PATIENT REGISTRATION

DEMOGRAPHIC INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

DATE OF BIRTH: _____ (mm/dd/yyyy) SEX: _____ RACE: _____

SOCIAL SECURITY #: _____ ETHNICITY: _____

ADDRESS 1: _____ ADDRESS 2: _____

CITY: _____ STATE: _____ ZIP: _____

LANGUAGE: _____ LANGUAGE COUNTRY: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNER ☐ DIVORCED ☐ WIDOWED

☐ PREGNANT (check if applicable) ☐ NURSING (check if applicable)

CONTACT INFORMATION

HOME PHONE: _____ WORK PHONE: _____ EXT: _____

CELL PHONE: _____ EMAIL: _____

EMERGENCY CONTACT INFORMATION

CONTACT FIRST NAME: _____ CONTACT LAST NAME: _____

CONTACT HOME PHONE: _____ CONTACT CELL PHONE: _____

RELATIONSHIP TO PATIENT: _____ CONTACT ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

FAMILY MEMBERS IN THE PRACTICE

_____ (name) _____ (relationship to patient)

_____ (name) _____ (relationship to patient)

_____ (name) _____ (relationship to patient)

_____ (name) _____ (relationship to patient)

PRIMARY CARE / OTHER PHYSICIAN

PHYSICIAN NAME: _____ PRACTICE NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHARMACY NAME: _____ PHARMACY PHONE: _____

PHARMACY LOCATION: _____

HOW DID YOU HEAR ABOUT US?

☐ Google Results ☐ Insurance Company ☐ Groupon

☐ Facebook ☐ Dr. Referral ☐ Postcard ☐ Event (Please Specify) : _____

☐ Family/Friend Referral ☐ Zocdoc ☐ Mall ☐ Other (Please Specify) : _____

By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ **Date:** _____

INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE COMPANY: _____ CO-PAY: _____

GROUP #: _____ SUBSCRIBER #: _____

INSURED FIRST NAME: _____ LAST NAME: _____ MI: _____

SOCIAL SECURITY #: _____ DOB: _____ RELATION TO PATIENT: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE #: _____ EXT: _____

ADVANCED DIRECTIVE? ☐ YES ☐ NO WHERE IS IT FILED? _____(what medical facility?)

INSURED EMPLOYED BY: _____ BUSINESS ADDRESS: _____

CITY: _____ STATE _____ ZIP: _____ BUSINESS PHONE #: _____

ADDITIONAL INSURANCE

IS THE PATIENT COVERED BY ADDITIONAL INSURANCE? ☐ YES ☐ NO

INSURANCE COMPANY: _____ CO-PAY: _____

GROUP #: _____ SUBSCRIBER #: _____

INSURED FIRST NAME: _____ LAST NAME: _____ MI: _____

SOCIAL SECURITY #: _____ DOB: _____ RELATION TO PATIENT: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE #: _____ EXT: _____

INSURED EMPLOYED BY: _____

BUSINESS ADDRESS: _____ CITY: _____ STATE _____ ZIP: _____

BUSINESS PHONE # : _____

EMPLOYMENT STATUS: ☐ Employed ☐ Unemployed ☐ Full Time Student ☐ Part Time Student ☐ Retired

LAST DEGREE EARNED: ☐ HIGH SCHOOL ☐ COLLEGE ☐ GRADUATE SCHOOL

OCCUPATION: _____ BUSINESS NAME: _____

BUSINESS PHONE: _____

DRIVERS LICENSE #: _____ STATE ISSUED: _____

IS THIS AN ACCIDENT? ☐ YES ☐ NO

DATE OF INJURY _____

IS THIS A MOTOR VEHICLE ACCIDENT? ☐ YES ☐ NO

YOUR INSURANCE CARD AND PHOTO ID ARE REQUIRED AT THE TIME OF YOUR VISIT
By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ **Date:** _____

Patient Communication Form

Patient Name:_____ Date_____

If Address has changed since last visit, please write: _____
If phone number has changed, please write:
_____

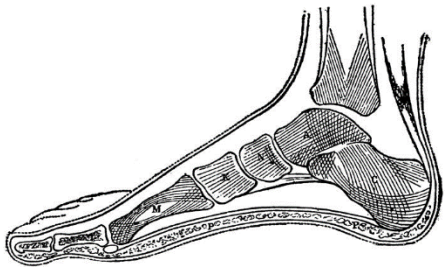
Please describe your complaint (Be as detailed as possible):

How long has problem been present?

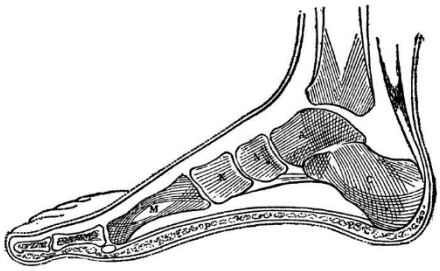
What specific incident started this complaint?

If pain is involved (on a scale of 1 – 10, 10 being the most severe) how severe is your discomfort?

Please indicate on the diagram area involved:



(Right Foot)



(Left Foot)

What treatments have you tried previously?

Are you diabetic? (please circle) YES NO

Name of Primary Care Physician: _____ City and State: _____

Last visit date of family physician: _____

What is your height? _____ What is your weight? _____
If you know your blood pressure, what is it? _____

Please list all medical problems:

Please list all prescription medications with dosage:

Please list any allergies:

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION AND DISCLOSURE FORM

I. Acknowledgement of Practice's *Notice of Privacy Practices:*

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain pieces of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my healthcare.

Print Name_____ **DOB or other identifier:** _____
Print Name_____ **DOB or other identifier:** _____
Print Name_____ **DOB or other identifier:** _____

III. Request to receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me as I have listed below:

Is home phone number [__] OK to leave a detailed message **[__]** Leave message with call back number only**?**

Is cell phone number [__] OK to leave a detailed message **[__]**Leave message with call back number only**?**

Is work phone number [__] OK to leave a detailed message **[__]**Leave message with call back number only**?**

Fax phone number: _____ **[__]** OK to fax a detailed message

Email Address: _____ **[__]** OK to email a detailed message

IV. The following person(s) are authorized to receive my Patient Health Information (PHI)

Print Name_____ **Print Name** _____

V. The HIPAA Privacy rule requires healthcare providers to make reasonable steps to limit the use or disclosure of and requests for PHI. I understand that this accounting will not reflect disclosures that are made in the course of the Practice's ordinary healthcare activities related to providing patient treatment, obtaining payment for its services, or for its internal operations. Also, the Practice does not have to account disclosures for which I have executed an Authorization permitting disclosures of my PHI.

a. The above authorizations are voluntary and I may refuse to their terms without affecting any of my rights to receive healthcare at the Practice.
b. These authorizations may be revoked at any time by notifying the Practice in writing at the Practice's mailing address marked to the attention of "HIPAA Compliance Officer."
c. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.
d. If you request it, a copy of information described in this form can be obtained at the front desk.
e. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction and that I fully understand this authorization form.
f. This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked.

_____	_____	_____
Name of Patient (Printed)	**Signature of Patient**	**Date**

PAYMENT POLICY

The purpose of this agreement is to allow us to more completely serve you and to get the best results in the shortest amount of time for you. It is our experience that those patients who adhere to the following agreements get the best results. This agreement also specifies all financial agreements.

Insurance
Knowing your insurance benefits is your responsibility.

Co-Payments and Deductibles
It is our policy to collect a co-payment at every visit. If you do not pay your co-payment at the time of the visit, you will be billed for the co-payment. It is impossible for us to know which company exempts which type of visit; often we must wait up to three months for the insurers' explanation of benefits statement to find this out. If we should find out about an exemption when we receive the statement, we will adjust your previously pain co-payment as a credit balance.

Claims Submission
We will submit your claims and assist you in any way we reasonably can to help get your claims paid. If your insurance company does not pay your claim within 90 days, the balance will automatically be billed to you. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Arriving for your appointment
Please be on time for your appointment. When you arrive, sign in. You will be called and assigned a treatment room in the order you signed in.

Financial Agreements
We will expect you to honor the financial agreements you have made with our office. Our office will submit claims to insurance carriers. In case of insurance partial payment, the balance is due by YOU and we will send you a billing statement. Should you require a payment plan, our billing department will be glad to discuss your options with you.

Name of Patient (Printed)	Signature of Patient	Date

680 Kinderkamack Road, Suite 204
Oradell, New Jersey 07649
(201) 734-3690

Credit Card Payment Authorization Form

Sign and complete this form to authorize NJ Foot and Ankle Centers PC to make a debit to your credit card listed below. Please fax completed form to **201-261-0058**.

By signing this form you give us permission to debit your account for the amount indicated on or after the indicated date. This is permission is for balances owed to NJ Foot and Ankle Center and does not provide authorization for any additional unrelated debits or credits to your account.

Please complete the information below:

I _____ authorize NJ Foot and Ankle Centers PC to charge my credit card
(full name)
account indicated below for _____ on or after _____
(amount) (Date)

_____ on or after _____
(amount) (Date)

This payment is for:
(description of goods/services)

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV2 (3 digit number on back of Visa/MC, 4 digits on front of AMEX) _____

_____ PLEASE CHARGE MY CREDIT CARD THE FULL BALANCE

_____ PLEASE CHARGE MY CARD $100.00 MONTHLY TILL THE BALANCE IS PAID OFF

SIGNATURE _____ DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only, and is valid for multiple uses. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this for

680 Kinderkamack Road, Suite 204
Oradell, New Jersey 07649
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I, _____, hereby acknowledge and understand that even with the best training, skill and experience, a medically trained professional is not always capable of solving my medical problems. Therefore, I understand it is important that any and all recommendations by doctors are followed completely in order to increase the likelihood of a positive and healthy treatment/outcome. I acknowledge and understand that if any physician in this office prescribes medicine to me that the proper taking of any such medicine shall be my sole responsibility (or my guardian who has attended this consultation). I agree to properly follow the prescribed dosage and frequency amounts of these medicines as recommended by my doctor.

I understand that if a doctor in this office refers me to see another doctor or receive another test including, but not limited to, a blood test, an MRI, or CT scan, this timely recommendation is important and essential to the ultimate success of my treatment/outcome. I understand that it is not possible for any person in this office to constantly follow up to ensure that I have followed these recommendations. Therefore, I understand that if I fail to see that specialist or obtain the test for which I was referred immediately, this can risk my current health or increase future health risks.

I understand that it is solely my responsibility to follow any of the medical advice given by any medical person at New Jersey Foot and Ankle Centers and any bad health outcome from my failure to follow the advice of my doctors should be expected.

Signature_____ Date_____

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24 Hour Cancellation & "No Show" Fee Policy

I recognize that everyone's time is valuable and the appointment time is limited, we ask that you provide a 24 hour notice if you are unable to keep your appointment. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, New Jersey Foot and Ankle Centers reserves the right to charge a fee of **$25.00** for each missed (No Show) appointment, which is, absent for a non-compelling reason, and is not cancelled within a 24 hour advance notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Thank you for your anticipated cooperation.

Signed_____ Date_____