CAPITAL PODIATRY ASSOCIATES CHTD.®
1145 19TH STREET, N.W., SUITE 409
WASHINGTON, D.C. 20036
Telephone (202) 223-0500
www.capitalpodiatry.com

PATIENT REGISTRATION INFORMATION

Date_____ Soc.Sec.#_____ Birthdate_____

Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Long Term Partner

Name_____
Last Name First Name Initial

Address_____

City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____

Work Phone_____ e-mail _____

Employer_____ Occupation_____

Employer Address_____

Who referred you to our office?_____

Emergency Contact_____ Phone_____

PRIMARY INSURANCE INFORMATION

Policy Holder_____

Relationship to Patient_____ Birthdate_____

Address_____

City_____ State_____ Zip_____

Policy Holder Employer _____

Insurance Company _____

Subcriber I.D. #_____ Group #_____

Do you have secondary ins? ☐ Yes ☐ No If so, Insurance Co _____

ASSIGNMENT AND RELEASE

I the undersigned have insurance coverage with _____ and assign *Capital Podiatry / Drs Ravick or Lazar* all medical benefits if any otherwise payable to me for the services provided. I understand that I am financially responsible for all charges whether my insurance company pays or not.

I hereby authorize Capital Podiatry to release all necessary information to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Responsible Party_____ Date_____

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PATIENT'S HEALTH INFORMATION

Primary Care Physician's Name:_____
Date of Last Physical Exam:_____
Address:_____
City:_____ State:____ Zip:_____ Phone:_____
Chief Foot Complaint:_____Shoe Size:_____

MEDICAL CONDITIONS AND MEDICINES HISTORY

Have You Had...
Please mark each box if the answer is yes, leave blank if the answer is no.

- ❑ Heart Problems
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Circulatory Problems
- ❑ Rheumatic Fever
- ❑ Hepatitis
- ❑ Diabetes
- ❑ Allergies/Hay Fever
- ❑ Shortness of Breath
- ❑ Alcoholism
- ❑ Radiation Treatments
- ❑ Removal of Tonsils
- ❑ Removal of Adenoids
- ❑ Epilepsy
- ❑ Kidney Problems
- ❑ Nervous Problems
- ❑ Tuberculosis
- ❑ Excessive Bleeding
- ❑ Ulcer
- ❑ Liver Problems
- ❑ Gall Bladder
- ❑ Cerebral Palsy
- ❑ Scarlet Fever
- ❑ Malignancies
- ❑ Asthma
- ❑ Chronic Sinus Problems
- ❑ Dizziness
- ❑ Arthritis
- ❑ Gout
- ❑ A.I.D.S
- ❑ H.I.V.
- ❑ Venereal Disease
- ❑ Other

Other Health Concerns

_____
_____
_____
_____
_____
_____

Medication Allergies

_____
_____
_____
_____
_____

Prescriptions

_____
_____
_____
_____
_____

Over the Counter

_____
_____
_____
_____
_____

Pregnancy
Are you Pregnant ?
If yes, how many months?____

Hospitialization
Have you ever been hospitalized?
If yes, please explain_____
_____
_____
_____
_____

Immediate Family Members' History
Please list any significant medical conditions experienced by immediate family:_____
_____
_____
_____
_____

Previous Podiatric Treatment

_____
_____
_____
_____
_____
_____
_____
_____

ARNOLD S. RAVICK, D.P.M.
TERRI L. WALTON, D.P.M.
LAWRENCE G. LAZAR, D.P.M.
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PODIATRY, FOOT SURGERY AND SPORTS MEDICINE OF THE FOOT

Financial Policy for Capital Podiatry Associates CHTD. ®

- Non insured patient payments are due in full at the time services are rendered, unless prior arrangements have been made.

- Office visit co-payments for insured patients are due at the time of service. If we have to generate a billing statement to collect your co-pay there will be a minimum billing fee of $6.00 added for the administrative costs.

- If we are a participating provider with your **PRIMARY HEALTH INSURANCE**, we are happy to file a claim on your behalf. Once your insurance company has been billed we allow 45 days for the claim to be paid. If the insurance company has not paid within 45 days, **the entire claim will become your financial responsibility.** If payment is received from your insurance company after you have submitted payment, we will gladly issue a refund. **Refunds will not be given until a complete review and an authorization has been given.**

- **Unfortunately we do not bill to SECONDARY INSURANCE PLANS under any circumstance.** You are responsible for your co-insurance; any part of the claim your primary insurance did not cover and you will be billed accordingly. You may file a claim directly to your secondary insurance to reimburse you. Payment will still be due as described above regardless of any secondary insurance claim payment status.

- An insurance claim denial due to not having a referral or prior authorization is the patient's financial responsibility. All referrals must be presented to our staff prior to being seen by the doctor.

- Please notify our office if there is any insurance change prior to being seen for proper filing on your behalf. **Otherwise your visit will not be covered and you will become fully responsible for payment for services rendered.**

- There is a $25.00 charge for all return checks.

- All unpaid balances are subjected to 1.5% interest or a minimum $6.00 service charge after 30 days.

- Please be on time for your appointment. If you need to reschedule your appointment, we require a 24 hour notice. If you have a scheduled appointment and you miss your appointment without notifying our office you will be charged $25.00 for an office visit and $250.00 for an out patient surgery.

- If your account is forwarded to a collection agency and/or attorney due to non-payment, you will be responsible for any fees associated with their services.

ASSIGNMENT OF BENEFITS

I, the undersigned, certify that I (or my dependent) have coverage with _____ and assign directly to **Capital Podiatry Associates CHTD. ®** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payment and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize **RELEASE OF MEDICAL INFORAMTION** to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

By my signature I acknowledge receipt of a copy of this policy and hereby agree to its terms.

Signature:_____

Print Name:_____ Date:_____

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Notice to HMO Patients

HMO insurance carriers require that a patient obtain a referral form or authorization number prior to an examination by a specialist. It is your responsibility to obtain this referral from your primary care physician. Your insurance company will not pay for services rendered without a referral. If you should choose to be seen without the required authorization, you will be responsible for any charges incurred for services received.

I have read the above paragraph and understand that failure to produce an authorization as required by my insurance policy will result me being held financially responsible for charges incurred.

_____ _____

Patient Signature Date

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Broken Appointment

Cancellations for any reason the day of and no-shows for a scheduled appointment are considered broken appointments. There is a $25.00 fee for an office visit and a $250 fee for an outpatient surgical appointment that is broken. Notification must be made to this office more than 24 hours before the scheduled appointment time.

I , the undersigned, have read the terms and conditions regarding any broken appointments and I understand that there is a fee due upon any appointments that are broken in the future and must be paid prior to the next visit for treatment.

Patient Signature

Date

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding the attached Notice of Privacy Practices

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

_____ _____

Patient Name (please print) **Date**

_____

Patient or Authorized Representative (if applicable)

_____

Signature