WELCOME TO OUR OFFICE

Blue Ridge Foot and Ankle Clinic, PLC
887 A Rio East Ct
Charlottesville, VA 22901
434.979.8116

417 S. Magnolia Ave
Waynesboro, VA 22980
540.949.5150

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Chart #

KEVIN P. MURRAY, DPM
STEWART M. CHANG, DPM
www.brfootandankle.com

Date:________________________

Patient____
Last name | First name | Initial | Name (desired to be called by)

Responsible Party (if a minor)____

Street Address______________________________ City ____________________State_____ Zip Code___________________

Home Phone_____________________________ Cell Phone___________________________

Birthdate ________________________ Age__________ Sex M F Single Married Widowed Separated Divorced

Social Security #___________________ Emergency Contact_______________________ Phone____________________

Primary Care Physician______________________________________ Last Visit ____________________________

Referred to our practice by ________________________ Heard about our practice by _____________________________

Employer__________________________ Work Phone____________________ Position/Occupation___________________

Date of Injury ________________ Date you were first treated _______________ By Whom ________________________

PLEASE PROVIDE ALL YOUR INSURANCE CARDS TO THE RECPTIONIST TO BE COPIED

Name of Insured (if not patient): _____________________ Relationship to patient : ____________ Employer: ____________
Date of Birth (Insured) : ________________ Occupation: ______________________ Work Phone: __________________
Social Security Number (Insured) : ___________________

Worker Compensation Cases: Claim number: __________________ Case manager/Phone: ____________________________
Workplace Contact – Name: ______________________ Position: __________ Title: __________ Phone: _____________
Date last worked: ________________ Are you working now?: ___________________

AUTHORIZATION FOR TREATMENT, ASSIGNMENT AND RELEASE

I hereby give the Blue Ridge Foot and Ankle Clinic, PLC and it's staff members permission to treat my feet and/or ankle disorders. I, the undersigned, have insurance coverage with ________________________and assign directly to Blue Ridge Foot & Ankle Clinic, PLC 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.

____ ____________________________
Signature of Insured/Guardian | Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Blue Ridge Foot & Ankle Clinic, PLC 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.

____ ____________________________
Beneficiary Signature/Guardian | Date

NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGEMENT OF RECEIPT

I acknowledge have received a copy of Notice of Privacy Practices and I have read (or had the opportunity to read if I so chose) and understood the notice.

____ ____________________________
Patient Signature/Guardian | Date