Lansdowne Podiatry

44135 Woodridge Parkway Ste
180, Leesburg, VA 20176

Phone: (571) 399 - 8171
Fax: (855) 515 - 5160

Name: _____ **Nickname:** _____

Sex: M / F **DOB:** _____

E<mail: _____ **Home #:** _____

Address: _____ _____ **Work #:** _____

City: _____ **State:** _____ **Zip:** _____ **Cell #:** _____

Primary Care Physician: _____ **PCP Phone:** _____

PCP Address: _____

Primary language: ☐ English ☐ Spanish **Race** *(optional)*: ☐ White ☐ Black/African American ☐ Hispanic/Latino

☐ Other: _____ ☐ Asian ☐ American Indian/Alaska native ☐ Native Hawaiian/Pacific Islander

Emergency Contact Name: _____ **Emergency Contact Phone:** _____

Relationship to Patient: _____ **Preferred Pharmacy:** _____

Marital Status: ☐ single ☐ married ☐ widowed ☐ divorced **Spouse/Partner name:** _____

Employer/School: _____

Please provide a copy of your insurance card to our staff. If the card is not in your name:

Insurance Policy Holder Name: _____ Policy Holder DOB: _____

Current medications prescribed by a doctor or over-the-counter: _____

_____

_____

Shoe size _____ **Height** _____ **Weight** _____

What type of shoes do you wear most often? _____

What shoes (if any) do you wear at home? _____

Are you allergic or sensitive to:

☐ Penicillin ☐ Sulfa ☐ Tape ☐ Latex ☐ Betadine *(iodine)* ☐ Aspirin ☐ NONE

☐ Tylenol™ ☐ Ibuprofen ☐ Vicodin ☐ Codeine ☐ Other *(specify)* _____

Please indicate if you have a problem with any of the following:

☐ Alcoholism	☐ Blood disorders	☐ Gout	☐ Liver	☐ Sleep apnea
☐ Allergies	☐ Breathing problems	☐ Heart disease	☐ Musculoskeletal	☐ Stomach/bowel
☐ Arthritis *(specify)*	☐ Circulation problems	☐ Heart murmur	☐ Neurological *(specify)*	☐ Thyroid *(specify)*
_____	☐ Depression/anxiety/	☐ High blood pressure	_____	_____
☐ Asthma	mental illness	☐ High cholesterol	☐ Skin disorders *(specify)*	☐ Other *(specify)*
☐ Blood clot/DVT/PE	☐ Diabetes (type 1, type 2)	☐ Kidney	_____	_____

☐ Yes ☐ No **Are you pregnant?** ☐ Yes ☐ No **Are you nursing?**

☐ Yes ☐ No **Have you ever had any surgical procedures on foot/ankle or anywhere else on your body**

If yes, please describe: _____

☐ Yes ☐ No **Do you have any artificial joints? Where?** _____

☐ Yes ☐ No **Do you have an artificial heart valve?**

Family History Is there any family history *(blood relative)* of: *(Please indicate family member)*

☐ Arthritis-_____
☐ Bleeding disorders- _____
☐ Blood clot / DVT / PE
☐ Bunions
☐ Cancer - _____
☐ Circulation problems
☐ Diabetes
☐ Neurological
☐ Heart disease
☐ Strokes
☐ Other (specify):
_____
_____
_____

Occupation or grade in school:
_____

Do you stand or sit at work?
_____

Social History

☐ Yes ☐ No Do you smoke? If yes: ☐ ½ ppd ☐ 1 ppd ☐ 1½ ppd ☐ 2 ppd

☐ Yes ☐ No Did you smoke in the past? If yes, how many years did you smoke? _____

☐ Yes ☐ No Do you drink alcohol? If yes: ☐ Socially ☐ 1 daily ☐ 2 daily ☐ >2 daily

Please check if you suffer from any of the following conditions:

☐ Flat feet
☐ Feet/toes feel numb
☐ Foot/toes/legs burn
☐ Pale or blue discoloration of the feet
☐ Heel or arch pain
☐ Pain in feet or heels when getting out of bed
☐ Non/poor healing sore, ulcer, or gangrene on the leg or foot
☐ Pain or fatigue of feet or legs in activity or exercise
☐ "Toe-in" or "toe-out" gait (walking)
☐ Ankle instability (easy twisting injuries)
☐ Ankle swelling or stiffness
☐ Achilles tendon pain
☐ Leg pain (shin splints)
☐ Coldness in the legs or feet that is uncomfortable
☐ Back pain
☐ Neck pain
☐ Poor coordination
☐ Absent or decressed pedal pulses
☐ Difficulty/pain with brisk walking or running occurring with some distance.
(This pain is relieved by rest: yes / no)

What is the reason for your visit today? _____

How long has this bothered you? Days / Weeks / Months / Longer

What treatments have you tried & have they been effecient?_____

_____

Is this condition causing or are you suffering with any of the following:

Tingling/numbness in:
☐ Legs R / L
☐ Ankle R / L
☐ Feet R / L

Pain radiating into:
☐ Toes R / L
☐ Ankle R / L
☐ Feet R / L

Weakness of the:
☐ Legs R / L
☐ Ankle R / L
☐ Foot R / L

Difficulty with:
☐ Standing
☐ Walking
☐ Sitting
☐ Bending
☐ Lifting
☐ Kneeling

HOW DID YOU HEAR ABOUT US?

☐ Newspaper (which one?)
_____
☐ Magazine (which one?)
_____
☐ Facebook
☐ Health Fair (which one?)
_____
☐ Google Ad
☐ Our website
☐ Other Website (which one?)
_____
☐ Physician (Dr.?)
_____
☐ Family / Friend
_____
☐ Yellow Pages
☐ Other

Assignment of Benefits & Authorization to Release Information

If I am entitled to benefits under the Medicare or any insurance policy or other health benefit plan (covering me or anyone legally responsible for me), in consideration for services provided to me by Lansdowne Podiatry. I assign, transfer and convey the benefits payable under such program, policy or plan for services rendered to me. I authorize payment of benefits directly to Lansdowne Podiatry, with such benefits to be applied to my bill. **I understand and acknowledge that this assignment does not relieve me of financial responsibility for charges incurred by me or anyone on my behalf, and I hereby acknowledge responsibility for and agree to pay charges not paid under this assignment, including any coinsurance amounts, deductibles, Durable Medical Equipment, and any charges for services deemed to be non-covered, not pre-certified, or not pre-authorized by my insurance.**

_____ *(initial)* I give my consent for examination and treatment by Lansdowne Podiatry.

Responsible Party Signature: _____

Relationship: _____ Date: _____

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION

I. Acknowledgement of Practice's *Notice of Privacy Practices*:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

Name of Patient: _____ Date of Birth: _____

Signature of Patient/Parent/Guardian _____ **Date: _____**

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain pieces of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my health care.

Name: _____ Last four digits of SSN or other identifier: _____

Name: _____ Last four digits of SSN or other identifier: _____

Name: _____ Last four digits of SSN or other identifier: _____

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home Telephone Number: _____ Written Communication Address:_____

_____

____ OK to leave message with detailed information.

____ Leave message with call back numbers only.

_____ OK to mail to address listed above

_____ OK to email at address on file.

Cell Phone Number: _____

___ OK to leave message with detailed information.

___ Leave message with callback number only.

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION (con't)

1. The preceding authorizations are voluntary and I may refuse to agree to their terms without affecting any of my rights to receive healthcare at the Practice.

2. These Authorizations may be revoked at any time by notifying the Practice in writing at the Practices mailing address marked to the attention of "HIPAA Compliance Officer."

3. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.

4. I may see and copy the information described in this form, if I ask for it, and I will get a copy of this form after I sign it.

5. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction, that I fully understand this authorization form, and have received an executed copy if one was requested.

6. This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked.

_____	_____	_____
Name of Patient (Printed)	Signature of Patient	Date

E-PRESCRIBING CONSENT FORM

ePrescribing is defined by a Physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribe program.

These include:

- Formulary and benefit transactions - gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions – provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

I authorize Lansdowne Podiatry to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my provider and staff at Lansdowne Podiatry, and it may include prescriptions back in time for several years, and may include prescriptions to treat HIV, substance abuse and psychiatric conditions, if applicable. I understand that my prescription history will become part of my Lansdowne Podiatry medical record.

Understanding all of the above, I hereby provide informed consent to Lansdowne Podiatry to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

This consent will remain enforce until revoked or changed.

_____

Patient Name (PLEASE PRINT)

_____	_____
Signature	Date

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www.lansdownepodiatry.com

We at Lansdowne Podiatry are committed to providing you with the best possible care. If you have Medical Insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding on our payment policy.

Unless INSURANCE ARRANGEMENTS have been approved in advance by our staff, payment for services is due at the time services are rendered. At our Virginia & DC locations, we accept payment in the form of cash, check, MasterCard, American Express, Discover, or Visa. We will be happy to help you process your insurance claim at each visit.

Returned checks and balances older than 30 days are subject to additional collection fees and interest of 1.5% per month. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize, however, that:
1. Insurance is a contract between you and your insurance company.

2. Our fees generally fall within the acceptable range by most insurance companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of U.C.R.. “U.C.R.” is defined as Usual, Customary and Reasonable fees for this region. Thus, our fees are considered Usual, Customary, and Reasonable by most companies. This does not apply to companies who reimburse based on arbitrary “schedule” of fees, which bears no relationship to the current standard of fees and cost of care in this area.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily refuse to cover certain services. We have no control over this.

4. MEDICARE PATIENTS: We would like you to understand that accepting assignment means that YOU are responsible for the YEARLY DEDUCTIBLE and for the 20% (co-insurance) of what Medicare allows. You are also responsible for services that your supplemental/ secondary insurance does not cover. If your supplemental/ secondary insurance does not pay this amount, YOU are responsible for it.

The filing of insurance claims is a courtesy that we have always extended to our patients. However, all charges are your responsibility, not your Insurance Company’s. We will make our best effort to collect from them, but if, despite our best efforts, we are not successful, you are responsible for the unpaid balance.

We realize that temporary financial problems may affect timely payment of your account. We don’t want any financial problems to get in the way of our good relationship with you. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please don’t hesitate to ask us. We really are here to help you.

1. All co-payments are due at the time of visit. Postdated checks are not accepted.

2. Co-insurance and unmet deductibles are due prior to scheduled surgeries and procedures. Once benefits are verified and your financial responsibility calculated, you will be notified of the payment amount and due date.

3. You are ultimately responsible for payment of charges for services you receive from our office.

4. In accordance with your insurance member handbook, it is your responsibility to provide accurate insurance information and to present your insurance ID card at the time of your visit. If you do not have insurance or do not present a valid insurance card, you will be responsible for payment at the time of service. We will provide you with a copy of our billing form so that you can obtain reimbursement from your insurance company.

5. It is your responsibility to ensure that our physician is in your insurance network.

6. If your plan requires a referral, it is your responsibility to obtain this prior to being seen by our provider.

7. Cancellations for appointments and procedures must be received at least 24 business hours prior to the scheduled appointment. Cancellations for scheduled surgery must be received at least 5 days prior to the scheduled surgery date and time. Patients who fail to cancel a scheduled appointment will be charged a $60.00 cancellation fee.

8. Payment is due for rendered services 30 days from the date of your billing statement. Unpaid previous balances must be paid in full prior to any additional visits, unless arrangements have been made with our financial counselor.

9. The returned check fee is $35.00.

10. Medical records requests must be received in writing at least 72 hours prior to the date needed. Fees for medical records are set in accordance with allowable amounts as defined by the state of state of Virginia and District of Columbia. Fees must be received prior to record delivery. No more than 5 pages may be faxed.

11. Administrative Services: There is a $25.00 charge for each Administrative Service payable prior to service completion. This Administrative Service Fee covers specific administrative services such as forms completion for family medical leave and disability, letters for insurance authorization for brand or non-formulary drugs, letters for employers, school, health clubs, and any other administrative item not covered by insurance.

12. All sales are final with any over the counter (OTC) or durable medical equipment (DME) items.

13. PATIENT REFUNDS - Please allow 60 days from the time your insurance company responds to a claim for your deposit refund to be processed. Refunds will be issued in the form of a paper check that will be mailed to your home address.

14. COLLECTIONS FEE: You will be sent up to three notices for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account will be forwarded to our collection agency. If your account is sent to a collections agency, a 35% fee will be added to your account. You bear complete financial responsibility for any fee(s) incurred.

I,_____, have received, read, and understand the financial policy at Lansdowne Podiatry.

_____ _____

Signature of Patient Date

_____ _____

Signature of Guardian Date

LANSDOWNE PODIATRY

44135 WOODRIDGE PARKWAY #180

LEESBURG, VA 20176

CONSENT TO TREAT AND AUTHORIZATION TO PAY

I consent treatment by Dr. Monique Muronda, DPM of Lansdowne Podiatry. I authorize the release of any medical or other information necessary to process insurance claims. I also authorize payment of medical benefits to Dr. Monique Muronda of Lansdowne Podiatry for services provided. I understand that in the event my insurance does not cover my treatment, I will be held responsible for any monies owed.

Medicare and other health care benefits providers do not always pay for all health care related costs and often impose special eligibility requirements that must be met before they will provide coverage.

Requirements for coverage for Routine Foot Care:

Paring or removal of corns and calluses, trimming or debridement of toenails, including fungal toenail and hygienic/preventative care of the foot in the absence of any localized illness or injury to the foot is usually not covered.

Patients who do not have a qualifying systemic disease and class findings which effects the foot's ability to heal are usually not covered.

Patients who are not under current care of their primary care physician for qualifying systemic conditions are usually not covered.

Patients must have at least one qualifying systemic condition and certain class findings required by Medicare to be covered for routine care. These systemic conditions and class findings are listed in the form letter provided. This letter must be filled out by the patient's Primary Physician and faxed or mailed to Lansdowne Podiatry at the address above in order to be covered by Medicare.

I understand that in the event I do not qualify for coverage and still wish to be treated, payment will be due at the time of service.

POA Name (Written and Signed) Relationship to Patient Date

Patient Name Printed _____ Date

Patient Name Signed _____ Date