NoVa Foot and Ankle PLLC

Name:_____ M☐ F☐ Date of Birth ____/____/____ Age_____

Address:_____ Home Phone # _____

City:_____ State VA 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? No 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:_____ Referral Needed? Yes____ NO____

Name of Policy Holder:_____ Date of Birth:_____

Relationship to Patient: _____

Secondary Insurance Policy

Secondary Insurance Company: _____

Name of Policy Holder_____ Date of Birth:_____

Relationship to Patient: _____

Office Policies

HMOs: All patients with HMOs are responsible for obtaining referrals from primary care physicians before seeing a specialist. Please ask your primary care physician's office to obtain authorization numbers and specify possible treatment (when necessary) in order for NOVA Foot and Ankle to treat you. I hereby **authorize** NOVA Foot and Ankle to apply for benefits on my behalf for coverage of services rendered by them. I request payment to be made directly to NOVA Foot and Ankle and **authorize** the release of any necessary information to my insurance company. NOVA Foot and Ankle 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 cases, NOVA Foot and Ankle will accept the usual and customary fee approved by your insurance company. If a referral is missing and insurance does not pay, balance will be the patient's responsibility. I understand that all balances are due at the time of the visit and that if I have a deductible higher than $500, I will be asked to make a payment of $120. I understand that for any in-office procedures require a $250 deposit and for any outpatient surgery, a deposit of $500 will be collected. **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 owed on my account, I authorize NOVA Foot and Ankle to retain the service of any attorney and/or collection agency to assist with the collection of any outstanding balance. In the event that my account is referred to an 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 costs 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. I understand that in order to obtain records copies of my medical records or have them sent, I will need to have a HIPAA release on file, I also understand that there may be a charge for the copy of my records. I understand that the office will not email me any records and that I will have access to my records through the portal if I choose to give my email to the office.

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: _____

Informed Consent for Telehealth Services

Introduction:
Telehealth involves the use of medical information exchanged from one site to another via electronic communications. Providers provide services using interactive audio and video telecommunication system that permits real-time communication to persons who are at some distance from the provider.

Privacy and Security: I understand that for this encounter, electronic systems used will incorporate security protocols as approved by Federal and State regulations, to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. I understand and acknowledge that security protocols could fail, causing a breach of privacy of personal medical information.

Nature of Telehealth Consultation: I consent the office of NoVA Foot and Ankle who explained to me how the video and conferencing technology will be used for the purposes outlined below:

1. Discuss and monitor examination/procedure/treatment
2. Diagnosis, follow-up and educational purposes
3. Photo recordings may be taken during the encounter
4. Non-medical technical personnel may be present in the telehealth area to aid in video transmission

Medical Records: I understand that the laws that protect the privacy and the confidentiality of medical information also apply to telehealth and that no information obtained in the use of telehealth, which identifies me, will be disclosed to researchers or other entities without my consent.

Alternatives: I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My Provider has explained the alternatives to my satisfaction.

Risks and Consequences: The telehealth consultation will be similar to a routine medical office visit, except interactive video technology will allow you to communicate with a Provider at a distance. The use of video technology to deliver healthcare and educational services is a new technology and may not be equivalent to direct patient to Provider contact. Following the telehealth consultation, your Provider may recommend that you come in for an office visit or go to a Hospital for further evaluation.

Rights: I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment. I understand that I have the right to inspect all information obtained and recorded in the course of a telehealth interaction, and may receive copies of this information for a reasonable fee. I understand that it is my duty to inform my Provider of electronic interactions regarding my care that I may have with other healthcare providers.

I will have a direct conversation with the doctor, to ask questions concerning telehealth service, if I have any further questions. My questions have been answered and the risks, benefits, and any practical alternatives have been discussed with me in a language in which I understand. All blanks or statements that required completion were completed before I signed this form.

I hereby consent to participation in a telehealth consultation.

_____ _____

Print Name of Patient and Date of Birth | Date

_____ _____

Signature of Patient | Witness