MISSION STATEMENT

Our office endeavors to provide our patients with prompt, competent, and courteous care while offering the best leading edge podiatric care possible.

PRACTICE'S REQUIREMENTS

The Practice is required by federal law to maintain the privacy of your Patient Health Information (PHI) and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practice with respect to your PHI.

Under the Privacy Rule, the Practice may be required by state law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.

The Practice is required to abide by the terms of this Privacy Notice.

The Practice reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

The Practice will distribute any revised Privacy Notice to you prior to implementation.

The Practice will not retaliate you for filing a complaint.

EFFECTIVE DATE

This notice is effect as of June, 2015

To obtain more information about your privacy rights of if you have questions you want answered about your privacy rights (as provided for by Privacy Rule, Section 164.520(b)(vii)), you may contact the Practice's HIPAA Compliance Officer as follows:

MAIL: **Dr. Jerald Kriger**
8605 Sudley Road
Manassas, VA 20110

EMAIL: **ManassasFootDoc@aol.com**

PHONE: **(703) 330-4450**

Amendments to this Privacy Policy: We reserve the right to revise or amend this Privacy Policy at any time. These revisions or amendments may be made effective for all protected health information we maintain even if created or received prior to the effective date of the revision or amendment. We will provide you with notice of any revisions or amendments to this Privacy Policy, or changes in the law affecting this Privacy Notice, within sixty (60) days of the effective date of such revision, amendment, or change.

NOTICE OF PRIVACY PRACTICE (HIPAA REGULATIONS)

❑ You were provided with a document entitled "Notice of Privacy Practices." It is required by governmental regulation that all medical facilities provide you with this notice. Please check the box to acknowledge that you have read (or had the opportunity to read if you chose) and understand the notice. This is a copy of the notice that is yours to keep. If you do not want the copy, simply return it to the receptionist with your other materials.

CONSENT

I certify that the information above is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures, including therapeutic and diagnostic injections, as may be deemed necessary in the diagnosis and/ or treatment of my feet.

FSOA 08/20/08

Signature: _____ Date: ____/____/____

JERALD A. KRIGER, D.P.M
8605 SUDLEY ROAD
MANASSAS, VIRGINIA 20110

PATIENT REGISTRATION Today's Date ____/____/____

Patient Name: _____ Birth Date ____/____/____

Street Address: _____ Apt#:_____

City: _____ State:____ Zip:_____ Preferred Language: _____

Male____ Female ____ Marital Status: S____M____D____W____ SS# _____-____-_____

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

Work Phone: (_____)_____-_____

Email: _____ Occupation: _____

Employer: _____ Employer's Address: _____

_____

Emergency Contact: _____ Relationship: _____

Phone: (_____)_____-_____

Primary Care: _____ Address: _____

Phone: (_____)_____-_____ Date Last Seen: ____/____/____

Do you smoke? Yes:____ No____ If yes: How many years?____ Packs/day____

Do you drink alcohol? Yes:____ No____ If yes: How many glasses/cans/day? _____

Height: _____ Weight:_____

Referred by? _____ Website:___ Google:___ Facebook:___ Twitter: ___

Office Sign:___ Angie's List: ___

PRIMARY INSURANCE COMPANY

Name of Company: _____ Policy ID#_____

Group ID#_____ Phone: (_____)_____-_____ Address: _____

_____ Policy Holder: _____

Relationship To Patient: _____ Date of Birth: ____/____/____

Secondary Supplemental Insurance Company

Name of Company: _____ Policy ID#_____

Group ID#_____ Phone: (_____)_____-_____ Address: _____

_____ Policy Holder: _____

Relationship To Patient: _____ Date of Birth: ____/____/____

PLEASE READ AND SIGN THE FOLLOWING STATEMENT

I certify that the above information given by me in applying for payment is correct. A photocopy of these assignments shall be valid as the original. Should any of this information change, I am responsible for notifying this office in a timely fashion.

Signature: _____ Date: ____/____/____

PATIENT CONSENT:

I _____ give my permission to Dr. Jerald A. Kriger to speak to the following people about my medical care: _____

_____. I give my permission to the staff at Dr. Kriger's office to leave a message on my phone: Yes _____ No _____

Phone Number to leave message: (_____)_____-_____

MY MEDICATION LIST

Patient Name: _____ Date: ____/____/____

Date of Birth: ____/____/____

Please list all drugs you are currently taking. Drugs include prescription and over-the-counter medications, herbal products, nutritional supplements, and recreational drugs. **Bring this list with you to your first appointment.**

Drug Name	Drug Strength	Amount and Times of Day Taken	Reason for Medication	Prescriber

Do you have any allergies: _____ Yes _____ No

If yes, please list:

_____

_____

Patient Name: _____ Date of Birth: ____/____/____

YOUR MEDICAL HISTORY

ALLERGIES: ▢ MEDICATIONS _____

▢ ANESTHESIA _____ ▢ FOODS _____

▢ TAPE ▢ LATEX ▢ SHELLFISH ▢ IODINE ▢ OTHER _____

▢ NONE KNOWN

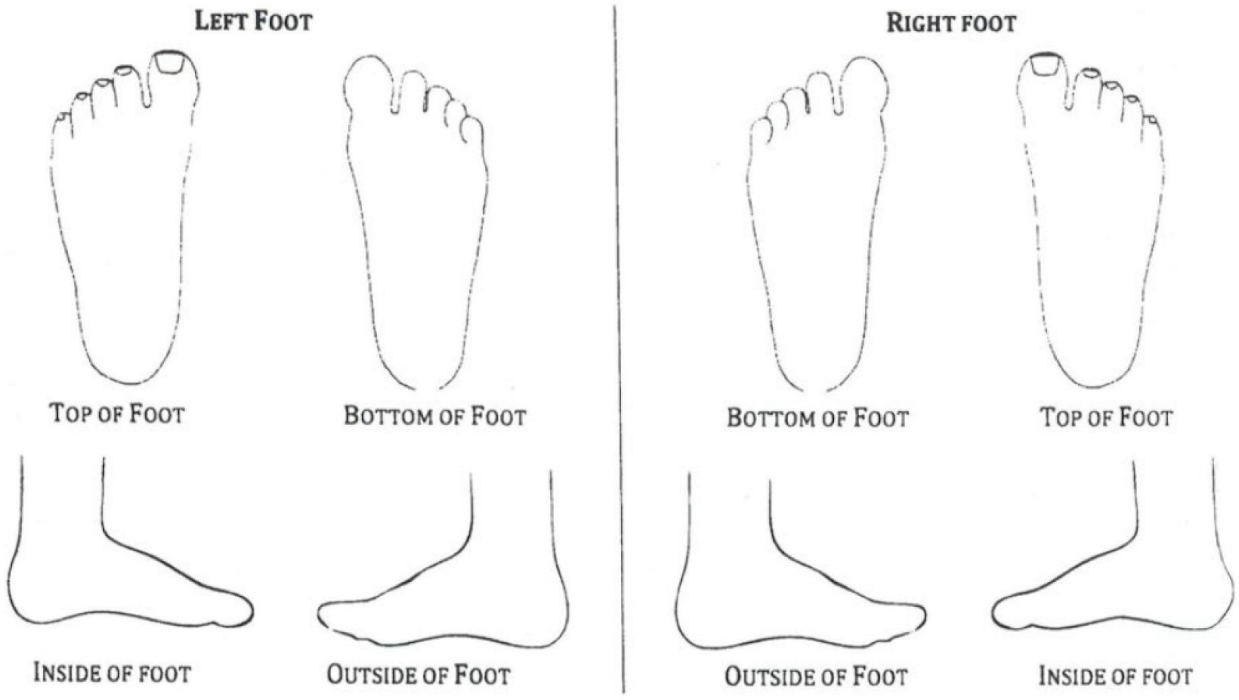
HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N		FIBROMYALGIA	Y	N		NEUROPATHY	Y	N
ANEMIA	Y	N		GOUT	Y	N		OPEN SORES	Y	N
ARTHRITIS	Y	N		HEART ATTACK	Y	N		PNEUMONIA	Y	N
ASTHMA	Y	N		HEART DISEASE/ FAILURE	Y	N		POLIO	Y	N
BACK TROUBLE	Y	N		HEPATITIS	Y	N		RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N		HIV+/AIDS	Y	N		SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N		HIGH BLOOD PRESSURE	Y	N		SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N		KIDNEY DISEASE	Y	N		SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N		LIVER DISEASE	Y	N		STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N		LOW BLOOD PRESSURE	Y	N		STROKE	Y	N
CANCER	Y	N		MIGRAINE HEADACHES	Y	N		THYROID DISEASE	Y	N
DIABETES	Y	N		MITRAL VALVE PROLAPSE	Y	N		TUBERCULOSIS	Y	N
OTHER CONDITIONS:										

CURRENT PROBLEM

What specific problem brings you to our office today? _____

Where is the pain/problem located? Please mark on the pictures below.



PATIENT FINANCIAL POLICY

Thank you for choosing Dr. Kriger as your foot care provider. The office is committed to providing you with quality and affordable health care. Please read the following office payment policy and feel free to ask us any questions you may have. Once you accept this policy, kindly sign in the space provided. Your signed copy will be provided to you.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, or do not have an up-to-date insurance carrier, payment in full is required until your insurance can be verified. **Knowledge of your insurance benefits is your responsibility.** Please contact your company with any questions you may have regarding your coverage.

2. **Proof of insurance.** All patients must complete the patient information forms before seeing the doctor. We must obtain a copy of your current insurance card and a valid photo i.d. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim. You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied. Patients presenting to our office without a valid referral, when required by their insurer, will be asked to pay in full at the time of service.

3. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service, this arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

4. **Non-covered services.** Please be aware that some, and perhaps all, of the services you receive may not be covered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of the visit.

5. **Claims submission.** We will submit yur claims and assist you in any way we reasonably can to help you get your claims paid. All health plans are not the same and do not cover the same services. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. **Please be aware that the balance of your claim is your responsibility, whether or not your insurance company pays your claim.** Your insurance benefit is a contract between you and your insurance company. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

OVER PLEASE

6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make appropriate changes to help you receive the maximum benefits.

7. **Non-payment.** Statements are sent out every 30 days. Your prompt payment will assist us in keeping the cost of healthcare down. A $10.00 rebilling fee will be charged invoices 30+ days past due, 60+ days will be charged $20.00; 90+ days past due will be charged $30.00 and considered for collections. Interest on your unpaid balance may be charged an additional 1.5% per month. **Partial payments will not be accepted unless otherwise approved by our billing department.** Payment plans are available; please contact the office as soon as your statement arrives in order to set up a plan and avoid rebilling fees. If your balance remains unpaid, your account may be turned over to a collections agency or to a law firm and you may be discharged from this practice. An additional 40% will be added to your statement to cover collections fees. Attorneys fees and court fees shall be your responsibility in addition to the balance due.

8. **Forms and documents.** It is our policy to charge a $15.00 fee for completion of all forms, such as disability applications, handicap stickers, detailed receipts for flex accounts and health savings accounts. No forms will be processed if a patient has an outstanding balance. Returned checks will incur a $45.00 service fee; no further checks will be accepted. If you fail to redeem a returned check, you may be liable for additional penalties and attorneys fees. To cover the cost of copying and handling medical records, the fee is $10.00 plus $0.50 per page and $10.00 for copying X-rays.

9. **Cancellation Policy.** It is important for patients to keep their scheduled appointments. If it is necessary to cancel or change an appointment, the office needs to be notified a minimum of 24 hours in advance; Monday appointments need to be cancelled by noon the previous Friday. No-show, or late cancellations will be charged a $35.00 fee.

Thank you for understanding our payment policy. Please feel free to discuss any questions or concerns you may have.

I have read and understand the policy and agree to abide by its guidelines.

_____ _____

Signature of patient or responsible party Date

Updated 01/18/18