Foot and Ankle Specialists of New Jersey

Visit us on the web at: www.faasnj.com

First Name	Middle initial	Last Name	Date of Birth

Residence Address	City	State	Zip

Home Phone	Cell Phone	Work Phone	Preferred contact
	Text reminders [ ]Y [ ]N		[ ] Home [ ] Work [ ] Cell Phone

Social Security Number	E-mail Address	Gender	Marital Status
		[ ] Male [ ] Female	[ ] Single [ ] Married [ ] Widowed [ ] Divorced

Race	Ethnicity
[ ] Asian [ ] Asian Indian [ ] Black or African American [ ] Pacific Islander [ ] White [ ] Prefer not to answer	[ ] Hispanic [ ] Non-Hispanic [ ] Prefer not to answer

Name of employer	Occupation

Spouses name or guardian if minor	Contact Number

Name of contact in case of emergency	Contact number	Relationship

Name of family physician	Phone number	May we contact you physician for your health records? [ ] Yes [ ] No

Have you had previous treatment by a medical doctor or podiatrist?	If yes, for what?

My chief foot complaint is:	This condition has existed for: [ ] Days [ ] Months [ ] Weeks [ ] Years

How did you hear about us?

[ ] Yellow pages [ ] Friend / Family [ ] Live nearby / Saw Office

[ ] Doctor [ ] Website [ ] Magazine [ ] ZocDoc [ ] Newspaper

Whom may we thank for referring you? _____

Name of magazine _____

I hereby give Dr. Plotkin / Turner / O. Mgbako / Patel / C. Mgbako / Spencer / Appel permission to examine and treat my feet

As a patient in this office, you or your guardian is responsible for all charges including any interest incurred on your account (0.6 % per month)

Patient's or Guardian's Signature _____ **Date** _____

FOOT & ANKLE SPECIALISTS OF NEW JERSEY

Our Financial Policy

We are committed to providing you with the best possible care. If you have medical insurance, we are ready to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance, and your understanding of our financial policy.

If you do not have insurance, payment for services are due at the time the services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, check, Mastercard, Visa, and debit cards.

If you have medical insurance, we will process your claim electronically as a courtesy. Co-payments on insurance are due at the time of service. We are participating providers with Medicare, Blue Cross Blue Shield of NJ, Aetna, United Health, QualCare, Oxford, Cigna, Magnacare , amongst others. We also belong to the NEIC network and can electronically submit claims to most major insurance companies as a courtesy to our patients. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize however, that:

- Your insurance is a contract between you, your employer, and the insurance company
- Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services that they will not cover. The patient is responsible for all non-covered services as well as anything deemed over the "usual, customary and reasonable" fees.
- If an insurance claim remains unpaid after 90 days, the responsibility will be turned over to the patient.
- Specific insurances require patients to go to an outside facility for Durable Medical Equipment (DME)

Returned checks are subject to a $20.00 service fee. Balances older than 90 days must be subject to the maximum finance charge allowed by law.

In special instances, we may accept assignment of insurance benefits. Your signature on this agreement will be kept on file and may be used as a direct assignment for all insurance benefits to be paid to the provider for service. In cases where an assigned insurance claim remains unpaid for greater than 90 days, this office may file a formal complaint on your behalf with the Insurance Commissioner of New Jersey. Your signature on this agreement authorizes this office to file a complaint with the Insurance Commissioner on your behalf.

We must emphasize that our relationship is with you, not with your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are ultimately your responsibility. We realize that temporary financial problems may affect the 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.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

I have read and understand the above policy and agree to its terms.

_____

Signature of responsible party

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

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.

_____ _____

Print Name Date of birth

_____ _____

Signature of Patient/Parent/Guardian Date

Designation of certain relatives, friends and 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 in 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. Indicate the names of the individuals below.

Print Name: _____ Phone:_____

Print Name: _____ Phone:_____

Print Name: _____ Phone:_____

E-PRESCRIBING CONSENT FORM

ePrescribing is defined by a physician's ability to electronically send an accurate, error-free and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribe program.

These include:

Formulary and benefit transactions – gives the prescriber information about which drugs are covered by the drug benefit plan.
Medication history transactions – provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events

By signing the consent form, you are agreeing that Foot & Ankle Specialists of New Jersey can request and use your pharmacy and medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Foot & Ankle Specialists of New Jersey to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction. This consent will remain until revoked or changed.

_____

Print name

_____ _____

Patient/Parent/Guardian Signature Date

_____

Relationship to patient

_____

Pharmacy (Name & Location)