PARSIPPANY FOOT & ANKLE, LLC

Podiatric Medicine and Surgery

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DIPLOMATES, AMERICAN BOARD OF PODIATRIC SURGERY

FELLOWS, AMERICAN COLLEGE OF FOOT AND ANKLE SURGEONS

*CERTIFICATION IN RECONSTRUCTIVE REARFOOT AND ANKLE SURGERY **ASSOCIATE, AMERICAN COLLEGE OF FOOT AND ANKLE SURGEONS

CONFIDENTIAL PATIENT INFORMATION

NAME_____ DATE OF BIRTH_____ AGE _____

(Last) (First)

SEX: M/F EMAIL_____ TODAY'S DATE_____

MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED

ADDRESS_____ PHONE_____ CELL _____

CITY_____ STATE_____ ZIP _____

EMPLOYER NAME_____ OCCUPATION_____

ADDRESS_____ PHONE _____

PRIMARY HEALTH INSURANCE CO._____ ID NO. _____

SUBSCRIBER'S DOB

SECONDARY INSURANCE CO._____ ID NO._____ SUBSCRIBER'S NAME

RESPONSIBLE PARTY'S EMPLOYER. _____

PERSON TO CONTACT IN CASE OF EMERGENCY_____ PHONE _____

REFERRED BY _____

FAMILY PHYSICIAN_____ CITY _____

PHARMACY NAME_____ CITY_____

WHAT IS YOUR CHIEF FOOT COMPLAINT? _____

ANY PREVIOUS FOOT PROBLEMS?_____

1. Are you now under a physician's care? Yes_____ No_____

   Physician's Name_____ For what problem _____

2. Are you allergic to any of the following? Aspirin_____ Codeine_____ Demerol_____ Morphine_____ Novocaine _____

   Penicillin_____ Sulfa_____ Tetanus_____ Iodine_____ Tape_____ Other _____

3. Have you ever been treated for any of the following?

Anemia	Diabetes	Heart Problems	Lung Disease	Sickle Cell Disease
Arthritis	Epilepsy	Hepatitis	Nervousness/Anxiety	Stroke
Asthma	Fibromyalgia	HIV	Phlebitis	Thyroid
Alcoholism	GI Reflux	High Blood Pressure	Prolonged Bleeding	Tumors
Cancer	Gout	Kidney Problems	Psychiatric Disorder	(Type)_____
(Type)_____	Glaucoma	Liver Problems	Rheumatic Fever	Ulcers
Depression				Vascular Disease

Other_____

4. Is there any family history of diabetes? Yes_____ No_____ If yes, who _____
5. Any other significant family medical history? _____
6. Do you smoke? Y N How much_____ Drink Alcohol? Y N How Much_____ Use Illicit Drugs? Y N
7. What medications are you now taking?_____
8. What type of surgery have you had? _____
9. What do you do for physical exercise? _____

*SOCIAL SECURITY NUMBER_____ SIGNATURE _____

Parsippany Foot and Ankle

ASSIGNMENT OF BENEFITS AND HIPAA FORM

Financial Responsibility

All professional services rendered are billed to the patient's insurance company if applicable. If no insurance then payment is due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments. I understand that I am financially responsible to Parsippany Foot and Ankle ("PFA") for any charges not covered by health care benefits. It is my responsibility to notify PFA of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by PFA and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for professional services received.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled, to PFA. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to PFA for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance. I hereby assign my rights, title and interest under the medical expense section and/or PIP section of my insurance policy to PFA to bring a lawsuit or arbitration against my insurance carrier(s). This allows PFA to retain an attorney of their choice to filing litigation or arbitration for any unpaid medical expenses, and/or denied proposed medical treatment, against my insurance carrier, or any other company, against which I may proceed for medical expense benefits. Unless revoked, this assignment is valid for all administrative and judicial reviews under the Patient Protection and Affordable Care Act, ERISA, Medicare and applicable federal or state laws.

Authorization to Release Information

I hereby authorize PFA to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment, including but not limited to filing arbitration/litigation in PFA's name on my behalf; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing. I have requested medical services from PFA on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA) WRITTEN ACKNOWLEDGEMENT FORM ALL PATIENTS (Health Insurance and Cosmetic Patients)

I, (PATIENT'SNAME)_____,
have been given the opportunity to review Parsippany Foot and Ankle Notice of Privacy Practices and acknowledge that it was made available to me as posted on the office website www.parsippanyfootandankle.com or in the office when requested by me. I acknowledge the opportunity to view the terms of the HIPAA policy as posted. I understand that this consent shall remain in force from this time forward.

_____

Patient/Responsible Party Signature Date

_____

Print Name Patient/Responsibility

Parsippany Foot and Ankle complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Parsippany Foot and Ankle

CONSENT to the USE AND DISCLOSURE OF HEALTH INFORMATION For the TREATMENT, PAYMENT, HEALTHCARE OPERATIONS & FINANCIAL POLICY

I _____(Patient Name) understand that as part of my treatment, Parsippany Foot and Ankle originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any future care or treatment. I understand that this information serves as:

• Basis for planning my care and treatment.

• A means of communication among any other health professionals who might contribute to my care, i.e.: via facsimile, telephone, etc.

• A source of information for applying diagnosis and surgical information to my account to process for payment.

• A means by which a third-party payer can verify that services billed and accurate and actual.

• As a tool for routine healthcare operations, such as assessing quality, and reviewing the competence of healthcare officials.

• A means by which an insurance appeal at any stage, may be filed.

• You are responsible to supply our staff with any and all insurance identification card(s) at the time of your appointment. If your insurance carrier requires a referral from your primary doctor, it is you are responsibility to present this to our receptionist prior to your visit, as we cannot bill your insurance company without it. If you do not obtain a referral when your insurance requires one, you will be required to pay for the visit in full at the time of visit. All co-pays are to be collected prior to your visit.

• Any outstanding balance for which a patient is responsible is due within 30 days of billing. Any patient balance that has gone 90 days without a patient payment is subject to immediate collection process. Services that are transferred to a collections status will be subject to a $50.00 service fee per occurrence.

• A returned check fee of $35.00 will be applied to any account for checks returned to us for insufficient funds. • I assign all benefits for my medical services to Parsippany Foot and Ankle. I understand Parsippany Foot and Ankle will take care to ensure that any and all information pertaining to me and my treatment at this facility will be handled with an emphasis on maintaining my privacy at all times.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations, and that this facility is not required to agree to these restrictions in the event of an emergency. I understand that I may revoke this consent in writing at any time, but not to the extent the organization has already acted in.

• I authorize Parsippany Foot and Ankle to release my medical records to the following friend or family member:

Name: _____Relationship: _____

Name: _____Relationship: _____

_____

Print Name of Patient or Legal Guardian

_____

Signature Date

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