Virginia Foot & Ankle Center, P.C.
www.vafootankle.com
Phone 804-285-3933

Account Number: _____

Scott T. Vantre, D.P.M.
Fellow, American College of Foot & Ankle Surgeons

John J. Kadukammakal, D.P.M.
Fellow, American College of Foot & Ankle Surgeons

Amy M. Kruger, D.P.M.
Associate, American College of Foot & Ankle Surgeons

Offices:

West End/Richmond
2008 Bremo Road
Suite #100
Richmond, Va 23226
Fax 804-288-1384

Mechanicsville
Dominion Medical Park
8239 Meadowbridge Road
Suite D
Mechanicsville, Va 23116
Fax 804-422-0971

Patient Demographics

Patient Name: _____
LAST FIRST MI

Check one: ☐ Male ☐ Female Birth Date: _____ SSN: _____

Is there any other identifying information you'd like us to know? (Nicknames, preferred pronouns, etc.) _____

Mailing Address: _____

If PO Box, Physical Address: _____

Preferred Phone #: _____ ☐ Cell ☐ Home ☐ Work ☐ Other

Alternate Phone #: _____ ☐ Cell ☐ Home ☐ Work ☐ Other

E-mail Address: _____

Place of Employment: _____ Phone #: _____

Check one: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed

Marital Status (**Check one.**): ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Referring Physician Name: _____

Primary Care Physician Name: _____

Pharmacy Name, Address, and Phone # **(REQUIRED):**

_____

Insurance & Billing Information

Bill To *(If different than patient, **REQUIRED** if patient is under 18 years of age.)*

Name: _____ Birth Date: _____

Relationship to patient: ☐ Parent/Child ☐ Spouse ☐ Other _____

Phone #: _____ Address: _____

Primary Insurance Provider: _____

Card/Member ID #: _____ Group #: _____

Cardholder Name: _____ Birth Date: _____

Relationship to Patient (**Check one.**): ☐ Parent/Child ☐ Spouse ☐ Self ☐ Other

Secondary Insurance Provider: _____

Card/Member ID #: _____ Group #: _____

Cardholder Name: _____ Birth Date: _____

Relationship to Patient (**Check one.**): ☐ Parent/Child ☐ Spouse ☐ Self ☐ Other

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Diagnostic History (Check conditions you have or have had in the past.) ☐ None

☐ Asthma ☐ Bleeding Disorders ☐ Blood Clot ☐ Cataracts ☐ Diabetes ☐ Dialysis ☐ Gout
☐ Emphysema ☐ Glaucoma ☐ Heart Disease ☐ High Cholesterol ☐HIV+ ☐ Kidney Disease
☐ High Blood Pressure ☐ Joint Replacement ☐ MRSA ☐ Polio ☐ Liver Disease/Hepatitis
☐ Lung Disease ☐ Multiple Sclerosis ☐ Osteoarthritis ☐ Pacemaker ☐ Rheumatoid Arthritis
☐ Sickle Cell ☐ Stroke/TIA ☐ Tuberculosis ☐ Thyroid Disease ☐ Cancer _____
☐ Genetic Disorder_____ ☐ Mental Illness/Mood Disorder_____

Medications (List all you are currently taking & dosage if known.) ☐ None

_____ _____
_____ _____
_____ _____

Medication Allergies

(Check all known allergies & list allergies not listed.)

☐Acetaminophen ☐Adhesive Tape ☐Latex ☐Sulfa
☐Aspirin ☐Codeine ☐Iodine ☐NSAIDS ☐Morphine
☐ Penicillin ☐Other _____
☐Local Anesthetics_____
☐ **No known drug allergies**

Environmental/Food Allergies

☐ Peanuts ☐ Tree Nuts
☐ Fish ☐ Shellfish ☐ Seafood
☐ Other_____
☐ **No known environmental or food allergies**

Please advise our staff of any severe/airborne allergies so accommodations may be made if necessary.

Social History (Check one.)

Do you currently smoke? ☐ Yes ☐ No - - - - Have you ever been a smoker? ☐ Yes ☐ No

Do you consume alcohol? ☐ Yes ☐ No - - - - Frequency: _____

Do you have a history of illicit drug use? ☐ Current ☐ Previous ☐ None
If yes, which ones?_____

Are you taking any chronic pain medication? ☐ Yes ☐ No - What kind? _____

Surgical History (List any surgeries you have had & the approximate year.) ☐ None

_____
_____
_____

Vitals

Height: _____ Weight: _____ Shoe Size: _____

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Reason For Visit:_____

_____ ☐ Right ☐ Left ☐ Bilateral

Is this the result of an accident? ☐ Yes ☐ No
If yes, so what happened, where did it occur, and what was the date of the accident?

_____

_____

How long have you had the issue?
_____days _____ weeks _____months _____ years

How would you describe your pain? **(Check all that apply.)**

☐ Dull, aching ☐ Sharp, stabbing ☐ Cramping ☐ Burning ☐ Tearing ☐ No pain

What makes it worse? **(Check all that apply.)**

☐ Physical activity ☐ Jumping ☐ Stairs ☐ Prolonged Rest ☐ Prolonged Standing

☐ Other:_____

What makes it better? **(Check all that apply.)**

☐ Nothing ☐ Rest ☐ Ice ☐ Elevation ☐ Heat ☐ Bracing ☐ Inserts

☐ Medication ☐ Other:_____

Have you had previous treatments for this issue? **(Check all that apply.)**

☐ Injections ☐ Inserts ☐ Surgery ☐ Brace/Boot ☐ Medication: _____

Have you had any previous testing for this issue? **(Check all that apply.)**

☐ Xray, when/where? _____ ☐ MRI, when/where? _____

Medical History

Review Of Systems (Check any you've had in the past year.)

General: ☐ Chills ☐ Fever ☐ Night sweats ☐ Weight gain / loss **(Circle one.)**

Skin: ☐ Rash ☐ Bruising ☐ Itching ☐ Hives

Cardiovascular: ☐Chest pain ☐ Irregular heartbeat ☐Swelling ☐Shortness of breath

Musculoskeletal: ☐ Ankle pain ☐ Foot pain ☐ Hip pain ☐ Leg pain
☐ Knee pain ☐ Back pain ☐ Hand pain

Neurological: ☐ Headaches ☐ Numbness ☐ Tingling ☐ Weakness

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We ask all patients to complete our information and insurance form before seeing our physician to ensure that we obtain the most current information, that helping us to better serve you. We are happy to file all insurance claims on your behalf.

Card On File-We require **ALL** patients to keep a credit card or debit card securely on file to cover any costs **NOT PAID** by your insurance, including any out-of-pocket deductibles. After we bill your insurance, any remaining balance deemed your responsibility will be mailed to you in a statement. If the balance is not paid within 30 days of that statement date, or other arrangements have not been made, the card on file will be charged for the amount owed – keeping your account current to avoid going into collections.

Should your patient responsibility amount exceed $200.00, we will automatically split the payment into two monthly payments.

Should your patient responsibility amount exceed $500.00, we will automatically split the payment into three monthly payments.

Copays & Balances Please come prepared to pay your co-pay at each visit. We are required to collect your copay at the time of your appointment per the contractual agreement we have with your insurance company. Additionally, any balance on the account will be due at the time of your visit. We accept cash & credit cards (Visa, Mastercard, Discover, American Express, & Care Credit) By signing this policy, you are authorizing your insurance benefits to be directly paid to Virginia Foot & Ankle Center, P.C. & acknowledge that you are financially responsible for any unpaid portion of your bill that was not collected on the date of or prior to the service.

Referrals - Some insurances require subscribers to have a referral from a primary care physician prior to being seen by a specialist. If no referral is obtained at the time of your visit, you agree to be responsible for all charges on the date of service.

Surgeries- Surgeries will not be scheduled until all out-of-pocket expenses are calculated and then collected. Our calculations are an estimate. There will be a $75.00 charge for any out-of-office surgeries that have already been scheduled & then cancelled.

Missed Appointments- Our policy is to charge a fee for any missed appointments. The fee for a no-show &/or an appointment not cancelled prior to 24 hours will be $35.00. A no-show &/or lack of 24 hours' notice for an in-office procedure appointment will incur a $50.00 charge. If a patient has more than 3 no-shows &/or same day cancellation appointments, we will no longer be able to make future appointments.

Fees for Letters and Forms - If forms such as Workers Compensation, FMLA, disability forms, or work forms need to be completed, the doctor & assistants will fill out those forms. Please be advised that due to the time required to dictate letters/complete forms, there will be a fee of $30.00 for this service. These costs are not covered by insurance companies and are due prior to the forms being completed.

Returned Checks - In the event that a check is returned for insufficient funds, a $50.00 returned check fee will be added to your account.

Collections Fees - In the event that your account becomes delinquent, you will be responsible for all costs of collection including administrative charges & attorney fees of 33.3% plus court costs & interest at the rate of 18% annually.

By providing a signature, you are acknowledging that you have read, agreed, and obtained a copy of the Financial Policy for Virginia Foot & Ankle Center, P.C.

Patient Print Name: **Patient OR Guardian Signature:** **Date**:

_____ _____ _____

Office Use ONLY:
Last 4 of credit/debit card number: _____ Credit/debit card expiration date: _____
Patient Account Number: _____

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Privacy Policies

"I hereby assign to Virginia Foot & Ankle Center, P.C. any & all rights & benefits pertaining to the services rendered under insurance policies & I authorize Virginia Foot & Ankle Center, P.C. to release whatever medical information is necessary for filing and processing any insurance."
"I acknowledge that I have access to and read, if I choose, a copy of the notice of privacy practices & understand the notice."
"It is understood that Virginia Foot & Ankle Center, P.C. is not allowed, by law, to give out medical information to anyone other than the patient unless written permission is granted to our office to do so. **Therefore, I authorize my medical information to be released to the following person(s):**

Name:	**Phone Number:**	**Please Check:**
_____	_____	☐ Medical ☐ Financial
_____	_____	☐ Medical ☐ Financial
_____	_____	☐ Medical ☐ Financial

☐ ***I do not authorize my information to be released to anyone***.

Voicemails *(Please check one.)*

☐ "Virginia Foot & Ankle Center **is** authorized to leave detailed information on the preferred phone number's voicemail solely including what is checked below."

☐ Medical ☐ Financial

☐ "Virginia Foot & Ankle Center **is not** authorized to leave detailed information on the preferred phone number's voicemail."

"By signing below, I understand the above Privacy Policies."

Patient OR Guardian Name Printed: _____

Patient OR Guardian Signature: _____

Date: _____