CHO FOOT AND ANKLE SPECIALISTS
1232 Perimeter Parkway Suite 102 ~ Virginia Beach, VA 23454

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 and 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 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 by 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 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**