MEDICAL HISTORY

Name:____**Date**: ____________________

Last First MI

Date of birth:________________**Weight**:____________________**Height**: __________________

Chief Complaint:________________________**Affected Side**: RT or LT **Date of Onset**: ____________

Injury Related? YES / NO **Auto Accident**? YES / NO **Work Injury**? YES / NO

Dominant Side: RT Handed / LT Handed **Compensation Carrier**: ______________________________

Employment Status:________________________**Occupation**: ______________________________

Alcohol Use? YES / NO Amnt:__________________**Tobacco Use**? YES / NO Amnt: __________________

Illicit/Recreational Drugs? YES / NO Type:__________**Caffeine Use**? YES / NO Amnt: __________________

Physical Exercise? YES / NO Amnt:_______________

Please describe reason for visit: ____

____

Past Medical History

Diabetes	YES/NO
Cancer	YES/NO
Ulcers	YES/NO
Depression/Nervousness	YES/NO
Blood Pressure	YES/NO
Lung Disease	YES/NO
Heart Problems	YES/NO
Past Blood Transfusion	YES/NO
Arthritis	YES/NO
Liver Disease/Hepatitis	YES/NO
Kidney Disease	YES/NO
VRE	YES/NO
MRSA	YES/NO

Review of Systems (Recent Problems)

GENERAL	Weight Loss/Fever/Chills	NONE
SKIN	Rashes/Sores/Swollen Nodes	NONE
HEART	Chest pain/Palpitations/Irregular Beats	NONE
LUNGS	Short of breath/Coughs/Bronchitis	NONE
G.I.	Gastritis/Nausea/Vomiting/Pain	NONE
G.U.	Painful urination/Leaking/Burning	NONE
MUSCLE	Joint pain/Swelling/Stiffness/Weakness	NONE
PSYCH	Anxiety/Depression/Addiction	NONE
BLOOD	Anemia/Abnormal Bleeding	NONE
ENT	Sinusitis/Hoarseness/Swallowing Problems	NONE
EYES	Vision Changes/Sensitivity to Light	NONE

Allergies/Reactions: ____

Family History: Do any of your blood relatives have or have had any of these diseases?

Diabetes	YES/NO	TB	YES/NO
Cancer	YES/NO	Thyroid Disease	YES/NO
Heart Problems	YES/NO	High Blood Pressure	YES/NO
Stroke	YES/NO		

Other: ____

Social History: Single Married Widowed Divorced Unknown

Past Surgeries: ____

____

Current Medications: ____

____

Referring Physician: ____

Primary Care Physician: ____

Pharmacy:____

Signature: ____

3998 Fair Ridge Dr Suite 100A, Fairfax VA 23033-2907
Ph 703-591-0077 • Fax 703-591-0080

Stephen W. Pournaras Jr. MD
Da Yon Park, PA-C

Patient Information

Patient Name (Last, First, MI)	Sex	Marital Status	Date of Birth	Social Security #
Street Address	City, State, Zip			Home Phone
Cell Phone	E-mail Address			Occupation
Work Phone	How would you like us to contact you? ☐ E-mail ☐ Mail ☐ Both			
Employer	Address		Phone	
Referring Doctor	Address		Phone	

Guarantor/Guardian Information (Responsible Party)

Guarantor/Guardian Name	Sex	Relation to Patient	Date of Birth	Social Security #
Street Address	City, State, Zip			Home Phone

Health Insurance Information

Primary Insurance Carrier	Mailing Address			
Phone	Policy #		Group #	
Policy Holder	Sex	Relation to Patient	Date of Birth	Social Security #
Secondary Insurance Carrier	Mailing Address			
Phone	Policy #		Group #	
Policy Holder	Sex	Relation to Patient	Date of Birth	Social Security #

Workers Compensation Information

Carrier Name	Mailing Address		Phone
Location of Accident	Date of Injury	Claim #	Adjuster/Case Manager

Auto Insurance/ Med Pay Information

Auto Ins./Med Pay Name	Mailing Address		Phone
Location of Accident	Date of Injury	Claim #	Adjuster

Attorney Information

Attorney	Mailing Address
Phone	Fax

Please remember that Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies may pay fixed allowances for certain procedures; they sometimes refer to as “Reasonable and customary fees.” We do not accept this as payment in full (unless otherwise restricted by law or agreement we may have with your insurer). Also, some of the insurance companies only pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance. IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE DO REQUEST THAT OUR CHARGE FOR OFFICE VISITS BE PAID AT THE INITIATION OF EACH VISIT. In the event the account is turned over for collections, the collection fees and /or legal fees, including attorney fees, shall be your responsibility. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, Medicare, private insurance and other health plans to the facility listed in the top header of this page. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment, via fax transmittal or hard copy. You are also responsible for durable medical equipment purchased at our clinics, which are not covered by your health insurance.

Patient/Parent or Legal Guardian Signature____ Date ____________

Fair Oaks Ortho, PLLC
3998 Fair Ridge Dr Suite 100A, Fairfax VA 23033-2907
Ph 703-591-0077 • Fax 703-591-0080

PATIENT AUTHORIZATION

I,____hereby authorize Fair Oaks Ortho, PLLC to apply for benefits on my behalf to my primary and/or secondary health insurance carrier(s) for covered services rendered by Fair Oaks Ortho, PLLC. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information, for this or any related claim, the above-named billing agent and/or other insurance carrier. I permit a copy of this authorization to be used in place of the original.

I understand that I am ultimately responsible for my bill and that Fair Oaks Ortho, PLLC has no control or authority over my insurance company. In the event of insurance claim denial or payment delay, I will be responsible for payment of all charges incurred. If my account is turned over to a collection agency, I will be responsible for the balance due, plus any collection and court costs incurred.

Cancellation policy: There is a $75 fee for new patient appointments not canceled at least 24 hours in advance. There is a $75 fee for 30+ min follow up appointments and a $50 fee for 15min appointments. This fee is not billable to your health insurance/ workers compensation company / Attorney and is your responsibility.

____ ____________________________
Patient/Guarantor Signature **Date**

3998 Fair Ridge Dr Suite 100A, Fairfax, VA 22033-2907
Ph – 703-591-0077 Fax – 703-591-0080

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my health information as described below. I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

Patient Name:____Date of Birth: _____________

PERSON/ORGANIZATION RECEIVING THE INFORMATION:
____
____
____

PERSON/ ORGANIZATION SENDING THE INFORMATION:
____
____
____

SPECIFIC DESCRIPTION OF INFORMATION TO BE SENT:
____

Patient/Guardian Signature:_________________________________Date: ___________________

Please send this information to the fax number listed above at your earliest convenience. Thank you.

Stephen W. Pournaras, M.D. • Da Yon Park. PA-C

FINANCIAL POLICY

Fair Oaks Ortho, PLLC is dedicated to providing our patients with the best possible care. We ask your help by understanding and cooperating with our financial policy.

Insurances:
We participate with many insurance companies. Please check with your insurance company to confirm that we participate with your plan. We will file secondary and tertiary insurances as a courtesy to our patients.

If we do participate with your insurance company, all services performed in our office and at the hospital will be submitted unless we have received prior notification of non-coverage**. <u>All copays and deductibles are the patient's responsibility and are due at the time of service.</u>**

HMO insurances generally require referrals for services. It is the patient's responsibility to obtain the referral. If a referral is not presented at the time of service, the practice reserves the right to reschedule the appointment.

If we do not participate with your insurance and you have no "out of network" benefits, payment is due in full at the time of service. We will provide you with an itemized bill so that you can submit the charges to your insurance company for reimbursement.

<u>It is the patient's/parent's/guardian's responsibility to:</u>
***Understand that your health insurance coverage is an agreement between you and your insurance company. <u>Ultimately, it is your responsibility to know the terms of your healthcare plan.</u>**
***Be aware that Durable Medical Equipment (DME) may not be covered under your plan.**
***Bring all of your current insurance cards to all visits.**
***Provide our practice with current information including address, phone numbers and employer.**

Payment for Services Performed:
For your convenience, our office accepts Visa, MasterCard and Discover as well as cash or checks. All payments are due at the time of service. The fee for the completion of FMLA and Disability Forms is $25.00 and is due at the time of the request.
Should your account become delinquent and be turned over to a collection agency, you will be financially responsible for all collection and legal fees that our office incurs.
The fee for a returned check is $50.00.

I have read and fully understand the financial policy set forth by Fair Oaks Ortho, PLLC and I agree to these terms. I also understand and agree that the terms of this policy may be amended by the practice at any time without prior notification to the patient.

____________________________________ ________________
Patient's/Guardian Signature Date

____________________________________ ________________
Printed name of patient Date

ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE

Patient Name:____

Patient Account # :____

Date of Registration:____

By signing this form, you acknowledge that Fair Oaks Ortho, PLLC has provided you access to a copy of its HIPAA Privacy Notice, which explains how your health information will be handled in various situations. By law, we are required to have you sign this form on your first date of service with us.

If your first date of service with us was due to an emergency, we must try to provide you access to this notice and have you sign this form as soon as we can after the emergency.

Please specify by checking the appropriate answer below if we may leave health-related information (e.g., lab/radiology results, billing issues or other doctor-patient communications) with/on:

Home Answering Machine	☐ Yes	☐ No
Work Voicemail	☐ Yes	☐ No
Personal/Work Email	☐ Yes	☐ No
Provide Email Address:__________________________________		
Cell Phone	☐ Yes	☐ No
Relative or Other Person Living With You	☐ Yes	☐ No

Please note that if the above section is not completed, we will assume that we have your approval to contact you using any one of these methods.

[ ] The Practice has provided me with a copy of its Privacy Notice.
I acknowledge that I have read, understand and agree to the above.

[ ] I have read the Privacy Notice and DO NOT AGREE to its provisions.

____ ___________

Patient's/Guardian Signature Date

FOR PRACTICE STAFF TO COMPLETE IF ACKNOWLEDGEMENT FORM NOT SIGNED:

1. Does patient have a copy of the Privacy Notice?______Yes _____No
2. Please explain why the patient was unable to sign an acknowledgement form and the Practice's efforts in trying to obtain the patient's signature:

______________ ____________

Employee's Initials Date

REIMBURSEMENT NOTIFICATION

Fair Oaks Ortho, PLLC does not participate with many of the Affordable Care Act insurance plans. Your health insurance is a contract between you, your employer and the insurance company. Therefore, it is the patient’s responsibility to know if the providers are "in network" with his or her insurance plan before any scheduled visits. While the practice makes every effort to help you determine your coverage we are not party to many of these contracts. Therefore, if you are seen by any of our providers with "out of network" benefits for your particular insurance plan you will be responsible for payment of all charges to Fair Oaks Ortho, PLLC.

I have read and understand that my insurance plan may not be "in network" with Fair Oaks Ortho, PLLC. I accept full financial responsibility for the cost of this service if uncovered by my insurance carrier.

____ __________

Patient Signature (Parent for minor) Date

Patient Acknowledgement
Appointment Cancellation/No Show Policy

Thank you for trusting your medical care to Fair Oaks Ortho. When you schedule an appointment with Fair Oaks Ortho, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Effective December 1st, 2023, any established patient who fails to show or cancels an appointment and has not contacted our office with **at least 24 hours notice**, will be charged a **$50.00 fee for 15min appointments** and a **$75.00 fee for 30+min appointments**. The first no-show fee will be waived however, any other no-show or late cancellations will incur **at the above specified rate**.
- Any new patient who fails to show for their initial visit will be charged a **$75.00 fee at the time of their rescheduled appointment or they will be sent a bill.**
- The fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit.**
- If you are **20 or more minutes late** for your appointment, the appointment **may be** cancelled and rescheduled.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. **If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee**. You may contact Fair Oaks Ortho, Monday to Friday 8am to 4:30pm. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message.

Please sign and date below your acknowledgement.

I have read and understand the Appointment Cancellation/No Show Policy and I acknowledge its terms. I also understand and agree that such terms may be amended from time-to-time by the office.

___________________________________	___________________________________
Signature (Parent/Legal Guardian)	**Relationship to Patient**
___________________________________	___________________________________
Printed Name	**Date**