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
Fax:(301) 441-2656
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________

INSURANCE INFORMATION (COPY OF CARD(S) REQUIRED)

Primary Insurance______________________________ Insured's Name_________________________________

Secondary Insurance_____________________________________ Insured's Name____________________________

HOW DID YOU HEAR ABOUT US?

☐ Doctor ☐ Phone Book ☐ Friend ☐ Google ☐ Women's Journal

☐ Family/Friend ☐ Insurance Plan ☐ Hospital/ER ☐ Gazette ☐ YELP ☐ 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? Right or Left____

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	REVIEW OF SYSTEMS (CIRCLE Y OR N		LIST OF CURRENT MEDICATIONS
❑ Penicillin	Headaches **Y / N**	Excessive Thirst **Y / N**	❑ **NONE**
❑ Sulfa	Nausea **Y / N**	Chest Pain **Y / N**	
❑ Local Anesthetic	Bloody Stool **Y / N**	Shortness of breath **Y / N**	
❑ Anti-inflammatory Medication	Abdominal Pain **Y / N**	Depression **Y / N**	
❑ Codeine	Pain on urination **Y / N**	Nosebleed **Y / N**	
❑ Adhesive Tape	Skin Rashes **Y / N**	Calf Pain **Y / N**	
❑ Latex	Fever **Y / N**	Healing difficulty **Y / N**	
❑ Iodine on Skin	Bone /Joint Pain **Y / N**	Dizziness **Y / N**	
❑ IV Radio contrast Dye	Blurred Vision **Y / N**	Inc weight loss **Y / N**	
❑ Cortisone			
❑ Other________			
❑ None___________			

WHAT PREVIOUS SURGERIES HAVE YOU HAD? CHECK ALL THAT APPLY AND LIST ANY OTHERS

- ❑ Hysterectomy
- ❑ Cardiac(valve, pacemaker, graft, etc)
- ❑ Implant surgery (knee, hip, etc)
- ❑ Gallbladder removed
- ❑ Vascular Leg Bypass
- ❑ Appendectomy
- ❑ Tonsillectomy
- ❑ Hernia repair
- ❑ Cosmetic
- ❑ Cancer Surgery
- ❑ Other surgeries including any FOOT/ANKLE surgery:

Have You Ever Been Put To Sleep For Surgery? Yes ☐ **No** ☐ **Complications with Anesthesia? Yes** ☐ **No** ☐

Height:_________	**Do you drink alcoholic beverages?**	**Do you smoke cigarettes?**	**Do you use "recreational" drugs?**
	❑ No	❑ No, never	❑ No, never
Weight:_________	❑ Yes, socially	❑ No, I quit	❑ No, I quit
	❑ Daily	❑ Yes currently	❑ Yes
Shoe size:_______	# Drinks/week_____________	Packs/Day______#Years_____	WHICH ONES?

INDICATE IF YOU OR A BLOOD RELATIVE HAS HAD OR DOES HAVE ANY OF THE FOLLOWING-CHECK ALL THAT APPLY

Condition				Condition			
Anemia	❑ Yes	❑ No	❑ family	High Blood Pressure	❑ Yes	❑ No	❑ Family
Arthritis/Rheumatism	❑ Yes	❑ No	❑ family	High Cholesterol	❑ Yes	❑ No	❑ Family
Asthma or Respiratory Problems	❑ Yes	❑ No	❑ family	H.I.V. Positive	❑ Yes	❑ No	❑ Family
Birth abnormalities	❑ Yes	❑ No	❑ family	Infections (MRSA, VRE)	❑ Yes	❑ No	❑ Family
Blood Clots or Bleeding Disorders	❑ Yes	❑ No	❑ family	Kidney Trouble	❑ Yes	❑ No	❑ Family
Cancer or tumor	❑ Yes	❑ No	❑ family	Liver Disease	❑ Yes	❑ No	❑ Family
Diabetes Insulin Dependent	❑ Yes	❑ No	❑ family	Neurological Disorder	❑ Yes	❑ No	❑ Family
Diabetes Non-Insulin Dependent	❑ Yes	❑ No	❑ family	Psychiatric/Psychological Care	❑ Yes	❑ No	❑ Family
Fibromyalgia/Reflex Sympath Dyst	❑ Yes	❑ No	❑ family	Stroke/CVA/TIA	❑ Yes	❑ No	❑ Family
Glaucoma	❑ Yes	❑ No	❑ family	Sickle Cell Disease/Trait	❑ Yes	❑ No	❑ Family
Heart (Surgery, Disease, Attack)	❑ Yes	❑ No	❑ family	Stomach Ulcers / Reflux	❑ Yes	❑ No	❑ Family
Hepatitis A (Infectious B or C)	❑ Yes	❑ No	❑ family	Ulcers (Diabetic)	❑ Yes	❑ No	❑ 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 of our financial polices as an essential element of your care and treatment.

I authorize payment of medical benefits to Drs. Deroy and Duggirala for all services 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, that our relationship is with you and not your insurance company. Your insurance is a contract between you and the insurance company. As a courtesy, we will file your insurance claim for you. The filing of a medical insurance claim is an expensive process and a courtesy that we extend to you at no charge**. However, we do ask that you pay all co-pay, deductible and non-covered charges on 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 have been made. If a service is not 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 fees 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**, a $10.00 re-billing 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 are rendered to me. If I cannot provide my current insurance card, my appointment will be rescheduled or I will choose to pay for services out of my pocket.

I understand that if I provide incorrect or expired information, I will assume full financial responsibility for all charges 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 scheduled appointment time. This amount must be paid prior to any further visits with our office.

I understand that my account may be charged a **$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 and 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 requires a minimum of 60 days between visits for at risk patients for routine foot and nail care. Please note that Medicare may not qualify for routine trimming of nails and/or 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_________________________

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding
the attached Notice of Privacy Practices

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_______________________________________ ________________________
Patient Name (please print) Date

____
Parent or Authorized Representative (if applicable)

____
Signature