JIMMY W. DOWNING D.P.M
THE PODIATRY GROUP 600 PETER JEFFERSON PARKWAY, SUITE 360 CHARLOTTESVILLE, VIRGINIA 22911
434-979-0763 (OFFICE) 434979-8681 (FAX)

# PATIENT REGISTRATION

Today's Date: _____ Chart No: _____

Full Name: _____

Name you wish to be called: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: ( )_____ Cell Phone: ( ) _____

DOB: _____ Age: _____ Race: _____ Sex: ____ SS#: _____

Employer: _____ Position: _____

Work Phone: ( ) _____ □ FT □ PT □ Unemployed □ Retired

E-mail address: _____

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed

If a child, name of responsible party (please print): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Relationship to Patient: _____

DOB: _____ SS#: _____ Home Phone: ( ) _____

Employer: _____ Position: _____ Work Phone: ( ) _____

Family Physician: _____ Referring Physician: _____

Emergency Contact: _____ Phone: ( ) _____

Relationship to Patient: _____

Pharmacy: _____

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# HEALTH QUESTIONNAIRE

**PERSONAL DATA:** Name: _____

**CHIEF COMPLAINT:** What is the reason for your visit today? _____

_____

When did this problem start? _____

Have you ever had these symptoms or similar symptoms in the past? _____

Previous medical care for this condition: _____

Have you had x-rays for this condition? Yes or No If so, where? _____

Previous surgeries on lower extremity: _____

Is your pain: □ constant □intermittent □ sharp □ dull □ burning □ other _____

Do you experience: □ numbness □ tingling □ cramping □ other _____

What activities or motions increase your symptoms? _____

What activities or motions decrease your symptoms? _____

**ALL** Medications: _____

_____

**ALLERGIES**: _____

Do you smoke? □ Yes □ No If so, for how long? _____ Smoked in the past? □ Yes □ No

**PAST MEDICAL HISTORY**

□ anemia
□ arthritis
□ asthma
□ bleeding tendencies
□ blood clots
□ cancer
□ coronary artery disease
□ COPD
□ diabetes
□ epilepsy
□ fracture
□ gout
□ heart attack
□ heart disease
□ high blood pressure
□ HIV/AIDS
□ joint replacement
□ kidney disease
□ liver problems
□ neurologic disorders
□ pinched nerves
□ peripheral neuropathy RT LT Both
□ peripheral vascular disease
□ rheumatic fever
□ stroke
□ tuberculosis
□ ulcers
□ venereal disease
□ other _____

Please mark where you are experiencing pain:

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## WELCOME TO OUR OFFICE

Our mission is to offer you the highest quality care in a comfortable, efficient, and safe manner. Listed below are some guidelines for your review. Throughout the time you receive services from our office, please feel welcome any member of our team with questions or need for any information.

Wishing you good health,
Jimmy W. Downing and Staff

MUST SIGN BELOW

**GUIDELINES (Required to sign to be seen in office)**

**1. Insurance Assignment and Release Authorization**

I, the undersigned, have health insurance coverage with the below insurance company and assign directly to Jimmy W Downing, DPM, The Podiatry Group, LLC, all medical benefits. I authorize the use of this signature on all my insurance submissions. I authorize Dr. Jimmy W. Downing to treat my feet and/or ankles. I request payment be made to Dr. Jimmy W. Downing/The Podiatry Group for any services rendered by the physician. I authorize the doctor and his staff to release all information necessary to secure the payment of benefits. I understand that my insurance carrier may pay less than the actual bill for services or supplies. I agree to be financially responsible for all charges whether paid or not paid by insurance. I agree to assume responsibility for all charges incurred should collection of this balance become necessary including court cost, collection agency fees, and attorney fees. This will remain in effect until revoked by me in writing.

Patient Name: _____

Insurance carrier: _____ Subscriber SS#: _____

Subscriber: _____ Subscriber DOB: _____

**If you do not have your insurance cards at the time of service, you have two (2) options:**

1. **reschedule your appointment**
2. **be responsible for the full amount of the bill**

**2. Co-Payments, Coinsurance, Non-covered Services & Supplies:**

Co-payments and deductibles must be paid at the time of service. All remaining balances are due upon receipt of invoice. Balances over 60 days from time of service are considered delinquent and will be turned over to an outside collection service. I understand that I am responsible for all deductibles, coinsurance, non-covered services and supplies. In the even that my account becomes delinquent, I agree to pay all costs related to collection including collection fees, court costs, and attorney fees. I also understand that all balances must be paid in full prior to receiving in surgical care. We accept **checks, Visa, Mastercard, and cash. Returned checks for insufficient funds are subject to a $35.00 processing fee per check.**

**X**_____ **Date:**_____
(Signature of patient/guardian)

**3. Primary Care Referrals:**

Please obtain all of the necessary referral forms (if required by your insurance) from your primary care physician in advance of your visit. It is your responsibility to obtain all necessary referral authorizations prior to your visit. Contact your insurance carrier if you have questions in regards to this issue.

**4. Uninsured Patients:**

Payment in full is required at the time of services are rendered and supplies dispensed.

**5. Repeated Missed Appointments:**

We will be unable to schedule future appointment for patients having three (3) missed appointments and/or cancellations without appropriate notice, particularly if we feel that these missed appointments are adversely affecting our intervention/treatment plan. If a patient does not contact the office in advance, a $25.00 "No Show" fee may be charged.

**6. General Consents:**

I voluntarily consent to medical and/or surgical treatment by Jimmy W. Downing, D.P.M which may include examinations, diagnostic tests, photographs, x-rays, and treatments by the doctor and staff. I understand that the general nature, purpose, risks, and alternatives associated with any procedure or treatment will be explained to me by the doctor, and in the case of other services, by healthcare staff. I understand that I will have an opportunity at that time to ask for more information and to ask questions. I further understand that medical care and treatment is not an exact science. No promises or guarantees have been made to me as to the results of examination and treatment.

I certify that I have read and accept all of the above mentioned terms and conditions

**X** _____ **Date:** _____

(Signature of patient/guardian)

# Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I was given the opportunity to receive a copy of the Notice of Privacy Practices and I have read or had the opportunity to read, if I so chose, and I understand this notice.

May we discuss any of your information with another individual? □ yes □ no

Financial matters: _____ _____ _____
Name relationship number

Medical matters: _____ _____ _____
Name relationship number

## Consent to Test

I understand that my physician or staff may come in contact with my body fluids such as blood. I understand that if this happens my physician may order a blood test drawn from me for (including but not limited to) HIV (AIDS) and hepatitis antibodies. I consent to withdrawal only if an employee or physician has had an accidental exposure to my body fluids. I understand that I could obtain the results of these tests from my physician who can explain them. I authorize the release of data necessary to process the testing and insurance claim and I understand there will be no cost to me for this test.

_____
Patient Name (please print)

_____ _____
Signature Date

_____
Parent or Authorized Representative (if applicable)