PODIATRY foot & ANKLE INSTITUTE

Podiatry Foot & Ankle Institute

Hackensack University Medical Plaza
20 Prospect Ave, Suite 803, Hackensack, NJ 07601
Phone: (201) 488-FOOT (3668) | Fax: (201) 488-9292
www.anklefootdoc.com

Please fill out completely or mark areas "n/a" if they do not apply

PATIENT INFORMATION:

Last Name_____, **First Name**_____: **Birth Date:**___ /___ /____ **Sex: M ☐ F ☐**

Social Security Number:___-___-____ **Marital Status: Single ☐ Married ☐ Other ☐**

Demographics: Black ☐ American Indian /Alaskan Native ☐ Hispanic ☐ Asian ☐ White – Non Hispanic ☐ Other ☐

Address: _____
Street City State Zip

Home Phone (___)-___-____ **Cell Phone** (___)___-____

Work Phone (___)___-____ **Email:**_____@_____

Are you employed? Yes☐ No ☐ Full Time ☐ Part Time ☐

Name of Employer:

Addresss:_____
Street City State

Emergency Contact:_____ **Relationship:** _____

Primary Phone (___) ___-____

INSURANCE: *Please give **ALL** cards to the receptionist so we may copy them to your patient chart.*

Primary Insurance Company Name:_____

Secondary Insurance Company Name:_____

RESPONSIBLE PARTY: *The person who supplies the patient's insurance or who is responsible for payment if insured.*

Name:_____ **DOB:**__/__/____ **Relation to Patient:** _____ **Phone:**(___)-___-____

NAME/PHARMACY INFORMATION:_____ City_____ ZipCode_____ **Phone:**___-___-____

I certify that the above insurance information is current and accurate; I authorize assignment of insurance to Podiatry Foot & Ankle Institute. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Podiatry Foot & Ankle Institute and its representatives may use my health care information and may disclose such information to the above named insurance company for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services received. This consent will end when my current treatment plan is completed or one year from the date signed below.

PATIENT NAME (PRINT):_____

PATIENT SIGNATURE _____

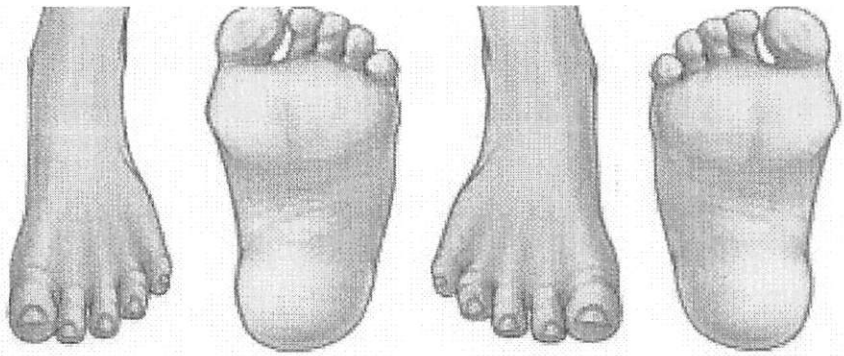
DATE: _____

All information provided on this form will remain confidential in compliance with our HIPAA guidelines

Patient's Current Chief Complaints (CC)/History of Present Illness (HOPI)

Left Foot

Right Foot



Please describe the problem that you are experiencing:

_____

_____

_____

Indicate the location of your problem or pain on the diagrams above. Does the pain radiate anywhere else on the foot/leg? Indicate the severity of pain/discomfort:

☐ **None** ☐ **Light** ☐ **Moderate** ☐ **Strong** ☐ **Severe**

How long ago did pain/discomfort start? (Please Be Specific. Fill in a number on the lines below)

_____ **Years** _____ **Months** _____ **Weeks** _____ **Days** _____ **Hours**

Pain occurs while:

☐ **Walking** ☐ **Standing** ☐ **Running** ☐ **Wearing Shoes**

Does pain/discomfort cause difficulty with daily activity? Yes ☐ No ☐

Is this problem work related? Yes ☐ No ☐

Date of injury: Date of report to employer:

Patient's Doctors *Please tell us who to thank and with whom to coordinate care:*

	Physician's Name	Phone number	City	Date Last Seen
Family/Primary	_____	_____	_____	_____
Specialist	_____	_____	_____	_____
Other Podiatrist	_____	_____	_____	_____

Who Referred You to Our Office?

Name:_____ Phone Number:_____

Pt. Shoe Size:_____ **Normal** _____ **Wide** _____ **Extra Wide** _____

Pt. Height: _____

Pt. Weight: _____

Pt. Blood Pressure:_____

Extra Imformation:

_____

_____

_____

_____

_____

_____

Foot/Ankle/Leg History

Do you currently have or have you ever been treated for:

(select all that applies):

- ☐ Corns/Calluses
- ☐ Warts
- ☐ Athlete's Foot
- ☐ Fungal Nails
- ☐ Ingrown Nails
- ☐ Leg/Foot Ulcers
- ☐ Neuroma
- ☐ Foot Numbness
- ☐ Neuropathy
- ☐ Bunions Broken
- ☐ Foot/Bone
- ☐ Broken Ankle
- ☐ Ankle Sprain
- ☐ Hammer/Mallet Toe
- ☐ Leg/Foot Cramp
- ☐ Flat Feet
- ☐ In-Toeing
- ☐ Toe Walking
- ☐ Arch pain
- ☐ High Arch Feet
- ☐ Knee Pain
- ☐ Lower Back Pain
- ☐ Heel Pain
- ☐ Rash
- ☐ Gait Problems
- ☐ Blood Disorders
- ☐ Childhood Foot Problems

Do you get leg cramps after activity? Yes ☐ No ☐

Does foot pain limit your desired activities? Yes ☐ No ☐

Do you have any difficult walking? Yes ☐ No ☐

Any pain in the calves or buttocks when walking? Yes ☐ No ☐

Is the pain relieved by stopping & standing still? Yes ☐ No ☐

List the sports and other actives in which you are involved:

_____

_____

General Medical History

Do you currently have or have you ever been treated for:

(select all that applies):

- ☐ AIDS/HIV
- ☐ Alzheimer's
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Chronic Diarrhea
- ☐ Dark Urine
- ☐ Eye Problems
- ☐ Gout
- ☐ Hemophilia
- ☐ Keloid/Thick Scar
- ☐ Low Blood Pressure
- ☐ Neuropathy
- ☐ Psychiatric Care
- ☐ Respiratory Disease
- ☐ Shortness of Breath
- ☐ Swelling in Ankles/Feet
- ☐ Swollen Neck Glands
- ☐ Tuberculosis
- ☐ Vascular Disease
- ☐ Allergies to Anesthetics / Medicine
- ☐ Anemia
- ☐ Angina
- ☐ Artificial Heart Valves / Joints
- ☐ Back Problems
- ☐ Bleeding Disorder
- ☐ Chemical Dependency
- ☐ Chest Pain
- ☐ Circulatory Problems
- ☐ Diabetes
- ☐ Ear Problems
- ☐ Epilepsy
- ☐ Fainting
- ☐ Foot Leg Cramps
- ☐ Headaches
- ☐ Heart Disease/Attack
- ☐ Hepatitis / Jaundice
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Lyme's Disease
- ☐ Osteoporosis
- ☐ Phlebitis
- ☐ Radiation
- ☐ Rash
- ☐ Rheumatic Fever
- ☐ Sciatica
- ☐ Sinus Problems
- ☐ Special Diet
- ☐ Stroke
- ☐ Tired Feet
- ☐ Thyroid Problem
- ☐ Ulcer(s)
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Weight Loss, Unexplained

☐ Other:

_____

_____

_____

Past Family & Social History

List immediate family members who have had:

Arthritis _____ Birth Defects _____

Cancer _____ Diabetes _____

Foot Problems _____ Gout _____

Heart Attack _____ High Blood Pressure _____

Kidney Disease _____ Stroke _____

# of Childbirths _____ Are you currently pregnant? Yes ☐ No ☐

Are you slow to heal after cuts? Yes ☐ No ☐

Any abnormal bruising, bleeding or scarring? Yes ☐ No ☐

Do you smoke now? Yes ☐ No ☐

Did you ever smoke? Yes ☐ No ☐

If you quit, what year did you do so? _____

Alcohol use? ☐None ☐Rarely ☐Moderately ☐Daily ☐Quit

Caffeine? ☐None ☐Rarely ☐Moderately ☐Daily ☐Quit

Recreational Drugs? Yes ☐ No ☐

Current or Past Substance Abuse Disorder? Yes ☐ No ☐

Are you currently taking any medications? Yes ☐ No ☐

Are you taking Insulin? Yes ☐ No ☐

List medications, dose & purpose below:

_____

_____

_____

Are you taking your medications as prescribed? Yes ☐ No ☐

Allergies: Is there a history of skin reaction or other outward reaction or sickness following an injection, oral or topical administration of:

- ☐ Latex, Adhesive tape
- ☐ Penicillin
- ☐ Other Antibiotics
- ☐ Empirin, Tylenol
- ☐ Aspirin, Advil, Aleve, Motrin
- ☐ Celebrex
- ☐ Other Pain Remedies
- ☐ Morphine
- ☐ Codeineemerol
- ☐ Other narcotics Novocaine
- ☐ Sulfa drugs
- ☐ Other Anesthetics
- ☐ Shrimp, Iodine or Merthiolate
- ☐ No Known Allergies

Clearly list additional medication, drugs, foods, etc.

_____

_____

_____

_____

Vaccinations:

Flu Shot: Yes ☐ No ☐ Date: _____

Pneumococcal Vaccination: Yes ☐ No ☐ Date: _____

Tetanus Vaccination: Yes ☐ No ☐ Date: _____

Surgical / Hospitalization History: Surgical procedures and complications and / or Hospitalizations:

_____

_____

Pace Maker / Defibrillator: Yes ☐ No ☐ Date: _____

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Injection Information Form
&
Patient Informed Consent

Injections are performed for a variety of conditions including joint pain due to arthritis, injury, or tendinitis. Usually, the injection consists of a mixture of medications including Lidocaine,Marcaine (Novocain-which is a local anesthetic agent), and a form of cortisone,which is used to counteract inflammation. The benefit from the injection varies from patient to patient. Symptomatic relief can be found for periods of several days to several months,depending on the type of injection and the patient's response to the injection. Some injections are off label, use dextrose,sugar or dehydrated alcohol. Each has its possible side effects and reactions, but they are discussed with the patient by the doctor about the use,effectiveness, and risks.

Risks of Injections

Risks of the injection include but are not limited to risk of infection of the joint,nerve injury from the nerves passing through the area, vascular injury from the needle in the vessels traveling through the area, as well as worsened pain. Other risks associated with the injection can commonly include flushing pain at the injection site,bruising, but these are self-limiting and usually do not cause any permanent side effects. It is very rare, less than 1 in 100, for a patient to have an allergic reaction to a component of the injection, although the lidocaine component of the injection can cause arrhythmias in some patients if injected intravascularly(within a vessel) other risks include steroid thinning of skin, increase in pain-like a flair, discoloration of skin, and/or attenuation/tear of ligaments and/or tendons.

On the day of the injection normal light activities may resume for the remainder of the day,with no heavy activities for a period of 72 hours following the injection (specifically,this means no heavy exercise or lifting.

By completing the following you acknowledge that you have received and reviewed the information that risks associated with injections, in the event your doctor deems it necessary to use injections in your treatment.
If you take Coumadin or any blood thinners, please inform the office prior to your injection along with any concerns with being pregnant or having allergies to any of the components.

Have you had previous injections? Yes or No
If yes, with whom_____Date_____
If yes, did you have any adverse reactions? Yes or No
If yes, what was your reaction_____
Are you currently taking any blood thinners? Yes No
Are you currently taking any as[irin or anti-inflammatories? Yes No

Patient Signature **Date**

_____ _____

We acknowledge that you have read this information. **Staff Initials:** _____

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AUTHORIZATION OF MEDICAL INFORMATION

Please read the following questions carefully and sign at the bottom of the page.
You have the right to review our privacy practices at any time.

Please refer to our HIPAA notice located in our reception area.

☐ I have read and understand the HIPAA notice.

☐ I decline reading the HIPAA notice but, am fully aware that it is always available to me.

Please **CHECK** where we may leave a message if necessary:

☐ HOME ☐ VOICE MAIL ☐ WORK ☐ CELL PHONE May we discuss your medical condition with members of your family or friends? YES ☐ NO ☐ If **YES**, please list the name of that person and their relationship to the patient. NAME:_____

RELATIONSHIP TO PATIENT: _____

PHONE NUMBER: ___-____-____

If you would like to be exempt from public reporting, please check here ☐

Please list ANY information from your medical record you would **NOT** like Podiatry Foot & Ankle Institute to disclose:

I give permission to Podiatry Foot & Ankle Institute to release information, either verbal or written regarding my medical condition only, for the purpose of medical management

Relationship to Patient_____
Date:___/____/____

_____

Signature of Patient / Legal Guardian

This release may be rescinded at any time in writing from the patient/legal guardian.

Please note: Podiatry Foot & Ankle Institute's HIPAA policy is in effect for the entire time you are a patient of ours not just for the date that you sign the policy. If we have any changes we will have you fill out a new form at that time.

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Welcome to our office. We appreciate your choosing us as your

Podiatrist. Name: Which Doctor are you seeing:

- ☐ **Dr. Edward Harris**
- ☐ **Dr. Neil Goldberg**
- ☐ **Dr. Adam Rozenstrauch**
- ☐ **Dr. Yakov Groysman**

Please tell us how you heard about our office:

- ☐ **Doctor Referred_____.**
- ☐ **Google Search for Podiatrist in Hackensack**
- ☐ **Search for a specific doctor**
- ☐ **Saw our Website**
- ☐ **Saw our Ad – (please indicate where):_____**
- ☐ **Friend** ☐ **Relative**
- ☐ **Insurance Listing**
- ☐ **Other Search Engine or Rating System**

Please list:_____

Thank you

FINANCIAL INFORMATION

We want you to receive the best care possible and be totally satisfied with our service. Our experienced office staff will be happy to answer any question regarding your account. Here are some important points to remember regarding your care in our office.

To keep medical care and billing costs down, payment for services is due at the time services are rendered unless payment arrangements have been approved in advance IN WRITING by our Office Manager.

We are contract providers for Medicare and many private insurance plans. In those cases, we have agreed to accept their determination of fees for covered services. These payments are due at the time of service. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered.

Not all services are a "covered" benefit in all insurance policies. Your policy is a contract between you and your insurance company. Medicare and some insurance companies select certain services that they will not cover. Payment for these services is the responsibility of you, the patient. We strongly encourage you to carefully read your insurance policy so that you will know the conditions and circumstances of your coverage.

Insurance companies may impose a waiting period before providing coverage and they may exclude coverage for what they determine to be "pre-existing conditions". They may also require that you obtain prior approval before treatment.

Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 70% or 80%) of usual, customary and reasonable (UCR) for this region.

When we are able to verify your coverage and benefits in advance for Medicare and our approved private insurance plans, we will accept assignment of your insurance benefits and will bill the carrier directly. Accepting assignment means that your insurance company will send us the bulk of the payment for treatment and that you, the patient, pay us directly for the deductibles, co-payments and non covered services and fees. In these circumstances, payment of your portion will be estimated at the time of services and must be paid at that time. When the insurance company does pay us, or at 45 days from the date of billing your insurance company, whichever occurs first (insurance companies are required by law to pay or deny claims, within 30 days), you will be responsible for any remaining balance or we will refund you any overpayment you have made. Our accepting assignment of your insurance benefits does not relieve you of your personal responsibility for prompt payment of the total bill. If your insurance company does not completely or promptly pay, you are responsible for paying the remaining balance immediately upon receipt of a bill. As a patient of this office, to expedite proper payment, we will complain to the Insurance Commissioner and/or Department of Corporations on your behalf regarding payment of claims.

Traditional Medicare Insurance:

Our office participates with Medicare. This means that we will send your claim to Medicare and we will adhere to Medicare's allowable fee schedule. Medicare sets an allowable fee for each service that they cover. Once you have met your annual deductible Medicare will pay us 80% of the allowable fee and you will be responsible for the remaining 20%. If you have a secondary insurance this amount will then be sent on to them and you will be billed for any remaining balance after their payment.

Medicare has strict guidelines concerning their coverage of routine foot care such as trimming nails, or paring corns and calluses. The doctor will be able to determine if your routine foot care is or is NOT covered by Medicare. **Should you have a non-covered service such as this performed, you will be asked to pay for that service at the time of your appointment. We will also ask you to sign Medicare's Advanced Beneficiary Notice (ABN) indicating you were informed that Medicare will not be paying for that particular service.** The ABN will be provided at the time of visit.

If you have any other service such as a new patient office visit or a visit for a new problem performed on the same day as routine nail care or another non-covered service, Medicare will be billed for the covered service and we will collect the uncovered service fee from you that day as well.

All Other Insurances including Medicare Replacement Plans:

Podiatry Foot & Ankle Institute will submit your claims to all other insurance companies providing: • At each visit we receive a copy of all current insurance identification cards.

- Our Patient Information Form is current and correctly completed.
- Our Financial Policy is signed.

If we have not heard from your secondary insurance within 60 days, you will be billed directly. In that event you must contact the insurance company directly to find out why your claim has not been paid. **It is the patient's responsibility to give us their current insurance information.** If we do not have a copy of your current insurance card, or have received incorrect or old insurance information, all charges will become the patient's responsibility. **All uncollected co-pays and co-insurances from prior visits will be due at the time of your next appointment,** as specified in your insurance contract and mandated by your carrier in our participating provider agreement.

For your convenience Podiatry Foot & Ankle Institute accepts cash, all major credit cards, debit cards, and personal checks. Payment is expected at each visit.

You will receive a billing statement for all personal balances due. If we have not received a response from you by phone or received a payment or letter regarding your unpaid balance within 90 days, your account will be sent to our collections department.

There is a $50.00 fee assessed for returned checks. Podiatry Foot & Ankle Institute understands that unexpected financial problems do arise. We encourage you to contact the office at (201) 488-3668 immediately for assistance in managing your account.

No Insurance:

If you do not have health insurance, charges for the day's medical service are due at the time of service unless other arrangements have been made with the office in advance. In many cases a cash payment discount may be given to patients without health insurance.

Referrals/Authorizations:

It is the patient's responsibility to obtain all referrals if your insurance requires one. We will do all we can to assist you, but it is ultimately your responsibility. If a required referral is NOT in place PRIOR to your appointment, we may reschedule the appointment until it is received.

Disability Forms:

Podiatry Foot & Ankle Institute will complete your insurance disability form for you for an administrative fee of $25. The fee is payable upon presentation of the forms. The forms will NOT be completed until the fee is received.

Missed Appointment Policy:

Podiatry Foot & Ankle Institute reserves the right to charge a patient for a missed appointment. If you

cannot make your scheduled appointment, you should give us 24 hours notice. A charge for a missed appointment is NOT a charge for the service itself. One missed appointment, or severe weather problems will NOT result in a patient being charged. **Consecutive missed appointments or repeated missed appointments will be assessed at a fee of $50.00 for each missed appointment.** Habitually missed appointments could lead to a patient being discharged from the practice.

Unpaid Balances:
Any account balance not paid in full within 30 days will be subject to a monthly late fee. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Collections:
Podiatry Foot & Ankle Institute will attempt to make payment terms that meet your needs. If we do not hear from you by phone, mail or partial payment within 90 days of a statement being sent, you may be referred to a collection agency. In the event your account is assigned to collection, the patient agrees to be responsible for a 25% collection fee, as well as all court costs and attorney fees.

Requests for non-customary assistance such as special billing, rebilling, completion of forms and special reports and information requests are not included in our fees and will be billed separately. **I understand that there is a fee for copies of medical records.** Please call the office to request medical records if necessary. Copies can be provided upon advance notice and payment of duplicating costs.

Durable Medical Equipment:
I understand that if a custom DME product is ordered for me, such as orthotics or special shoes, or I receive an air cast, night splint, surgical shoe, and ankle brace, that they are non-refundable and non-returnable. If my insurance denies them for any reason, I understand it is ultimately my responsibility and I will pay for the product(s) I have received.

If your diagnosis or treatment involves others, such as hospitals or laboratories, you will be billed by these entities separately.

I understand that Podiatry Foot & Ankle Institute's financial policy is in effect for the entire time I am a patient, not just for the date that I sign the policy. If Podiatry Foot & Ankle Institute has any changes; our office will have you fill out a new form at that time.

I authorize Podiatry Foot & Ankle Institute, to release information regarding my medical history and treatments to my insurance company in order for them to be paid. I also authorize payments for services to be paid directly to Podiatry Foot & Ankle Institute from my insurance company.

I acknowledge by signing my name below, as the patient or guardian of the patient, that I have read and initialed all of the above financial disclosures and understand and will comply. I have asked questions, if necessary, and I have had those questions answered and I understand.

Signature of Patient/Legal Guardian _____

(Print)_____ **Date:**___/____/____