



Cho Foot & Ankle Specialists, PLLC

Corporate Landing Medical Center
1232 Perimeter Parkway
Virginia Beach, Virginia 23454
(757) 427-7447

Carrie T. Cho, D.P.M., FACFAOM
David J. Cho, D.P.M., FACFAS

Patient: _____ Responsible Party (if under 18) _____
Last name First name Initial

Home Phone: _____ Cell: _____ Work: _____ Marital Status: Single Married Widowed Separated Divorced

Street Address: _____ City _____ State _____ Zip Code _____

Patient DOB: _____ / _____ / _____ Sex: M or F Patient Social Security # _____ - _____ - _____

Email address: _____ Emergency Contact: _____ Phone: _____

May we utilize the email you provided above for appointments, statements, and financial information? YES ___ NO ___

Primary Care Physician _____ Date Last Saw PCP? _____ How did you learn of our office? _____

Patient Employer: _____ Address _____ City, State, Zip _____

Race: (Circle One) American Indian/ Alaska Native || Asian || Black or African American || Native Hawaiian Other Pacific || White
Ethnicity: (Circle One) Hispanic or Latino || Not Hispanic or Latino Preferred Language: _____ Military History? _____

COMPLETE INSURANCE INFORMATION IF PATIENT IS NOT PRIMARY SUBSCRIBER

Primary Insurance / Subscriber Name _____ DOB: _____ / _____ / _____ SSN _____ - _____ - _____

Secondary Insurance / Subscriber Name _____ DOB: _____ / _____ / _____ SSN _____ - _____ - _____

Please READ and INITIAL A - D, then sign and date below. Medicare recipients also read and sign -E- below.

A. _____ ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____ and assign directly to Dr Cho all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

B. _____ GENERAL MEDICAL RELEASE

In the event of an emergency, I authorize Cho Foot and Ankle Specialists to release any or all pertinent medical information regarding my care to my significant other, spouse, designated family member or physician to facilitate expedient treatment.

C. _____ ACKNOWLEDGEMENT OF PRIVACY PRACTICES AND RESPONSIBILITY OF PAYMENT

I have received the Notice of Privacy Practices and I have been provided with an opportunity to review it. I accept responsibility and guarantee payment for all services rendered to me and my family and upon default on any payment due, I agree to pay all cost of collections, including collection agency fees of **33 1/3 percent plus a \$25.00** returned check fee should a check be returned for any reason.

D. _____ NO SHOW/CANCELLATION POLICY

I understand and agree that Cho Foot and Ankle Specialists require a **24-hour notification for appointment cancellations**. In the event that an appointment is not cancelled within 24 hours or a "No Show" occurs, we may charge a **\$42 fee**. When we hold an appointment time for patients that do not plan to make their scheduled visit, it reduces our same day availability for urgent need patients. The fee will be determined and assessed on a case-by-case basis and is not meant to be discriminatory in any regard.

NOTICE – Virginia Prescription Monitoring Program may be used in order to meet your medical needs.

X _____
Signature of Patient/Guardian

Date

E. MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Cho for any services furnished for me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

X _____
Beneficiary Signature

Date

Family Medical History:

Please mark which family member has/had the following health conditions:

Conditions:	Self: Please Explain	Father	Mother
Anesthesia Problems?			
Arthritis?			
Asthma?			
Bleeding Disorders?			
Cancer (be specific)			
Diabetes?			
Gout?			
Heart Conditions?			
High Blood Pressure?			
High Cholesterol?			
Kidney Disease?			
Liver Problems?			
Lung Conditions?			
Neurological Issues (Alzheimer's, Dementia, Parkinson's)			
Strokes?			
Gastrointestinal Issues? (gallbladder, IBS, GERD, Acid Reflux, Chron's, UC)			

Social History:

*Marital Status: _____

*Occupation _____

*Number of Children _____

*Caffeine Consumption: Yes No
Amount daily/weekly _____

*Alcohol Consumption Yes No
Drinks per week? _____

*Tobacco Use: Yes No
#packs per day _____

*Weight: _____ lbs

*Height: _____ ft _____ Inches

Female: Any Pregnancy or Childbirth Issues/ Hysterectomy/Cancers? YES / NO : _____

Male: Any Prostate Issues (Cancer, Enlargement, ect)? YES / NO ; _____

.....

****ONLY FOR Patients Over 65 yrs:**

Do you have an Advanced Care Plan in Place? YES / NO If yes, please complete the following information:

Maker: _____

Contact Info: _____

Have you received a Pneumococcal Vaccine in the past 5 yrs? YES / NO

Have you or anyone in your household had a positive Covid-19 test? YES / NO

***Have you experienced any symptoms related to Covid-19? (fever/body aches/loss of taste or smell or trouble breathing) YES / NO**

.....

The above information is correct to the best of my knowledge Patient/Parent

Signature: _____ Date: _____



Cho Foot & Ankle Specialists, PLLC

Corporate Landing Medical Center
1232 Perimeter Parkway
Virginia Beach, Virginia 23454
(757) 427-7447

Carrie T. Cho, D.P.M., FACFAOM
David J. Cho, D.P.M., FACFAS

Patient Responsibility Agreement Form

Patient Name: _____

Date of Birth: _____

INDIVIDUAL'S FINANCIAL RESPONSIBILITY:

I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service. Co-payments are due at time of service. If my plan requires a referral, I must obtain it prior to my visit. In the event, my health plan determines a service to be "non-covered", I will be responsible for the complete charge and agree to pay the costs of all services provided. If I am uninsured, I agree to pay for the medical services rendered to me at the time of service.

INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS:

I hereby authorize and direct payment of my medical benefits to *Cho Foot & Ankle Specialists, PLLC* on my behalf for any services furnished to me by the providers.

AUTHORIZATION TO RELEASE RECORDS:

I hereby authorize *Cho Foot & Ankle Specialists, PLLC* to release to my insurer, government agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

MEDICARE REQUEST FOR PAYMENT:

I request payment of authorized Medicare benefits to me or on my behalf for any services rendered to me at *Cho Foot & Ankle Specialists, PLLC*, I authorize any holder of medical or other information about me to release to Medicare and its agents, any information needed to determine these benefits or benefits for related services.

By signing below, I hereby acknowledge that I have completely read and fully understand the guidelines and policies set in place by *Cho Foot & Ankle Specialists, PLLC* stated above in the Patient Responsibility Agreement Form.

Signature of Patient: _____

Date: _____

Authorized Representative: _____ Relationship: _____