EVERGREEN FOOT & ANKLE
Dr. Tina P. Huynh, DPM, AACFAS
6928 B little River Turnpike
Annandale, VA 22003
Phone 703-462-9339 Fax 571-565-3144

New Patient Registration

Date: _____ **Primary Care Doctor: _____Phone#_____**

First Name: _____ Last Name: _____ DOB: _____ Gender: M / F

SSN: _____ Marital Status: Single / Mar / Div / Sep / Minor/ Wid Ethnicity: _____

Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____ Cell: _____
Email: _____

Occupation: _____ Employer: _____

Address: _____ Work No. _____

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

Policy No. _____ Policy No. _____

Subscriber: _____ Subscriber: _____

Employer: _____ Relationship to patient: Self/ Spouse/Parent/Other_____

Emergency Contact

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell Phone: _____

PREFFERED PHARMACY

Name: _____ Address: _____

Phone: _____ City: _____ State: _____ Zip: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to **Dr. Tina P. Huynh**. I understand that I am financially responsible for any balance that is not covered by my insurance. I also Authorize **Evergreen Foot & Ankle** or insurance company to release any information required to process my claims.

If you are unable to keep the appointment, please contact us within 24 hours to avoid a **$35.00** charge for **NO SHOW** appointment.

I have read and understand all above statement.

Name: _____ Signature: _____ Date: _____

Thank you for choosing Evergreen Foot & Ankle. www.Evergreenfootandankle.com

What is the main reason for your visit today? _____

When did symptoms start? _____ If injury, place & date: _____

Please indicate which foot problems you have had in the past:

Ankle Pain: ☐ Yes ☐ No Corns & Calluses: ☐ Yes ☐ No Athlete Foot: ☐ Yes ☐No

Bunions: ☐ Yes ☐ No Foot or Leg Cramps: ☐ Yes ☐ No Plantar Warts: ☐ Yes ☐ No

Flat feet: ☐ Yes ☐ No Ingrown toenails: ☐ Yes ☐ No Heel Pain: ☐ Yes ☐ No

Cramps/Numbness in feet or legs: ☐ Yes ☐ No Swelling in ankles or feet: ☐ Yes ☐ No

Medications:

Please list **all** medications you are taking now. Including vitamins/supplement

Are you allergic to any medication or latex? ☐ YES ☐ NO If yes, please list them.

History:

Are you a current smoker? ☐ YES ☐ NO Previous smoker? ☐ YES ☐ NO How many packs per day? _____

Previous foot surgery? ☐ YES ☐ NO If YES, what are the procedure: _____

Please list any other surgeries: _____

Please indicate any past medical history of:

☐ Arthritis ☐ Anemia ☐ Asthma ☐ Autoimmune Disease ☐ Blood Clots ☐ Cancer ☐ Charcot Joint

☐ CVA-Stroke ☐ Epilepsy ☐ Gastric Reflux/GI Ulcers ☐ Gout ☐ Heart Disease - _____ ☐ Hypothyroidism

☐ High Blood Pressure ☐ High Blood Pressure ☐ Kidney Disease - _____ ☐ Liver Disease- _____

☐ Neuropathy ☐ Peripheral Vascular Disease ☐ Rheumatic Fever ☐ Varicose Veins ☐ Vision Problem

Family History: Does anyone in your family suffer from any of the following? If yes, who?

Diabetes: ☐ Yes ☐ No _____ High Blood Pressure: ☐ Yes ☐ No _____

Cancer: ☐ Yes ☐ No _____ Arthritis: ☐ Yes ☐ No _____

Kidney Problem: ☐ Yes ☐ No _____ Heart disease: ☐ Yes ☐ No _____

Patient consent Treatment:

I _____ (Print name) certify that the above information is accurate to the best of my knowledge. I give permission to Dr. Huynh and associates of Evergreen Foot and Ankle to administer and perform the procedure necessary in the diagnosis and treatment. I understand that a perfect result Is not guaranteed.

_____ _____ _____

Printed name of patient/parent/guardian Signature Date

EVERGREEN FOOT & ANKLE

Dr. Tina P. Huynh, DPM AACFAS

6928-B Little River Turnpike, Annandale, VA 22003

Phone 703-462-9339 www.evergreenfootandankle.com

Podiatric Medicine	Foot and ankle Surgery	Wound care/Limb Salvage	Sport Medicine

NOTICE OF PRIVACY PRACTICES

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPAA)

Our commitment to your privacy:

Our Practice is dedicated to maintain the privacy of your individual identifiable health information (Also called protected health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we have in effect at the time.

We may use or disclose your PHI in the following ways:

The following categories describe ways in which we may use and disclose you PHI.

Treatment: Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine test), and we may use the results to help us reach diagnosis. In addition, we may disclose your PHI to other healthcare providers for purposes related to your treatment.

Payment: Our practice may use and disclose your PHI in order to bill and collect payment for the services, and items you may have received from us. We may disclose your PHI to other healthcare providers and entities to assist in their billing and collecting efforts.

Health care operations: Our practice may use and disclose your PHI to operate our business. An examples of the ways in which we may use and disclose your information for our operations: our practice may use your PHI to evaluate the quality service you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other Health care providers and entities to assist in their Health care operations.

Disclosures required by law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

The entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal Health information. Under this law, we have the right to refuse to treat you should you choose to refuse your personal Health information (PHI).

Confidential Communications: you have the right to request that our practice communicate with you regarding your health-related issues in a particular manner or at a certain location.

If you have any questions regarding this notice or our Health information Privacy policies, please speak with your HIPPA compliance officer.

I have read and understand the notice of privacy practices.

_____ _____ _____

Print Name Signature Date

Evergreen Foot & Ankle, LLC

Dr. Tina P. Huynh DPM

6928- B Little River Turnpike

Annandale, VA 22003

Phone: 703-462-9339

Fax: 571-565-3144

Financial Responsibility Agreement

Dr. Huynh make every effort in keeping the cost of your case down. *Full payment is due at the time of service (i.e. co-pays, deductibles, or full fee). To assist you in making payment we accept cash, checks, Visa, MasterCard, Discover, CareCredit, and More MasterCard

We are not contracted with all insurance plans, but we are happy to file a claim on your behalf. If you have a plan we are not contracted with, we will verify benefits for you, and you can decide if you wish to continue with us. Your insurance is a contract between you, your employer, and the insurance company. If you have questions concerning your insurance plan, please contact your employer's human resource department or your insurance company directly.

It is the patient's responsibility to know which benefits are covered or not covered by their insurance. The patient/guardian is responsible for all co-payments, deductibles, and fees that are denied or non-covered. Any balance pending with insurance more than 90 days will be due by the patient. If there is an additional balance after the insurance company payment is received the payment is due by the patient within 30 days.

The parent or guardian that bring a minor in for treatment is financially responsible party. A financial arrangement between individual parental parties does not absolve the parent bringing the minor from their financial obligation to our practice.

If timely payment is not made the services of an collection agency may be utilized. In addition, we won't be able to see you until your balance is cleared. The cost of additional collection liabilities will be assessed to the patient's account.

We have a return check fee $25.00. There is no fee to transfer x-rays into a flash drive, if you bring your own flash drive, and there is a fee of $15.00 if there any other paperwork that the doctor need to fill out.

It is the policy of this office for the courtesy of our patient who want Saturday appointments, if a patient Breaks or Cancels a Saturday appointment, with less than 24 Hour Notice the patient will not have the opportunity to schedule a Saturday appointment with our office for one year.

There will be a $35 missed appointment fee if we are not given 24 hours' notice to cancel any appointment.

Patient's Name (PRINTED): _____

Parent/Guardian Name: _____

(if patient is a minor)

Patient or Parent or Guardian Signature:_____Date:_____