CLIFFSIDE PARK 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

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: _____

CLIFFSIDE PARK 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

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 _____

Cliffside Park 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 $35.00 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 CLIFFSIDE PARK FOOT & ANKLE CENTER for medical services provided. I agree to pay FOOT & ANKLE CENTERS 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 CLIFFSIDE PARK 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: _____