested.

- ***I understand that honest and complete answers to each question stated above are important to the provision of my medical care and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on the form I should ask the doctor or a member of the office staff for assistance.***

Patient Name: _____

Patient Signature: _____

Parent/Guardian Signature: _____

Date: _____

PATIENT NAME _____DOB_____

PATIENT ACCOUNT # _____

PATIENT IS: PLEASE CHECK ONE:

Employed ☐ Unemployed ☐ Full time student ☐ Part time student ☐

PATIENTS RELATIONSHIP TO INSURED: PLEASE CHECK ONE:

Spouse ☐ Child ☐ Other: _____

PRIMARY INSURANCE:

SUBSCRIBER'S NAME _____

SUBSCRIBER'S DATE OF BIRTH _____

SUBSCRIBER'S SS# _____

SUBSCRIBER'S EMPLOYER _____

ADDRESS OF EMPLOYER _____

_____

_____

PHONE NUMBER: _____

SECONDARY INSURANCE:

SUBSCRIBER'S NAME: _____

SUBSCRIBER'S DATE OF BIRTH _____

SUBCRIBER'S SS#_____

SUBCRIBER'S EMPLOYER_____

ADDRESS OF EMPLOYER _____

_____

PHONE NUMBER: _____

ALL INSURANCE COVERAGE MUST BE DISCLOSED. FAILURE TO DO SO CONSTITUTES **FRAUD…**

REVISED 07/26/2017

Patient's Name_____ DOB_____

PATIENT AUTHORIZATION

I hereby authorize **RESTON PODIATRY ASSOCIATES LTD** to release medical information acquired in any examination or treatment, according to the following:

(ASSIGNMENT OF BENEFITS)

I request that payment of authorized insurance benefits be made to **RESTON PODIATRY ASSOCIATES LTD,** for services furnished to me by the physician.

(MEDICARE PATIENTS)

This office accepts Medicare assignment. Medicare patients are fully responsible, for the initial yearly deductible and the 20% co-payment. Federal law requires that physicians collect this amount. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related service

I also understand that I (husband, wife, dependent) am fully responsible for my charges, and filing of claims on my behalf by **RESTON PODIATRY ASSOCIATES LTD** is done, **PURELY AS A COURTESY.**

I understand that any outstanding balance after 90 days of the date of service will be referred to an outside collection agency for recovery. Accounts referred to an outside collection agency will be subject to a collection fee. Unpaid accounts will be reported to Equifax, TransUnion, Experian, and CBC Innovis.

PLEASE NOTE: A $25.00 WILL BE CHARGED FOR ALL RETURNED CHECKS. INTEREST WILL BE CHARGED AT 18% ON ANY BALANCE NOT PAID WITHIN 30 DAYS.

PATIENT SIGNATURE _____

DATE _____

WE WILL WAIT UNTIL WE HEAR FROM YOUR INSURANCE COMPANY, THEN IT WILL BE YOUR RESPONSIBILITY TO CLEAR YOUR ACCOUNT IN FULL.

ALL COPAYS AND CASH ITEMS ARE PAYABLE ON THE DATE OF SERVICE

THANK YOU

WORKMAN'S COMPENSATION/COMPENSATION CLAIMS

I understand that this claim is being submitted as a compensation claim for an injury. If compensation is denied, I understand that I will be fully responsible for all charges.

PATIENT SIGNATURE _____

DATE _____

Reston Podiatry Associates, LTD

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices described in this notice while it is in effect. This notice takes effect September 1, 2013, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health information

We will use and disclose your protected health information about you for treatment, payment and health care operations.

Following are examples of the types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. That includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment from your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits; reviewing services provided to you for protected health necessity; and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, licensing, and conducting or arranging for other business activities

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your protected health information with third party "business associates: that performs various activities (e.g., billing, and transcription services) for the Practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Sale of Health Information: We will not sell or exchange your health information for any type of financial remuneration without your written authorization.

Fundraising Communications: We may use or disclose your health information for fundraising purposes, but you have the right to opt out from receiving these communications.

Uses and Disclosures Based on Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosures permitted by your authorization while it is in effect. Without your written authorization, we will not disclose your health care information except as described in the notice.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such information as necessary and if we determine that it is in your best interest based on our professional judgement. Then we may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of location, general condition or death.

Marketing: We may use your protected health information to contact you with information about treatment to an alternative that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities. If we are paid by a third party to make marketing communication to you about their products or services, we will not make such communications to you without your written authorization. Except as stated above, no other marketing communications will be sent to you without your authorization.

Research; Death; Organ Donation: We may disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company requested by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent treat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Required by Law: We may use or disclose your protected health information when we are required to do so by law, for example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes for determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

Process and Proceedings: We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances, such as a court order, warrant or grand jury subpoena; we may disclose your protected health information to law enforcement officials.

Law Enforcement: We may disclose limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Patient Rights

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you $0.25 for each page, $15.00 per hour for staff time to locate and copy your protected health information, and postage if you want the copies mailed to you. If the Practice keeps your health information in electronic form, you may request that we send it to you or another party in electronic form. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Accounting of Disclosure: You have the right to receive a list of instances in which we or our business associates disclose your non-electronic protected health information for purposes other than treatment, payment, health care operations and certain other activities during the past six (6) years. For disclosures of electronic health information, our duty to provide an accounting only covers disclosures after January 1, 2011 and only applies to discourses for the three (3) years preceding your request. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosure your protected health information, a description of the protected health information we disclosed, the reason for the disclosures, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional request. Contact us using the information listed at the end of this notice for a full explanation of our fee structure

Restriction Request: You have a right to request that we place additional restrictions on our use or disclosure of your protected health information. Except as noted herein, we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). We are required to accept and follow requests for restriction for health information to insurance companies if you have paid out-of-pocket and in full for the item or services we provide to you. Any agreement we may make to request additional restrictions must be in writing signed by a person authorized to make such an agreement on your behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or locations, and continues
to permit us to bill and collect payment from you.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of your disagreement requesting we amend the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of the information.

Electronic Notice: if you receive this notice on our website or by electronic mail (email), you are entitled to receive this notice in written form. Please contact using the information listed at the end of this notice to obtain this notice in written form.

Notice of Unauthorized Disclosures: If the Practice causes or allows your health information to be disclosed to an unauthorized person, the Practice will notify you of this and help you mitigate the effects.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below.

If you believe that we may have violated your privacy rights, or you disagree with a decision we made about that access to your protected health information or in response to a request you made, you may complain to us using the contact information below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with U.S. Department Health and Human Services.

Name of Contact Person: Donna Jens
Practice Manager

Telephone (703) 368-7166

Fax (703) 368-5103

Address 8577 A Sudley Rd
Manassas, VA 20110

Revised 07/26/2017

Patient's Name_____ DOB_____

Please provide the name(s) of person(s) if any, to whom you would permit Reston Podiatry Associates, LTD (RPA) to disclose personal health information as necessary for your continued health care. Please also note if specific health care information cannot be disclosed (i.e.; test results, appointment information, etc.) Otherwise, we will disclose only what is necessary for your continued health care in accordance to this Privacy Policy.

List below those individuals (family, friends, interpreter services, etc.) you will allow disclosure of your personal health information from RPA as necessary during the course of your health care services:

Name and Relation (circle one) **Allowed Disclosures(s)** **Please circle ALL or specify**

Spouse: _____ All or Specify:_____

Family/Friend-Name_____All or Specify:_____

Family/Friend-Name_____All or Specify:_____

Family/Friend-Name_____All or Specify:_____

_____Initial if you will allow interpreter services if necessary for communication with health care providers

____**(Initial)** I acknowledge and understand that Reston Podiatry Associate's policy is to send copies of test results and/or other medical information to physicians who either ordered the procedure/consult or are in need of this health information to ensure coordinated and effective diagnosis and treatment. (i.e.; your designated primary care provider or physicians/dentist seen for consult/treatment.) RPA's policy is to only disclose specific information necessary for coordination of your health care or medical treatment.

List below physicians who you **DO NOT** want specified private health information sent, which could be sent in the usual course of facilitating or coordinating medical treatment.

DO NOT SEND PHI: Provider Name:_____All or Specify:_____

DO NOT SEND PHI: Provider Name:_____All or Specify:_____

___**(Initial)** I acknowledge and understand Reston Podiatry Associate's policy to contact me by various means when necessary for my health care services that may include my home/work/cell phone, fax, and/or email. I also understand that private health information may be included in that communication to me.

I **DO NOT** want RPA to use the following methods of communication which may include my private health information:

Please list:

_____ **(Initial)** I hereby acknowledge that I have had the opportunity to read the Reston Podiatry Associates LTD Notice of Privacy Practices and received a copy (if requested).

Signature:_____ Date:_____

Printed Name:_____

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