LANDMARK FOOT & ANKLE CENTER, P.C.

Physician and Surgeon of the Foot and Ankle

Name: First ________________________ **MI**___ **Last**_____________________________________

Home Address: ____**APT#**______________

City: ____________________________ **State**: __________________ **Zip Code**: _____________

Date of Birth: _____________________ Age: ___________ Height: _______ Weight: _________lbs

Home Phone: _____________________ Work Phone: _________________________________

Cell Phone: _______________________ Sex: M / F Marital Status: S M D Sep W

E-Mail: ______________________________Social Security #: ________________________

Please check any method(s) we can contact you:

Home Phone___________ **Cell Phone** __________ **Work Phone** ____________

Email __________ **Text**__________ **Does Not matter**______

Patient's Employer: ___________________________ Occupation: ____________________

Type of work: Sedentary, some sitting/some standing, on feet all day, manual labor **(circle one)**

Are You A Student? Yes or No Grade: ___________ **(circle one)**

Emergency Contact's Name: ____

Phone Number: ______________________________

Pharmacy Name: ____________________________ Phone: _________________________

Address/Location: _______________________________ City: __________________________

Who is you **Primary Care Physician**?____

Medications

Please list all current medications (with dosage). Include over-the-counter, vitamins, herbal supplements.

Name of Medication	Dosage/Frequency	Reason for taking medicine

INSURANCE INFORMATION

Insurance Company Name: _______________________________________

☐ *Please check here if you, the patient listed above, are the main policy holder*

Policy Holders Name:________________________________ Birthday__________________

SSN#: ______________________ **Relationship to Patient:** Parent: ___Spouse: ____Other:_________

Please Sign and Date Below

Patient/Representative_______________________________________ **Date**__________________________

LANDMARK FOOT & ANKLE CENTER, P.C.

www.landmarkfootandankle.com

5249 Duke Street, Suite 212 Telephone: 703-370-2313
Alexandria, VA 22304 Fax: 703-370-2490

OFFICE POLICY

We would like to welcome you to our office. We strive to provide top quality care in a comfortable atmosphere.
We submit claims to your primary, secondary and tertiary insurances. We have found, however, that few insurance plans cover the entire cost involved in your visit(s). **Your policy is between you and your insurance company and it is important that you understand its provisions**. **We cannot guarantee payment of your claims or accept responsibility for negotiating your claim. At this time, we are not accepting state issued health plans from any new patients (e.g. Medicaid, Anthem Healthkeepers Plus, Famis, Amerigroup, etc).**

Co-payments are due at the time of your visit. Please note that you will be required to pay the bill in full if you are a ***SELF-PAY*** patient. We accept cash, checks, Visa, MasterCard, Discover and money orders for payments.

At the beginning of each month, a billing statement will be sent to you, informing you of your account status. Any returned checks will be a fee of $35.00 plus any bank fees associated with the returned check. **Any account overdue after 90 days will be turned over to collections**. *Any attorney fees, court costs, and all fees involved with the collection process are the sole responsibility of the patient. Be aware that 33 1/3% will automatically assessed at the time the account is sent to collections.*

It is the responsibility of the patient to inform us of ANY address changes or insurance changes. *(Note: If your insurance changes and we need to re-bill any claims out under your new policy you will be charged a $10 fee).*

If your insurance company requires a referral to be seen by Landmark Foot and Ankle Center, you are responsible for providing this to us the day of your appointment. **If you do not have a valid referral you will need to reschedule your appointment.**

It is important that you cancel any office appointment at least 24 hrs in advance, so that we can utilize that appointment time for emergencies if need be. If you fail to cancel within 24 hrs or you do not show up to your appointment, you will be charged a fee of $35.00. If you are scheduled for surgery and cancel within seven business days, you will be charged $100.00. If you do not show up for any scheduled surgery, you will be charged $250.00. This charge is not reimbursable by your insurance company and is your sole responsibility.

Due to increasing administrative and personnel costs, we will be charging for the following:
Medical records: 1-20 pages $20.00; $1.00 each additional page, ***X-Rays***: $20.00 per set of x-rays, ***Disability, Work or Medical forms***: $20.00. Please allow up to **7 business days** for your request to be completed.

I, by voluntary and mutual consent, agree to the treatment recommended by Dr. Garrett or Dr. Kim that may include, but are not limited to surgical procedures, diagnostic tests and medical care. I understand that the risks, benefits, and alternatives will be explained by my physician. I understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I authorize my physician, and such associates, technical assistants, and other health care providers to perform such other procedures which are advisable in their professional judgment.

I, the patient or representative, authorizes Landmark Foot & Ankle Center, P.C. to apply for benefits on my behalf for covered services rendered by Landmark Foot & Ankle Center, P.C. I request that the payments from my providing insurance company be made directly to Landmark Foot & Ankle Center, P.C. I understand that I am, and I agree to promptly pay all charges for medical services at the time services are rendered and accept legal responsibility for any and all charges for myself or the patient, including all costs incurred by our collection attorney. I understand that I am responsible for all professional fees and charges regardless of insurance coverage or any other source of payment.

I certify that the information I have reported, with regard to my insurance coverage, is correct. I further authorize the release of any necessary information, including medical information for this or any related claim, to the above name billing agent. I permit a copy of this authorization to be used in place of the original.
This authorization may be revoke by either the above named carrier or myself at any time in writing.

____________________ ________________________ ____________

Signature Relationship to patient Date