



Renaissance Foot & Ankle Center, PC
Alan R. Deroy, DPM, FACFAS
Aparna Duggirala, DPM, FACFAS

7223-B Hanover Parkway
Greenbelt, MD 20770
Ph:(301) 441-2655
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www.RenaissanceFAC.com

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Date _____ Home Phone() _____ Cell Phone() _____ Email _____

Last Name _____ First Name _____ Middle Initial _____ Date of Birth ____/____/____

Street _____ City _____ State _____ Zip _____

Social Security # _____ - _____ - _____ Age _____ Sex M F Marital Status _____ Primary language: _____

Ethnicity: (Circle one) _ American Indian _ Asian _ Black African American _ Native Hawaiian/Pacific Islander _ White _ Hispanic

Occupation _____ Work phone() _____

Employer _____

Pharmacy: _____ Address: _____ City & Zip _____ Phone # _____

In case of Emergency contact _____ Relationship _____ Phone () _____

FINANCIALLY RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT)

Relationship to patient _____ Home Phone () _____ Cell Phone () _____

Last Name _____ First Name _____ Middle Initial _____ Sex M F

Street _____ City _____ State _____ Zip _____

Social Security # _____ Age _____ Date of Birth ____/____/____ Marital Status _____

Occupation _____ Work phone () _____

Employer Name & address _____

INSURANCE INFORMATION (COPY OF CARD(S) REQUIRED)

Primary Insurer _____ Phone () _____ Group# _____

Insured's Name _____ Insured's ID # _____

Secondary Insurer _____ Phone () _____ Group # _____

Insured's Name _____ Insured's ID # _____

HOW DID YOU HEAR ABOUT US?

Doctor Phone Book Friend Magazine Television ER

Family Insurance Plan Hospital Newspaper Internet Other _____

FAMILY PHYSICIAN INFORMATION

Did your Family Physician or other specialist refer you? Yes No Did you independently come for an opinion? Yes No

Referring/Family Physician: _____ Date last seen: _____

Address: _____ City _____ State _____ Zip _____ Phone: () _____

MEDICAL HISTORY

PATIENT NAME	BIRTH DATE / /
What is your foot/ankle problem? _____ _____ Location? <u>Right</u> or <u>Left</u> _____ When did the problem begin? Date: _____ Describe any accident/event: _____ Is the problem work related? Yes No _____ First visit to a doctor for this problem? Yes No, who? _____ On a scale of 0-10 with 10 being worst please rate your pain today: 0 1 2 3 4 5 6 7 8 9 10	Describe any previous treatment or home remedies? _____ _____ List any sports/activities: _____ _____

ALLERGIES	Current MEDICATIONS (PLEASE LIST)	REVIEW OF SYSTEMS (circle yes or no)
<input type="checkbox"/> Penicillin		Y N Headaches Y N Excessive thirst
<input type="checkbox"/> Sulfa		Y N Nausea Y N Chest pain
<input type="checkbox"/> Local Anesthetic		Y N Bloody stools Y N Shortness breath
<input type="checkbox"/> Anti-inflammatory Medication		Y N Abdominal pain Y N Depression
<input type="checkbox"/> Codeine		Y N Pain on urination Y N Nosebleeds
<input type="checkbox"/> Adhesive Tape		Y N Skin rashes Y N Calf pain
<input type="checkbox"/> Latex		Y N Fever Y N Healing difficulty
<input type="checkbox"/> Iodine on Skin		Y N Bone/Joint Pain Y N Dizziness
<input type="checkbox"/> IV Radiocontrast Dye		Y N Blurred vision Y N inc weight loss
<input type="checkbox"/> Cortisone		
<input type="checkbox"/> Other _____		

WHAT PREVIOUS SURGERIES HAVE YOU HAD IN YOUR LIFE?

<input type="checkbox"/> Hysterectomy <input type="checkbox"/> Cardiac(valve, pacemaker, graft, etc) <input type="checkbox"/> Implant surgery (knee, hip, etc) <input type="checkbox"/> Gallbladder removed <input type="checkbox"/> Vascular Leg Bypass	<input type="checkbox"/> Appendectomy <input type="checkbox"/> Tonsillectomy <input type="checkbox"/> Hernia repair <input type="checkbox"/> Cosmetic <input type="checkbox"/> Cancer Surgery	<input type="checkbox"/> Other surgeries including any FOOT/ANKLE surgery:
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Have You Ever Been Put To Sleep For Surgery? Yes No Complications with Anesthesia? Yes No

Height: _____	Do you drink alcoholic beverages? <input type="checkbox"/> No <input type="checkbox"/> Yes, socially <input type="checkbox"/> Daily # Drinks/week _____	Do you smoke cigarettes? <input type="checkbox"/> No, never <input type="checkbox"/> No, I quit <input type="checkbox"/> Yes currently Packs/Day _____ #Years _____	Do you use "recreational" drugs? <input type="checkbox"/> No, never <input type="checkbox"/> No, I quit <input type="checkbox"/> Yes WHICH ONES?
Weight: _____			
Shoe size: _____			

Indicate which of the following you have had or have at present. Indicate if any blood relative has had any of the following.

Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> family	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Family
Arthritis/Rheumatism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> family	High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Family
Asthma or Respiratory Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> family	H.I.V. Positive	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Family
Birth abnormalities	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> family	Infections (MRSA, VRE)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Family
Blood Clots or Bleeding Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> family	Kidney Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Family
Cancer or tumor	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> family	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Family
Diabetes Insulin Dependent	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> family	Neurological Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Family
Diabetes Non-Insulin Dependent	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> family	Psychiatric/Psychological Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Family
Fibromyalgia/Reflex Sympath Dyst	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> family	Stroke/CVA/TIA	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Family
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> family	Sickle Cell Disease/Trait	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Family
Heart (Surgery, Disease, Attack)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> family	Stomach Reflux / ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Family
Hepatitis A (Infectious B or C)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> family	Ulcers (Diabetic)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Family

I understand the above medical information is necessary to provide me with medical care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, which may release such information to you. I will notify the doctor of any changes in my health or medication. I HEREBY GIVE AUTHORIZATION FOR TREATMENT.

X	
Patient/Guardian Signature	Date
MEDICAL HISTORY REVIEWED BY (DR. SIGNATURE):	DATE



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FINANCIAL POLICIES

We are dedicated to providing the best possible care and service to you and regard your complete understanding to our financial policies as an essential element of your care and treatment.

I authorize payment of medical benefits to Drs. Deroy and Duggirala, for all service provided. As our patient, you are responsible for making sure that the bill is paid in full. All charges are your responsibility and not the insurance company's. We must emphasize, as your podiatric medical care provider, our relationship is with you and not your insurance company. Your insurance company is a contract between you and the insurance company. As a courtesy, we will file your insurance claim for you. The filling of a medical insurance claim is an expensive process that we extend to you at no charge. **However, we do ask that you pay all co-pay, deductible and non-covered charge the day of your service.** If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. Self-pay patient are required to pay in full at the time of service unless prior arrangements. A service to be non-covered, applied to your deductible, or part of your coinsurance, you will have (30) days to pay the balance in full. If you fail to pay in a timely manner, you understand that your account will be subject to collection proceedings. **All fees including collection fees, attorney fee and court fees shall become your responsibility in addition to the balance due to this office.**

If payment is not received in the (30) days required and additional statements must be sent to collect the balance, **\$10.00 rebilling fee** will be added to each statement until the balance is paid in full.

I understand that it is my responsibility to provide the office with my current insurance card at the time services rendered to me. If I cannot provide my current insurance card, my appointment will be rescheduled or I will chose to pay for services out of my pocket.

I understand that id I provide incorrect or expired information; I will assume full financial responsibility for all charged incurred.

I understand that my account may be charged a **\$30.00 cancellation** fee, if I do not call to cancel my appointment at least (24) hours before my schedule appointment time. This amount must be paid prior to any further visits with our office.

I understand that my account may be charged **\$150.00 cancellation fee**, if I do not call to cancel my surgery at least (72) hours in advance before my scheduled surgery time. This amount must be paid prior to any future visits with our office.

For your convenience our office accepts all major credit cards, checks, money orders or cash. You agree to be responsible for a **\$25.00 service fee for all returned checks.**

The courts have established the x-rays are the property of the doctor who takes them as part of the patient's medical record. If you need to take your x-rays, copies of the films will have to be made after we receive a signed release from the patient. **There is a \$20 charge per film copied.**

Medicare required a minimum of 60 days between visits for at risk patients "routine foot/nail care". Note that Medicare status may not qualify for routine trimming of nails/calluses. Any charges outside of Medicare guidelines will be the responsibility of the patient.

By signing this document, I acknowledge that I have read it, understand and agree to the above stated terms and conditions.

Printed Name: _____

Signature: _____

Date _____



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Notice of Privacy Practices Effective November 15, 2004

This notice describes how healthy information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your healthy information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your healthy information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclose of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Office Manager.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the Office Manager. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practice.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Office Manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact us at above location.



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Patient name: _____

The Practice:

a. Is required by federal law to maintain the privacy of your Personal Health Information (PHI) and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

b. Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.

c. Is required to abide by the terms of this Privacy Notice.

d. Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.

e. Will distribute any revised Privacy Notice to you prior to implementation.

f. Will not retaliate against you for filing a complaint.

EFFECTIVE DATE

This notice is effective as of 11/15/04

PATIENT ACKNOWLEDGMENT

By signing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and agreement to its terms.

Print Name: _____

Signature: _____

Date: _____