WELCOME TO OUR OFFICE

Albemarle Family Foot & Ankle

Bryan R. Snyder, DPM, FACFAOM ***Heather Snyder, DPM, FACFAOM***

Patient Information

Last Name:	First Name:	Middle:	Sex: *(circle one)* M F
Mailing Address:	City:	State:	Zip:
E-Mail:	Cell Phone:	Home Phone:	
Preferred method of contact: *(circle one)* Email Cell phone Home phone	Social Security #:	Date of Birth:	
Preferred Name or Nickname:	Marital Status: *(circle one)* Single Married Divorced Separated Widowed		
Employer:	Status: *(circle one)* F/T P/T Retired	Work Phone:	
Ethnicity: *(circle one)* Non-Hispanic Hispanic Not Specified	Preferred Language:		
Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ White ❑ Native Hawaiian or Pacific Islander ❑ Other_____ ❑ Not Specified			

How did you hear about us? ❑ Yellow Pages ❑ Internet ❑ Insurance company ❑ MJH ❑ UVA
❑ Doctor_____ ❑ Patient_____ ❑ Other_____

Responsible Party (Financial) Information *(if other than patient)*

Last Name of Responsible Party:	First Name:	Middle:	Sex: *(circle one)* M F
Patient Relation to the Responsible Party: *(circle one)* Spouse Child Other_____	Social Security #:	Date of Birth:	
Billing Address:	City:	State:	Zip:
Email:	Cell Phone:	Home Phone:	

HIPAA NOTICE OF PRIVACY PRACTICES

In signing below, you acknowledge that you have received or have been given the opportunity to read our Notice of Privacy Practices. The Notice of Privacy Practices explains how our office may use and disclose your protected health information for the purposes of treatment, payment, and health care operations. The terms of the Notice of Privacy Practices may change. A current copy is available for review in the waiting room binder, on our website at www.affapodiatry.com, or may be requested at the front desk. You may refuse to sign this acknowledgment, if you wish.

I authorize the release of medical information including my diagnosis, examination findings, test results, and treatment plan to the following individual(s):

☐Spouse/Partner_____

☐Child(ren)_____

☐Other_____

☐Do **NOT** release my medical information to anyone.

This Release of Medical Information authorization will remain in effect until terminated by me in writing.

Signed_____Date_____

Patient Financial Agreement

_____**Initials** All accounts with an unpaid balance over **30 days** will be assessed a **$5.00 fee** per billing statement until the balance is paid in full. There will be a **$25.00 surcharge** added to the account for any returned checks. If the account becomes assigned to a collection agency, you agree to pay all costs of collection, including agency fees, court costs, and attorney fees.

_____**Initials** A patient may return any defective or ill-fitting durable medical good or product dispensed by this office within **ten (10) days** from the date of service. The issue may be remedied by replacing the product, adjusting or modifying the product, or accepting the product for a return with a credit issued for the full amount. Custom-made or special order items are NOT returnable.

_____**Initials** We do our best to keep on schedule. When a patient arrives late, it is impossible to stay on schedule. If you arrive past your scheduled appointment time, we reserve the right to reschedule your appointment so that other patients are not inconvenienced. We ask that you give us the courtesy of at least 24-hour advanced notice if you can not keep your scheduled appointment. We reserve the right to charge a **$60.00 "no-show" fee** to your account for each missed scheduled appointment if you do not call to cancel in advance.

Insurance Assignment and Release

_____**Initials** Please be advised that certain items and services necessary to provide you with optimum foot care are generally NOT covered by Medicare or most other insurance carriers.

Non-covered services include:

- Routine foot care, including the cutting or removal of corns and calluses, and the trimming, cutting, clipping, or debriding of toenails – *estimated cost $60-$150*
- Evaluation and treatment of flat feet or bunions, including the prescription of supportive devices (orthotics) – *estimated cost $90-$390*
- Certain supplies, including supportive devices (insoles), splints, paddings, or medicated creams and solutions dispensed by this office – *estimated cost $25-$150*

_____**Initials** Insurance coverage is a contract between you and your insurance company. The ultimate responsibility for understanding your insurance benefits rests with you. Your insurer may deny payment for certain items or services rendered in this office. **You are financially responsible for payment of all co-pays, deductibles, co-insurance, and all non-covered services or supplies not paid by your insurance.**

Specialist Co-pay_____
Deductible_____
Co-insurance_____

_____**Initials** If we have a contract with your insurance, this office will file a claim on your behalf. In order to do so, we will require a copy of your insurance card(s) and photo identification for our records. **Without an insurance card or proper identification, we will be unable to file your claim**, and you will be responsible for the full amount of all charges accrued. If we are not a contracted provider with your insurance, this office will NOT submit a claim, and you will be responsible in full for all charges at the time of service. You must inform the office of any changes in your demographic or insurance information. In the event the office is not informed or any changes in my insurance or demographic information, you agree to be responsible for any charges denied by your insurance company.

_____ **Initials** I, the undersigned, assign directly to Albemarle Family Foot & Ankle, PLLC. all insurance benefits, if any, otherwise payable to me for services rendered. I authorize any holder of medical information about me to release all information needed in order to secure the payment of benefits. **I understand that I am financially responsible for all charges whether or not paid by my insurance**. I authorize use of this signature on all insurance submissions. This authorization is valid for current and subsequent treatment unless I submit a written revocation.

Patient Name_____ **DOB**_____

Responsible Party (if other than patient)_____ **Relationship**_____

Signed_____ **Date**_____