Central Jersey Ankle & Foot Care Specialists, PC

Division of New Jersey Podiatric Physicians & Surgeons Group. LLC

Patient Information Form *(PLEASE **PRINT** ONLY)*

Date: _____

Patient Name: _____ Date of Birth: _____

Age: ____ Sex: *M* *F* Other: _____ Preferred Pronouns: _____

Address: _____ **(NO P.O. BOX)**

City: _____ State: _____ Zip code: _____

PRIMARY Phone: (_____) _____ -_____ **SECONDARY** Phone: (_____) _____ -_____

Email address: _____ *(will not be shared)*

Emergency contact: _____ Phone: (_____) _____ -_____

Relationship: _____

Employer: _____ Work Phone: (_____) _____ -_____

Primary Care Physician: _____ Date last seen: _____

Phone: (_____) _____ -_____ Address: _____

City: _____ State: _____ Zip code: _____

Pharmacy: _____ Location: _____ Phone: (_____) _____ -_____

Who is responsible for payment? _____ Relationship: _____

Address: _____ City / State: _____ Zip: _____

Insurance information

Primary insurance Company: _____

ID#: _____ Group # :_____

Insured Name: _____ Date of Birth: _____ Employer: _____

Address: _____ City / State: _____ Zip: _____

Phone: (_____) _____ -_____

Secondary insurance Company: _____

ID#: _____ Group # :_____

Insured Name: _____ Date of Birth: _____ Employer: _____

Address: _____ City / State: _____ Zip: _____

Phone: (_____) _____ -_____

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Medications

*(Please list **ALL** medications you are currently talking (include prescriptions, over the counter meds and herbal supplements)*

Medications Name:	**Dose:**	**How often do you take?**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Surgery, *Please list ALL prior surgeries:*

Type of Surgery:	**Date:**
_____	_____
_____	_____
_____	_____

Hospitalizations, *please list ALL prior hospitalizations (other than Surgeries*)

Reason for hospitalization:	**Date:**
_____	_____
_____	_____
_____	_____

Social History

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Used of Alcohol: ☐ Never ☐ No longer use ☐ History of alcohol abuse ☐ Current use – Type: _____

☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

Use of tobacco: ☐ Never ☐ Quit – how long? _____ ☐ Current Smoker ____ pks/day for _____ years

Use of recreational drugs: ☐ Never ☐ Quit – how long? _____

Current use – Type: _____ ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

Family History:

Do you have a family history of: ☐ Diabetes: Type 1 or 2 ☐ Cancer ☐ Heart Disease ☐ Stroke

☐ High Blood Pressure ☐ Coronary Artery Disease ☐ Bleeding Disorder ☐ Rheumatoid Arthritis

Other_____

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Your Medical History

Allergies: ☐ No known allergies

☐ Medications _____

☐ Anesthesia _____ ☐ Foods_____

☐ Tape ☐ Latex ☐ Shellfish ☐ Iodine ☐ Other_____

Reaction: _____

Have you ever had any of the following?

Acid Reflux	Y	N	Fibromyalgia	Y	N	Neuropathy	Y	N
Anemia	Y	N	Gout	Y	N	Open Sores	Y	N
Arthritis	Y	N	Heart Attack	Y	N	Pneumonia	Y	N
Asthma	Y	N	Heart Disease/Failure	Y	N	Polio	Y	N
Back Trouble	Y	N	Hepatitis	Y	N	Rheumatic Fever	Y	N
Bladder Infections	Y	N	HIV+ / AIDS	Y	N	Sickle Cell Disease	Y	N
Abnormal Bleeding	Y	N	High Blood Pressure	Y	N	Skin Disorder	Y	N
Blood Clots	Y	N	Kidney Disease	Y	N	Sleep Apnea	Y	N
Blood Transfusion	Y	N	Liver Disease	Y	N	Stomach Ulcers	Y	N
Bronchitis/ Emphysema	Y	N	Low Blood Pressure	Y	N	Stroke	Y	N
Cancer	Y	N	Migraine Headaches	Y	N	Thyroid Disease	Y	N
Diabetes: Type 1 or 2 ⬇	Y	N	Mitral Valve Prolapse	Y	N	Tuberculosis	Y	N

If DIABETIC, last A1C: _____

Other medical history not listed:_____

Current Problem **What specific problem brings you to our office today?,** *please check one below or explain*

☐ **Routine foot care (***nails and callouses***)** ☐ **Internal Pain** ☐ **Other:**_____

Which foot (please circle one): RIGHT LEFT BOTH

How long ago did this problem first start? _____ DAYS / WEEKS / MONTHS / YEARS

Did your pain or problem: ☐ Begin all of a sudden ☐ Gradually develop over time

How would you describe your pain or symptoms?

☐ No Pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Radiating ☐ Itching ☐ Stabbing

☐ Other_____

Since the time your pain or problem begun, has it: ☐ Stayed the same ☐ Become worse ☐ Improved

What makes your pain or problem feel worse: ☐ Walking ☐ Standing ☐ Daily Activities ☐ Resting

☐ Dress shoes ☐ High heels ☐ Flat shoes ☐ Any closed to shoe ☐ Running ☐ Other _____

What makes your symptoms feel better: _____

What treatments have you had for this problem: _____

Was this problem caused by an injury? YES NO (describe)_____

Work Related? YES NO

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E-Prescribing Consent

E-Prescribing is defined by a physician's ability to electronically send an accurate, error free, and understandable prescription directly to your pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act 2003 listed standards that have to be included in an E-Prescribing program. These include (1) Formulary and benefit transactions, which gives the prescriber information about which drugs are covered by a drug benefit plan; (2) medication history transactions, which provide the physician with information about medications the patient is already taking to minimize adverse drug events.

I authorize ***CENTRAL JERSEY ANKLE & FOOT CARE SPECIALISTS. PC*** *Division of NJPPSG* to view my external prescription history vis electronic E-Prescribing services. I understand that prescription history from multiple, other unaffiliated, providers, insurance companies, pharmacies, and pharmacy benefits managers may be viewable by the providers and staff of ***CENTRAL JERSEY ANKLE & FOOT CARE SPECIALISTS. PC*** *Division of NJPPSG,* and it may include prescriptions back in time for several years and my included prescriptions to treat HIV, substance abuse, and psychiatric conditions. If applicable, I understand that my prescription history will become part of my record at this practice. Understanding all of the above, I hereby provide informed consent to ***CENTRAL JERSEY ANKLE & FOOT CARE SPECIALISTS. PC*** *Division of NJPPSG, to enroll me in the* E-Prescribing program. This consent will remain enforced until revoked or changed.

_____ _____

Patient Signature Parent/Legal Guardian Signature

I certify, to the best of my knowledge, I have answered the questions on this form accurately. I understand that proving incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

I give permission to the doctors at ***CENTRAL JERSEY ANKLE & FOOT CARE SPECIALISTS. PC*** *Division of NJPPSG* to administer and perform any diagnostic, therapeutic and/or operative procedures as may be deemed medically necessary in diagnosis and / or treatment of my condition.

Patients / minors under the age of 18, will not be treated without a parent of legal guardian present. If another family member, caretaker or friend, over the age of 18 will be present, written consent from the parent/legal guardian stating as such must be presented at the time of the appointment. Thank You.

_____ _____

Print name of patient print parent/legal guardian

_____ _____

Patient Signature Parent/Legal Guardian Signature

_____

Date

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Patient HIPAA Acknowledgment and Designation Disclosure Form

i. Acknowledgement of Practices 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.

_____ _____ _____

Name of Patient | Date of Birth | Signature of patient/ legal guardian

ii. Designation of Certain Relatives, Close friends and other Caregivers as my personal Representative:

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

_____ _____

Print Name | Relation

_____ _____

Print Name | Relation

_____ _____

Print Name | Relation

iii. Request to Receive Confidential Communication by Alternative Means:

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

_____ _____

Home telephone number | Written communication address

- ☐ Ok to leave message with detailed information
- ☐ Leave message with call back numbers only
- ☐ Ok to mail to address listed above
- ☐ E-Mail me :_____

_____ _____

Work number | Fax Number

- ☐ Ok to leave message with detailed information
- ☐ Leave message with call back numbers only
- ☐ Ok to mail to address listed above
- ☐ E-Mail me :_____

Other: _____

_____ _____

Name of Patient (PRINT) | Signature of patient / parent/legal guardian

_____ _____

Witness signature | Date

Central Jersey Ankle & Foot Care Specialists, PC ***Division of New Jersey Podiatric Physicians & Surgeons Group. LLC***

Financial Policy for Central Jersey Ankle & Foot Care Specialists, PC

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.

MEDICARE: We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However, that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any coinsurance, which is usually 20% of the allowed amount for an item or service.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

COPAYMENTS & DEDUCTIBLES: All copayments and deductibles must be paid at the time of service; this agreement is part of your contract with your insurance company. Failure on our part to collect copayments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your copayment at each visit.

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

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 care 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 (coinsurance, 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 collection, 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, check, Visa, Mastercard, Amex, and Discover**. An additional **$30.00** will be added to your statement of the check is returned for insufficient funds. If your insurance company should happen to send payment to you, the patient, we expect that you will forward it to our office to be applied to your balance.

I have read the above policy regarding my financial responsibility to ***CENTRAL JERSEY ANKLE & FOOT CARE SPECIALISTS. PC*** *Division of NJPPSG* for medical services provided. I agree to pay ***CENTRAL JERSEY ANKLE & FOOT CARE SPECIALISTS. PC*** *Division of NJPPSG* 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 ***CENTRAL JERSEY ANKLE & FOOT CARE SPECIALISTS. PC*** *Division of NJPPSG* all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, copayments, 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 to release all information necessary to secure payment benefits, I authorize the use of this signature on all insurance submissions.

_____ _____

Print Patient Name | Signature of Patient / Parent / Legal Guardian

_____ _____

Financially Responsible Party (print) | Signature

_____ _____

Relationship to patient | Date

PATIENT HEALTH QUESTIONNAIRE-9(PHQ-9) Adults and Modified for Adolescents (PHQ-A)

Patient Name_____ **Date**_____

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Please circle to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading, schoolwork or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts of ending your life or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
⑤	⑤	⑤	⑤