NORTH JERSEY FOOT & ANKLE CENTER

MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have any of the following conditions:

AIDS / HIV	☐ Yes ☐ No	Anemia	☐ Yes ☐ No	Angina	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Artificial Heart Valve	☐ Yes ☐ No	Artificial Joint	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Back Problems	☐ Yes ☐ No	Bleeding Disorders	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	COPD	☐ Yes ☐ No	Drug Abuse	☐ Yes ☐ No
Fainting	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Heart Attack	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No
Liver Disease	☐ Yes ☐ No	Neuropathy	☐ Yes ☐ No	Obesity	☐ Yes ☐ No
Osteoarthritis	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Peripheral Vas. Dis.	☐ Yes ☐ No
Rheum. Arth.	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	Varicose Veins	☐ Yes ☐ No
High Cholesterol	☐ Yes ☐ No	Gastritis	☐ Yes ☐ No	Dementia	☐ Yes ☐ No

Diabetes ☐ **Yes** ☐ **No** Recent HbA1c _____ FBS _____

History of Foot Ulcers ☐ Yes ☐ No Smoking: ☐ Current ☐ Former ☐ Never

Other Medical Conditions: _____

Surgical History _____

Hospitalizations _____

Primary Care Doctor _____ Last Visit Date _____

Height _____ Weight _____ Blood Pressure _____ Shoe Size _____

What is the reason you came in today? _____

Have you ever been to a Podiatrist before? ☐ Yes ☐ No

Please indicate which foot problems you have now or had in the past:

Athlete's Foot	☐ Yes ☐ No	Bunions	☐ Yes ☐ No	Corn Calluses	☐ Yes ☐ No
Numbness in Feet	☐ Yes ☐ No	Flat Feet	☐ Yes ☐ No	Heel Pain	☐ Yes ☐ No
Ingrown Toenails	☐ Yes ☐ No	Plantar Warts	☐ Yes ☐ No	Swelling in Ankles or Feet	☐ Yes ☐ No
Ankle Pain	☐ Yes ☐ No				

HIPAA CONSENT

I understand that I have certain rights to privacy regarding my protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I have also been given the right to review and secure a copy of your Notice of Privacy Practices.

Patient Name: _____ Date: _____

Signature: _____

NORTH JERSEY FOOT & ANKLE CENTER

PATIENT INFORMATION

Date _____

SSN _____

Patient Name: Last _____

First _____Middle _____

Address _____

City_____ State_____ Zip Code_____

Email _____

Sex M / F Age _____ Birthdate_____

☐ Married ☐ Widowed ☐ Single ☐ Minor

Patient Employer / School _____

Employer / School Phone _____

Spouse's Name _____

Spouse's Phone _____

HOW DID YOU FIND US? _____

PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

At Which Number Should We Contact You?

☐ Home ☐ Cell

IN CASE OF EMERGENCY CONTACT,

Name _____

Relationship _____

Cell Phone (_____) _____

Work Phone (_____) _____

INSURANCE

Subscriber's name _____

Relationship to patient _____

Insurance Co. _____

Member # _____

Group # _____

Is patient covered by additional insurance? Y/N

MEDICATIONS & ALLERGIES

Include prescriptions and OTC medications

_____

_____

Pharmacy Name _____

Pharmacy Phone _____

Pharmacy Address_____

ALLERGIES

☐ Adhesive/Tape ☐ Codeine ☐ Aspirin

☐ Iodine ☐ Lidocaine ☐ Penicillin

☐ Sulfa ☐ Seafood ☐ Latex ☐ NONE

Other_____

TREATMENT CONSENT

I hereby consent and give my permission to the doctor to administer such procedures as the doctor deems necessary

Signature _____

Patient Name _____

Date _____

NORTH JERSEY FOOT & ANKLE CENTER

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. **Knowing your insurance benefits is your responsibility**. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE: We are a participating Medicare provider. Medicare as well as your secondary insurance will be billed for you. However; that does not mean that all services are covered. Patients are responsible for paying their annual deductible. You are also responsible for any coinsurance.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary.

COPAYMENTS AND DEDUCTIBLES: All co-payments and deductible 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.

NO SHOW FEE: If you do not cancel or reschedule your appointment with at least 24 hours' notice, **we may assess a $25 "no-show" service charge** to your account. This "no-show charge" is not reimbursable by your insurance company. You will be billed directly for it.

SELF PAY: Payment in full is due at the time of service if you do not have health insurance.

FORMS COMPLETION POLICY: Forms will be assessed a fee that will be collected before the provider completes the document. This fee will be charged at a rate of $25 for up to 2 pages and an additional $15 for each additional page. Forms will be filled out within 5 business days of payment.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment of these services.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Obtaining referrals from your primary physician and keeping track of your visits is your responsibility. If you do not have a valid referral at the time of your visit, your appointment will be rescheduled.

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. 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. Your insurance benefit is a contract between you and your insurance company.

PATIENT BILLING: You will be sent up to three notices for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. **After the third and last notice, your account may be forwarded to collections with interest accruing on balance.** It is also your responsibility to pay for the interest accrued if sent to collections. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Credit/Debit Cards, Checks. An additional $40.00 will be added to your statement if the check is returned for insufficient funds. In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance.

I have read the above policy regarding my financial responsibility to NORTH JERSEY FOOT & ANKLE CENTER for medical services provided. I agree to pay NORTH JERSEY FOOT & ANKLE CENTER any balance unpaid by my insurance carrier for myself or the below named person. Assignment of Benefits I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to NORTH JERSEY FOOT & ANKLE CENTER all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

PRINT Patient Name: _____ **Signature**: _____

FINANCIALLY RESPONSIBLE PARTY **(if other than yourself)**:

PRINT Name: _____ Signature: _____

Relationship to Patient: _____ Date: _____

NORTHJERSEY
FOOT AND ANKLE CENTER

542 Anderson Avenue, Cliffside Park, NJ 07010
Phone: 201.943.7977

4 Hunter Street Suite 201, Lodi, NJ 07644
Phone: 862.233.8438

310 Central Ave Suite 301 East Orange, NJ 07018
Phone: 973.673.3668

Fax : 201.945.4650

www.njfootandankle.com

Dear New Patient,

Welcome to our Practice!

First and foremost, thank you for entrusting us with your podiatric care. I look forward to helping you address all questions and concerns. In this letter you will find some general information regarding insurance terms and policies. We hope this information will help you understand your insurance plan. Should you have any questions regarding your insurance policy, please contact your insurance directly.

Allowed Amount: Also referred to as approved charge, allowable charge, this is the dollar amount typically considered payment in full by your insurance company along with its network providers. The allowed amount is a discounted rate rather than the actual charge. For example, you visit a doctor who is an in-network provider of your insurance, and the total charge for the visit was $100. Your doctor is required to accept $80 as payment in full for the visit. This is the allowed amount. Your insurance will pay your doctor $80, minus any co-pay or deductible that you may owe. The remaining $20 is considered "write off", and you cannot be billed for it. If your doctor is not within your insurance network (an out of network provider) you may be responsible for the full charge of $100.

Co-Payment (Copay): A dollar amount your insurance may require you to pay for an office visit at the time of your appointment. It is required to be paid at every office visit.

Coinsurance: The amount that your insurance may require you to pay for covered medical services **AFTER** you have satisfied co-payment and/or deductible. It is typically expressed as a percentage (%) of the allowable charge for covered medical services. For example: if the coinsurance is 80/20 your insurance covers 80% of the allowable charge, then you are required to pay the remaining 20% of coinsurance.

Deductible: A dollar amount that your insurance may require you to pay out of pocket each year **BEFORE** your insurance plan begins to make payments for claims. Not all plans require a deductible; therefor always check with your insurance company to see if your plan has any deductibles. Deductibles reset on a renewal date, which is typically January 1st.

Out-of-network Providers: Healthcare providers who are not contracted with the health insurance plan. Typically, if you visit a provider within your insurance's network (in-network provider), the dollar amount for the medical services will be less than if you go to an out-of-network provider.

Out-of-Pocket Limit (OOP Limit, Stop-Loss or Coinsurance Limit): The most you have to pay for covered medical services in a plan year. After you spend this amount on a deductible, co-pay, and coinsurance than will your insurance pay 100% of the costs of covered benefits. Just like the deductibles, out-of-pocket maximum resets with the plan every year.

North Jersey Foot & Ankle Center

Notice of Privacy Practices

Phone: (201) 943-7977 Fax: (201) 945-4650

Website: njfootandankle.com

Your Information. Your Rights. Our Responsibilities

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests and must say "yes" if you tell us, you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of times we've shared your health information for six years prior to the day you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your right by contacting us using the information on the back page.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care.
- Share information in a disaster relief situation--

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

- We can use your health information and share it with professionals who are treating you
  Example: *A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

Run our organization

- We can use and disclose your information to run our organization and contact when necessary.
  Example: *We use health information about you to develop better services for you.*
- **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.

Pay for your health services

- We can use and disclose your health information as we pay for your health services.
  Example: *We share information about you with your dental plan to coordinate payment for your dental work.*

Administer your plan

- We may disclose your health information to your health plan sponsor for plan administration
  Example: *Your Company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be able available upon request, on our website, and we will mail a copy to you.

This Notice of Privacy Practices applies to the following organization – North Jersey Foot & Ankle Center