

PATIENT NAME: _____

DATE OF BIRTH: ____ / ____ / ____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?

____ YES NAME(S) _____

____ NO

WHO IS RESPONSIBLE FOR PAYMENT? _____ RELATIONSHIP TO PATIENT? _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____ - ____

WHO REFERRED YOU TO US? _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____ - ____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CONTRACT # _____ GROUP # _____

SECONDARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____ - ____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CONTRACT # _____ GROUP # _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME	DOSE	HOW OFTEN DO YOU TAKE?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENT NAME: _____

DATE OF BIRTH: ____ / ____ / ____

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SOCIAL HISTORY

MARITAL STATUS: SINGLE MARRIED PARTNERED SEPARATED DIVORCED WIDOWED

USE OF ALCOHOL: NEVER NO LONGER USE HISTORY OF ALCOHOL ABUSE
 CURRENT USE - TYPE _____ RARE OCCASIONAL MODERATE DAILY

USE OF TOBACCO: NEVER QUIT - HOW LONG AGO? _____ SMOKE ___ PACKS/DAY FOR ___ YEARS

USE OF RECREATIONAL DRUGS: NEVER QUIT - HOW LONG AGO? _____ TYPE _____
 CURRENT USE - TYPE _____ RARE OCCASIONAL MODERATE DAILY

EMPLOYER: _____ OCCUPATION: _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? 10% 25% 50% 75% 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? CHILDREN-AGE(S) _____ PET(S)-WHAT KIND? _____
 ELDERLY OR DISABLED FAMILY MEMBER OTHER _____

EXERCISE: NEVER RARE OCCASIONAL WEEKLY SEVERAL TIMES A WEEK DAILY

TYPES OF EXERCISE: _____

PATIENT NAME: _____

DATE OF BIRTH: ____ / ____ / ____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: DIABETES: TYPE 1 OR TYPE 2 CANCER HEART DISEASE
 HIGH BLOOD PRESSURE STROKE CORONARY ARTERY DISEASE THYROID DISEASE
 RHEUMATOID ARTHRITIS
 OTHER _____

YOUR MEDICAL HISTORY

ALLERGIES: MEDICATIONS _____
 ANESTHESIA _____ FOODS _____
 TAPE LATEX SHELLFISH IODINE OTHER _____
 NONE KNOWN

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES: TYPE 1 OR TYPE 2 (CIRCLE)	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:								

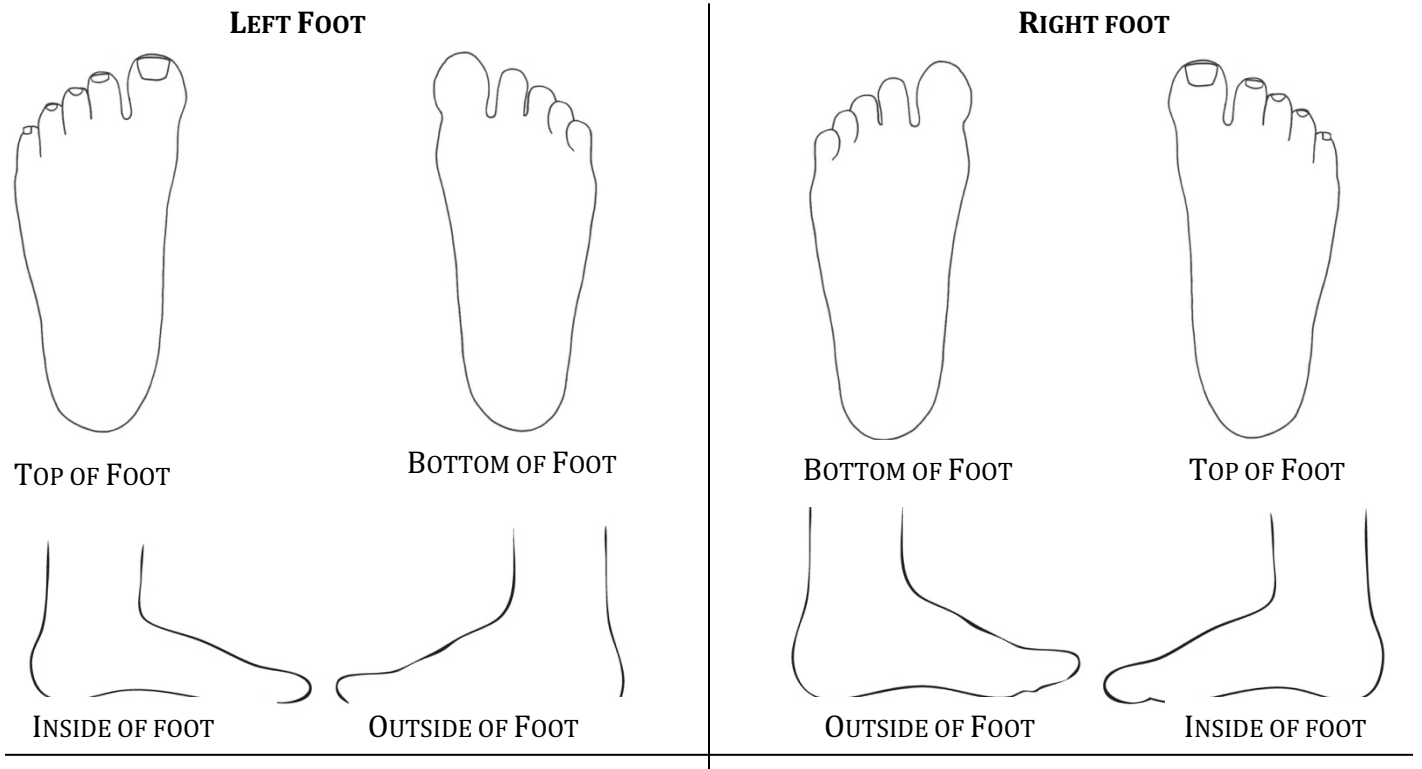
PATIENT NAME: _____

DATE OF BIRTH: ____ / ____ / ____

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.



HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: BEGIN ALL OF A SUDDEN GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? NO PAIN SHARP DULL ACHING BURNING
 RADIATING ITCHING STABBING OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN POSSIBLE)

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: STAYED THE SAME BECOME WORSE IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? WALKING STANDING DAILY ACTIVITIES
 RESTING DRESS SHOES HIGH HEELS FLAT SHOES ANY CLOSED TOE SHOE
 RUNNING OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

PATIENT NAME: _____

DATE OF BIRTH: ____ / ____ / ____

WAS THIS PROBLEM CAUSED BY AN INJURY? YES (DESCRIBE) _____ No

IF YES, WAS IT A WORK-RELATED INJURY? YES No

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

PRINT NAME OF PATIENT, PARENT OR GUARDIAN

SIGNATURE OF DOCTOR

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

DATE

SIGNATURE

DATE



8101 Hinson Farm Rd Suite 301
Alexandria, VA 22306
Tel (703)560-3773 Fax (703)799-0050

Financial Policy

Revised December 4th 2018

Thank you for choosing CPA as your podiatric care provider. Our goal is to provide you with quality care without compromise and with that the need to maintain financial policies.

We accept Cash, Check, Visa, MasterCard, Debit cards, HSA, HRA. Returned checks are subject to a \$35.00 returned check fee and a retraction of the unpaid fees.

Please read and sign the office policies below, and feel free to ask any questions should you require further clarification.

Office Responsibility

1. An exact fee cannot be determined until after the physician has seen the patient. There are separate charges for the office visit, X-rays, Injections, Cast, Cast Changes and any other procedure done within the office setting. **Please note** Cosmetic or Laser treatments are currently a non-covered charge by any insurance provider and will be applied directly to patient responsibility.
2. As a courtesy we will file your claim if you provide us with adequate insurance information. Please keep in mind that insurance coverage is not a guarantee of payment. If a claim is denied or not paid within thirty (30) days, the balance is patient responsibility.
3. Please provide updated information for any insurance changes up two (2) business days prior to your scheduled appointment. Please note failure to do so may result in rescheduling of your appointment if proper insurance verification cannot be obtained.
4. Any balance that remains unpaid after three (3) billing statements (Provided in office or mailed) or unpaid promissory payment arrangements will be forwarded to an attorney for collections. You will be responsible for the principle balance, interest, collections fees, Legal fees, and court cost.

Patient Responsibility

1. It is our office belief that your time is as valuable as ours, please arrive on time for your appointment. If you are more than (20) minutes late to your scheduled time, we may need to reschedule your appointment. **No Show Fee \$35.00, Same Day/Missed Cancellation fee \$35.00, Surgery cancellation \$350.00 fee.**
2. Please cancel appointments within a minimum of twenty-four (24) hour notice to avoid fees.
3. Our physician and management reserves the right to review the untimely cancellation/missed appointment to determine if a waiver of fee is done and will only be considered in case of an emergency .

Payment of copayments, Balance or fees are due at the time services are rendered unless a prior financial arrangement has been made with management.

Signature (Patient/Guardian)

Print Name of signature

Date