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

PLEASE PRINT CLEARLY

Patient Name: _____ SSN: _____

Street Address: _____ Apt. # _____

City: _____ State: _____ Zip Code: _____

Home Number: _____ Cell Phone: _____

Email Address: _____

(You will receive emails regarding inclement weather or announcements from us when our phone lines are not available.)

Age: _____ Gender: □ F □ M Date of Birth: _____ Height: _____ Weight: _____ Shoe Size: _____

Marital Status: □Single □Married □Divorced □Widowed □Partner Spouse Name: _____

Name Emergency Contacts: _____

Emergency Contact Number: _____ Relationship to Patient: _____

Employer: _____ Address: _____

Chief Complaint/ Reason for Visit:

_____

_____

Date of Last General Physical exam:

_____

Primary Care Physician Name: _____Phone Number: _____

List Allergies:

_____

_____

List Medications:

_____

_____

Do you have: □High Blood □Pressure □Diabetes □Cardiac Problems □ Blood Disorder?

Pharmacy Name: _____ Pharmacy Phone Number: _____

Who referred you to our Office? _____

INSURANCE AND BILLING 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 have the right to request payment in full until receipt of the insurance card. Thank you for your cooperation so we may assist you in billing your insurance.

Primary/Secondary/ Tertiary Insurance Coverage (EMAIL: office.fairoaksfeet@gmail.com)

Primary Insurance: _____ Policy Holder: _____DOB:_____.

Policy holder's relationship to patient: _____.

Secondary Insurance: _____ Policy Holder: _____DOB:_____.

Tertiary Insurance: _____ Policy Holder: _____DOB:_____.

If you have, One-Net, Carefirst Indemnity/PPO/HMO/OA, Cigna PPO/POS/OA/HMO, MAMSI, MDIPA, Medicare, Medicare Advantage, United Healthcare PPO/POS/ Choice Plus/ Optum Choice, Great West, One Health, Aetna PPO/POS/OA/HMO, Aetna Medicare or PHCS/Multiplan, 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 rendered 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/Fair Oaks Podiatry and Sports Medicine. I authorize the release of any medical information necessary to process my insurance claims. Further, I understand that I can be billed for any insurance claim left unpaid by my carrier after 60 days. **PLEASE NOTE THAT THERE WILL BE A $25.00 FEE FOR MISSED APPOINTMENTS.** By signing below, I agree to the terms of Dr. Shabazz's office policy. If unsigned, no treatment will be rendered to 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.

I acknowledge that I understand the above information and will abide by this office Policy.

Patient Name: _____Patient Signature: _____

Guardian Name (if minor): _____ Guardian Signature: _____

Date: _____

I consent to disclose my medical records/medical billing information to:

NAMES: _____

Patient Signature: _____ Date: _____

FAIR OAKS PODIATRY AND SPORTS MEDICINE, P.C.

12011 Lee Jackson Memorial Hwy., Suite 440

Fairfax, VA 22033

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

Office.fairoaksfeet@gmail.com

NOTICE OF PRIVACY PRACTICES

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 the treatment directly and indirectly.
- Obtain payment from third party-payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may request and electronic/printed copy of the NOTICE OF PRIVACY PRACTICES with a more complete description of the uses and disclosure 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 correct 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 heath 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 (if the patient is a minor): _____
SIGNATURE OF PATIENT: _____
DATE: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature of this NOTICE OF PRIVACY PRACTICES but was unable to do so as documented.

DATE:	INITIALS:	REASON: