NoVa Foot and Ankle PLLC

Name:_____ M____ F ____ Date of Birth ____/____/____ Age_____

Address:_____ Home Phone # _____

City:_____ State_____ Zip_____ Cell Phone #_____

Email Address:_____ Work Phone # _____

Employer:_____ Social Security #_____

Family Physician:_____ Physician'sPhone#_____

Parent/Spouse's Name:_____ Referred by:_____

Pharmacy: _____ Location:_____ Phone # _____

Please check any one of the following which you have had or currently have:

____ Arthritis	____diabetes	__asthma	____stroke
____ kidney disease	____high blood pressure	__ulcers	____blood clot
____ liver disorders	____poor circulation	__hiv pos	_ __heart probs
____ rheumatic fever	____lung disorders	__ankle swell	

Other: _____

Social History __non-smoker ___ smoker: Number of packs a day_____

Alcohol use: ___ none ___ social ___ moderate

Family History: Mother: ____alive ____deceased List medical problems_____

Father: __alive __deceased List medical problems_____

Have you ever had surgery? _____ When? Type ? _____

Please list all medications taken on a regular basis? Dosage _____

_____

_____

Do you have any allergies to medicine? Type? Reaction? _____

Describe your foot problem (note which foot and area of the foot) _____

_____

How long has this problem existed? _____

Shoe Size_____ Weight_____ Height_____

Primary Insurance Information

Primary Insurance Company:_____ HMO? Yes_____ NO_____

Address:_____

_____

Name of Policy Holder:_____ Date of Birth:_____

Relationship to Patient: _____

ID/ Subscriber Number_____ Group Number:_____

Policy Holders Social Security Number:_____

Secondary Insurance Policy

Secondary Insurance Company: _____ HMO? Yes_____ NO_____

Address: _____

Name of Policy Holder_____ Date of Birth:_____

Relationship to Patient: _____

ID/ Subscriber Number:_____ Group Number:_____

Policy Holders Social Security Number:_____

Office Policies

HMOs: All patients with HMOs are responsible for obtaining referrals from primary care physicians before seeing a specialist. Please ask your physician's office to obtain authorization numbers and specify possible treatment (when necessary) in order for Dr. Parikh to treat you.

I hereby **authorize** Dr. Parikh apply for benefits on my behalf for coverage of services rendered by her. I request payment to be made directly to Dr. Parikh and **authorize** the release of any necessary information to my insurance company.

Dr. Parikh is a participating provider for many insurance companies. As a **courtesy** to our patients, this office may file claims with your insurance company. In most case Dr. Parikh will accept the usual and customary fee approved by your insurance company. **I understand and agree that I am financially responsible for payment of any for services rendered that are not paid by my insurance company. Interest will accrue on any unpaid balances after 30 days.**

I agree that any balance must be paid in full within 30 days, or an arrangement made in writing with this office. If I do not make timely payment of any amount owned on my account, I authorize Dr. Parikh to retain the service of any attorney and/or collection agency to assist with collection of any outstanding balance. In the event that my account is referred to any attorney or collection agency I authorize all my records may be released to them for use in collection of charges for services rendered. I agree to pay such cost that may be incurred in the collection of these charges, which are but not limited to collection agency fees of 30%, attorney fees of 30% and court costs.

Signature _____ Date_____

Nova Foot and Ankle PLLC
112 Elden Street, Suite D
Herndon, VA 20170

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996" (HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications. I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature:_____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date: _____ Initials: _____ Reason: _____