13510 Midlothian Turnpike
Midlothian, VA 23113
Telephone (804) 794-4550
Fax (804) 794-7648

ASSOCIATED PODIATRISTS, INC

Neeraj Narang, DPM & Anita Patel, DPM

Specializing in Podiatric Surgery

PATIENT INFORMATION

Patient Name: _____ **Date of Birth:** _____ **S.S. #**_____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home #:_____ **Cell#:**_____

Please check 1 box to indicate where you would like reminder calls made. ☐ **Home** ☐ **Cell** ☐ **Work**

Email: _____

Employer_____ **Work #:** _____**Occupation:** _____

****

Primary Insurance: _____ **Subscriber:** _____

Relationship to Patient: _____ **Date of Birth:** _____

ID #: _____ **Group #:** _____

****

In case of an emergency who should we contact: _____

Relationship to Patient: _____ **Phone #:** _____

****

Please explain why you are seeing the doctor today. Indicate the area you are having pain:

_____

How long have you had this problem? _____ **Were you previously treated for this problem?**

YES or NO By whom and when? _____

Were you referred to our office? YES or NO By whom?: _____

****

Primary Care / Family Physician, Phone number, Date of last visit to PCP: _____

_____

<u>Past Medical History</u>: Are you currently receiving treatment or have received treatment in the past for any of the conditions below? (Please circle all that apply)

Alzheimer's	Convulsions	HIV	Psychological
Anemia	Currently Pregnant	Intestinal Disorders	Recurrent Infections
Arthritis	Delayed Healing	Jaundice	Respiratory Problems
Asthma	Diabetes	Kidney Disease	Rheumatic Fever
Back Pain	Epilepsy	Kidney Stone	Scarlet Fever
Birth Defects	Glaucoma	Lung Problems	Skin Disorders
Bladder Problems	Gout	Nervous Disorders	Stroke
Bleeding Disorder	Heart Disease	Past Fractures	TB
Bowel Problems	Hepatitis	Phlebitis (blood clots)	Thyroid
Cancer	High Blood Pressure	Polio	Ulcers

Past Surgical History: Please list surgery, date performed, and name of surgeon.

_____

_____

Have you ever had general anesthesia? (Please check one) ☐ YES ☐ NO ☐ Never Had

Have any problems with anesthesia? (Please check one) ☐ YES ☐ NO ☐ Never Had

If yes, please explain:_____

Current Medications List: _____

_____

Drug Allergies: _____

Family Medical History: Example: Diabetes, Stroke, Hypertension, Arthritis.

Mother: _____ Father: _____ Grand Parents: _____

Siblings: _____ Children: _____ Other (Please Specify): _____

Social History: (Please check one)

Do you abuse drugs? ☐ YES ☐ NO If yes, how much/how often? _____

Did or Do you use tobacco? ☐ YES ☐ NO If yes, how much/how often? _____

Do you use alcohol? ☐ YES ☐ NO If yes, how much/how often? _____

Review of Systems:

Please circle any of the following symptoms you experience on a regular basis.

General	Eyes	Throat	Gastrointestinal
Fever	Blurring	Soreness	Nausea
Night Sweats	Eyestrain	Hoarseness	Vomiting
Weight gain	Glasses/contacts	Difficulty Swallowing	Belching
	Discharge		Diarrhea

Skin	Ears	Genitourinary	Neuromuscular
Eruptions/Rashes	Deafness	Pain	Weakness
Cyanosis (blueish tint)	Ringing in ears	Frequent Urination	Joint Pain
Jaundice (yellowish tint)	Pain	Incontinence	Tingling
	Discharge		Varicosities
			Deformities

Head	Nose	Cardiovascular	Respiratory
Headache	Sinusitis	Chest pain	Chest pain
Fainting/Blackouts	Obstruction	Rapid/throbbing heart	Difficulty breathing
Trauma		Faintness	Bloody sputum
		Fluid/swelling on legs/arms	Last Chest X-ray: ____

I certify that all of the information above is correct.

Signature: _____ Date: _____

Witness from API: _____ Date: _____

13510 Midlothian Turnpike
Midlothian, VA 23113
Telephone (804) 794-4550
Fax (804) 794-7648

ASSOCIATED PODIATRISTS, INC

Specializing in Podiatric Surgery

OFFICE POLICY AND CONTRACTURUAL AGREEMENT

Thank you for choosing us as your podiatrist. Please understand that payment of you bill is considered part of your treatment. The following is a statement of our office policy and contractual agreement which we require that you read and sign prior to any treatment or services being rendered. All patients must complete our patient information form before seeing the doctor. Please be aware that some of the services provided may be **"NON-COVERED"** services and not considered medically necessary under the Medicare program and/or other medical insurance. Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. Please let us know if you have any questions or concerns.

TERMS OF PAYMENT: PAYMENT IS DUE WHEN SERVICES ARE RENDERED. Your insurance policy is a contract between **YOU** and **YOUR INSURANCE CO**. We are **NOT** a party to that contract. Please check with our receptionist to see if we accept your insurance. **All CO-Payments and Deductibles are due BEFORE services are rendered.** Services that are not covered will be due at the time of service. We will extend our courtesy in filing your insurance claims for you.

You will be directly responsible to Associated Podiatrists for any insurance payment sent directly to you. If your insurance company requires a special form other than a standard HCFA 1500 form, please supply us with that form. The determination of payment is made by your insurance carrier according to your individual plan. Fees for services rendered are due to Associated Podiatrist, Inc., regardless of the action of your insurance company. An account is considered past due if payment is not received within **30 days**. If payment is not received from your insurance carrier within **60 days** from date of service, then the balance becomes the patient's responsibility. If the patient's account is not maintained, a collection procedure will be taken after **60 days**. If your account is turned over to our attorney for collections, a collection cost of 33.3% of your total bill will be added plus court costs. There will be a $40 charge for all missed appointments, if we are not notified at least 24 hours in advance.

REFFERALS: It is the **PATIENT'S RESPONSIBILITY** to obtain and update **ALL REFERRALS** required by their insurance company. It is the **PATIENT'S RESPONSIBILITY** to pay for all services that are rendered **WITHOUT PRIOR APPROVAL.**

I authorize the release of all medical information to my insurance company for the processing of my claims.

I hereby request that payments from my insurance company be made directly to Associated Podiatrists, Inc., and/or Neeraj Narang, DPM and/or Anita Patel, DPM on any bill for services rendered by the physician listed above, unless I have paid for the services during the time that I am covered by the insurance company that I have listed on my Patient Information Sheet. I am responsible to give my new insurance information should it change.

I have read this agreement and understand that this a binding contract between Associated Podiatrist, Inc. and myself. I agree to the terms and conditions set forth above. I understand that if I breach a term or condition in this agreement or default in my payments to Associated Podiatrist, Inc. for services rendered, this agreement may be used against me in court.

PATIENT/GUARDIAN SIGNATURE: _____Date: _____

Revised 9/2016

13510 Midlothian Turnpike
Midlothian, VA 23113
Telephone (804) 794-4550
Fax (804) 794-7648

ASSOCIATED PODIATRISTS, INC
Specializing in Podiatric Surgery

Disclosures to Family Members and Friends

Place inside medical record.
Patient does not have to sign.

I have explained to the patient, _____, that disclosures may be made to family and friends related to the patient's health or as needed for payment of health care services. I have explained that we will only disclose information relevant to current treatment. Our patient has agreed that we may disclose health care information to: (check and list all that apply)

In person with patient	By phone	
☐	☐	**Spouse Name:** _____
☐	☐	**Parent(s) Name(s):** _____
☐	☐	**Sibling(s) Name(s):** _____
		Other:
		Relationship **Name**
☐	☐	_____
☐	☐	_____
☐	☐	_____
☐	☐	_____
☐	☐	_____