THE ANKLE & FOOT CLINIC
OF NORTHERN VIRGINIA, PLLC

"Dedicated to Excellence in Medicine and Surgery"

Welcome to The Ankle and Foot Clinic of Northern Virginia, PLLC. We are excited about your decision to visit our practice. Our goal is to provide you with comprehensive medical care and quality services. To reach this goal effectively, we need your cooperation in complying with our office policies and procedures. You can reach our office at **703-743-5457** during normal business hours. We ask that routine calls for appointments, prescription refills, and test results are done during this time. During our lunch hour from 12pm to 1:30pm you may leave a message and we will return your call promptly. Please carefully review the following policies; a copy can be provided at your request.

Office Policies and Procedures

Cancellation/No Show Policy:

Our staff will make every effort to accommodate you with a convenient appointment. To protect the flexibility of our schedule, **we require patients to notify us with at least 24 hours advanced notice if you need to cancel or reschedule a scheduled appointment. Failure to contact us may result in a $50.00 fee.** No further services will be rendered until this fee is paid. Also, we reserve the right to terminate the doctor/patient relationship after two missed appointments, without notifying us within 24 hours.

Late Policy:

As a courtesy to our patients, we attempt to contact every patient via email and/or phone call to remind them of their appointment; however, it is the responsibility of the patient to arrive for their appointment on time. To respect the time of our other patients and protect the flexibility of our clinic schedule, **patients late 10 minutes or more may have to reschedule unless the office has an available opening at the time of their arrival.** If your appointment is the last appointment of the day and you arrive late, you may be asked to reschedule to allow adequate time for the clinical visit.

Health Insurance:

Your insurance policy is a contract that exists between **you and your insurance company**. Our relationship is with you, the patient, and not the insurance company. We always advocate on behalf of our patients, but if you have specific questions about your policy, please call the phone number provided on the back of your insurance card. We participate with most major insurance providers in our area, however this does change periodically. Therefore, you should always contact your insurance company to confirm our continued participation in your plan. It is your responsibility to know your insurance benefits.

Proof of Insurance:

All patients are required to present a valid insurance card along with a copy of your driver's license or other state identification. Insurance card must be presented at the time of service for claims to be processed. Failure to provide proof of valid insurance at the time of service will result in the patient being responsible for any balance of the claim. If your insurance changes, please notify us as soon as possible to avoid any unnecessary out of pocket expense.

Initial: _____

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Office Policies and Procedures (cont.)

Non-Covered Services:

Please be aware that some services you receive may be considered non-covered or not medically necessary by your health insurance plan. This is dictated by your health insurance policy. You will be financially responsible for these charges. This includes routine foot care services such as nail and/or callus care, unless there is a medically qualifying diagnosis as indicated by your insurance policy.

Claim Submission:

We will submit your claims and assist in any way we can to help get claims paid. At times however, our insurance may require additional information from the patient and/or the subscriber. Failure to provide additional information may result in the outstanding balance becoming your personal responsibility.

FMLA/Disability/Medical Records:

Typically, we do not charge for completing brief forms. However, for complex or lengthy forms, or multiple signed copies of the same form, there will be a fee of $25. Some complex forms may involve an office visit to ensure that the information provided on the form is correct. We require up to 5 business days for completion of any requested forms.

Medication Refill Requests:

Please allow 1-2 business days for a response on all refill requests. Please plan ahead if a refill is required near the weekend and note all requests are required to be made by Thursday at 4:30 pm.

Referrals:

Often, our office does not require a referral, though **if your insurance plan requires a referral from your primary care doctor, it will be required prior to your appointment.** Without a referral, we will need to reschedule your appointment.

Financial Policies

Payment:

All co-payments, deductibles, and co-insurance payments are due at the time of your visit. It is your responsibility to know your insurance benefits. Payment for services that are not covered by insurance is also due at the time of service. Outstanding balances will be collected prior to rendering of additional services.

Overpayment:

In the event of an overpayment, the credit may be applied towards future visits, or the credit will be refunded to the patient. Refund checks will be mailed to the address we have on file; please update our office if your address changes. If you misplace your refund check, a new check can be reissued with a fee of $30 for stopping payment of the original check.

Initial: _____

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Financial Policies (cont.)

Account Balances:

Patient balances are billed immediately upon receipt of payment from your insurance company and **must be paid within fourteen days** of your statement date. A **$10.00 surcharge** will be added to your account if a second or third statement must be sent. Account balances over **60 days** will be sent to our collection agency and will be subject to a monthly finance charge. In addition, if legal action is taken and we win a judgment, you agree to reimburse all cost and expenses for attorney fees incurred in collecting any amounts past due.

Returned Checks:

If for any reason a check is returned on your account, you will be responsible for a $50.00 returned check fee in addition to the original fees for service.

Returns:

All non-custom durable medical equipment items may be returned to the office within 7 days as long as items have not been used. Unused over the counter items may be returned if unopened and in original packaging within 7 days.

Claim Submission:

We bill all participating insurance companies (including secondary insurance) as a courtesy to you; however, if your insurance denies payment of a claim, you will be responsible for all charges. By signing this you agree to allow The Ankle and Foot Clinic of Northern Virginia, PLLC to submit insurance claims on your behalf. By signing this you also agree to authorize the release of pertinent medical information to your insurance companies so that proper reimbursement can be made directly to The Ankle and Foot Clinic of Northern Virginia, PLLC.

By signing here I acknowledge I have read, fully understand, accept, and agree to comply with the office and financial policies of The Ankle and Foot Clinic of Northern Virginia, PLLC. I understand that I can request a copy of these policies at any time. You also permit a copy of this to be used in place of the original. This authorization form will expire 3 years from date of signature.

_____ _____

Signature of Patient (Parent/Guardian if patient is a minor or unable to sign) Date

THE ANKLE & FOOT CLINIC
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HIPAA Acknowledgement of receipt of Notice of Privacy Practices

I have been offered a copy of the Notice of Privacy Practices for The Ankle and Foot Clinic of Northern Virginia, PLLC. Be advised that we will not sell or solicit your name unless authorized.

_____ _____

Signature of Patient (Parent/Guardian if patient is a minor or unable to sign) Date

During the duration of my care, I give permission for my medical information to be released to:

_____ _____ _____

Name Relationship Phone

Email Communication Consent

I have been offered a copy of the email communication information from The Ankle and Foot Clinic of Northern Virginia, PLLC.

I acknowledge that I have read and fully understand the email communication information. I understand the inherent risks associated with the communication of health information via unencrypted email between the office and me, and consent to receive such communications despite those risks **as well as any other instructions that the office may impose to communicate with patients by email. Any questions I may have had were answered. I understand that this consent is valid until I revoke the consent as outlined above.** By signing, you agree to hold The Ankle and Foot Clinic of Northern Virginia harmless for unauthorized use, disclosure, or access of your protected health information sent to the email address you provide.

_____ _____

Signature of Patient (Parent/Guardian if patient is a minor or unable to sign) Date

Email Address: _____

Phone Messages

Excluding our reminder calls, may we leave messages regarding medical information on your answering machine? Yes No

_____ _____

Signature of Patient (Parent/Guardian if patient is a minor or unable to sign) Date

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Acknowledgement and Consent of Voice Recording

Please be advised that our office uses HIPAA compliant voice recording and artificial intelligence (A.I.) during your visit as a part of our clinical practice to assist with the generation of your medical record. This voice recording and A.I. adheres to the Health Insurance Portability and Accountability Act (HIPAA) guidelines to ensure your data is secured and protected. Your voice recording data is stored for a maximum of 30 days. Only the healthcare professionals involved in your care will have access. Due to the integration of this technology within our office, without your consent we will not be able to provide medical care. By signing here, I acknowledge and consent to voice recording and use of A.I. during my clinical encounters. This consent is valid unless revoked in writing.

_____ _____

Signature of Patient (Parent/Guardian if patient is a minor or unable to sign) Date

_____

Printed Name