WELCOME TO FAIR OAKS PODIATRY AND SPORTS MEDICINE, P.C.

## PLEASE PRINT CLEARLY

Patient Name _____ SSN: _____

Street Address _____ Apt.# _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email Address _____

Age _____ Sex _____ Date of Birth _____ Height _____ Weight _____ Shoe Size _____

Employer _____ Address _____

Name of Spouse/Parent _____ Spouse/Parent SSN: _____

Chief Complaint/Reason for visit _____

Date of last general physical exam _____

Name and Phone # of doctor _____

Allergies _____

List of Medications _____

Do you have: ( ) High Blood Pressure ( ) Diabetes ( ) Cardiac Problem ( ) Blood Disorders?

Who referred you to our office? _____

**If you have, One-Net, Carefirst Indemnity/PPO only, Cigna PPO/POS, MAMSI, MDIPA, Medicare, Optimum Choice, United Healthcare PPO/POS/Choice Plus, Great West, One Health, Aetna PPO/POS/HMO or PHCS/Multi-Plan, we will submit to your insurance company. Your copay is due at the time services are rendered. We will submit to your insurance carrier when given all the necessary information to process your insurance claim (i.e., full name of insured, date of birth, social security number, copy of card, and authorization number/referral if necessary). If you can not provide us with this necessary information, you are assuming financial responsibility for your medical care. Payment is due when services are rendered.**

I understand that I am financially responsible for all charges of services to me, regardless of any insurance billing. This includes balance remaining after payment of possible insurance benefits, copays, and deductibles. Accounts over 60 days old are subject to a 1.5% finance charge per month, rebilling charges, and collection fees. I authorize payment of insurance benefits directly to Dr. Shabazz. I authorize the release of any medical information necessary to process my insurance claims. Please note that there will be a $25.00 fee assessed for an appointment cancelled within 24 hours of a missed appointment. Further, I understand that I can be billed for any insurance claim left unpaid by my carrier after 60 days. By signing below, I agree to the terms of Dr Shabazz's office policy. If unsigned, no treatment will be rendered me. This policy will be enforced. **UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE WITH DR. SHABAZZ OR THE OFFICE MANAGER.** Thank you in advance for accepting our policy.

Signed _____ Date _____

I consent to disclose to my spouse/parent/guardian about my medical records/medical billing information. I further understand that I can reverse this authorization at any time.

Signed _____ Date _____

**FAIR OAKS PODIATRY AND SPORTS MEDICINE, P.C.**

**3620 Joseph Siewick Drive, Suite 303**

**Fairfax, VA 22033**

**Phone: (703) 865-6783 Fax (703) 865-6784**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), 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 you 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 personal restrictions, but if you do agree then you are bound to abide to such restrictions.

In addition, I understand that I may contact the organization above at any time and cancel this agreement.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

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**OFFICE USE ONLY**

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

| Date: | Initials: | Reason: |
|---|---|---|
| | | |

## INSURANCE INFORMATION

It should be noted that if we are missing any of the following required information, we have the right to request payment in full for services rendered. We also request a copy of the insurance card. If there is none present, we will have the right to have payment in full until receipt of the card. Thank you for your cooperation so we may assist you in billing your insurance.

**Insurance Co. Name:** _____

**Policy Holder's Name:** _____

**Policy Holder's D.O.B.:** _____

**Relationship to Policy Holder:** _____

I acknowledge that I understand the above information and will abide by this office's policy.

_____ _____

Signature Date