DR. JAY BHUTA, P.C.

ASSOCIATE OF THE AMERICAN COLLEGE OF FOOT & ANKLE SURGEONS

225 Millburn Ave, Suite 104B
Millburn, NJ 07041

200 South Orange Ave, Suite 123
Livingston, NJ 07039

2565 Morris Ave Union, NJ 07083

Phone: (732) 532-3668 Fax: (973) 577-4003

First Name:	**Last Name:**
Address:	
City:	**ST:** **Zip:**
DOB: / /	**Age:** ****** SS#**
Phone:	**Work/Cell:**
****** E-Mail Address:**	
Race: **Ethnicity:**	**Primary Language:**
Marital Status:	**Occupation:**
Emergency Contact:	
Phone:	**Relations:**

Primary Insurance : _____ **Policy#** _____
Name of Policy Holder: _____ **Date Of Birth:** _____

Secondary Insurance: _____ **Policy#** _____
Name of Policy Holder: _____ **Date Of Birth:** _____

Referring Doctor / Person:
First Name: _____ **Last Name:** _____

Referring Internet:
Name: _____

Primary Care Physician / Doctor:
First Name: _____ **Last Name**: _____
Town/City of Office Location: _____
Telephone# _____

Pharmacy:
Name: _____ **Address:** _____

Disclosure to Designated Family/Friend/Caregivers

I allow Dr. Bhuta to disclose medical information as needed to the following designated individual(s) involved with my health care. I understand that I am not required to list anyone. I also understand that I may change the list in writing anytime.

_____	____/____/____	_____	_____
Print Name	**Date of Birth**	**Relationship**	**Telephone Number**
_____	____/____/____	_____	_____
Print Name	**Date of Birth**	**Relationship**	**Telephone Number**

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Foot and Ankle History

1. What is your current complaint?

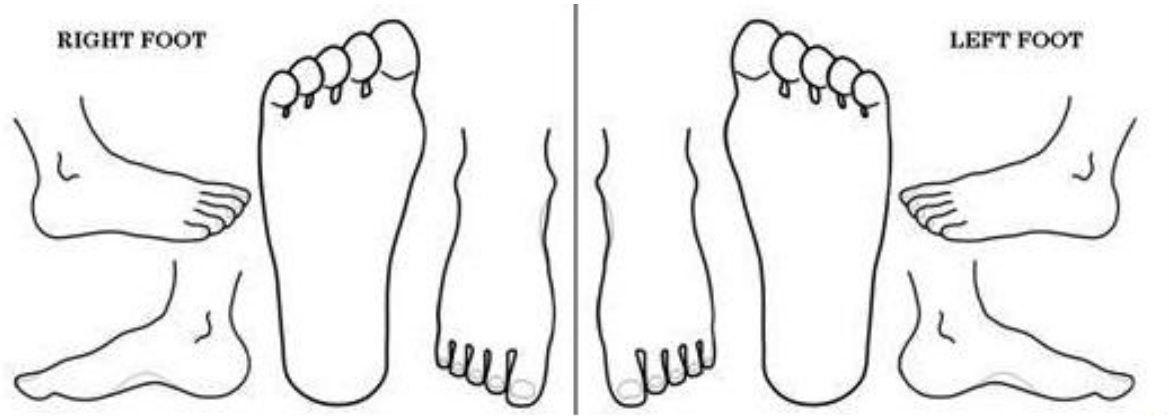
   _____

2. When did this problem begin?

   _____

3. What treatment, if any, have you tried?

   _____



Shoe Size:_____ **Height:**_____ **Weight:**_____

SOCIAL HISTORY:

TOBACCO USE: NEVER PREVIOUSLY BUT QUIT YES PACKS/DAY_____

USE OF ALCOHOL: NEVER PREVIOUSLY BUT QUIT YES TYPE_____

USE OF "RECREATIONAL DRUGS": NEVER PREVIOUSLY BUT QUIT YES WHAT?_____

PLEASE LIST ANY ALLERGIES:

_____

_____

PATIENT MEDICAL HISTORY: *(CIRCLE ALL THAT APPLY)*

ANEMIA	CANCER	HIV	MIGRAINE HEADACHES	KIDNEY DISEASE
DIABETES	STROKE	DVT	STROKE	TUBERCULOSIS
ARTHRITIS	HYPERLIPIDEMIA	HEPATITIS	SEIZURES	HYPERCHOLESTEROLEMIA
ASTHMA	GLAUCOMA	HYPERTENSION	LEG ULCERS	
HEART DISEASE	HYPOTENSION	LUNG DISEASE	THYROID DISEASE	

LIST ANY OTHER DISEASES: _____

MEDICATIONS:

Please list any medications (including vitamins and herbal supplements) that you have taken in the past six months:

Drug name	Dose

SURGICAL HISTORY: *(LIST PROCEDURE AND DATE)*

_____
_____
_____
_____

FAMILY HISTORY: *(CHECK ALL THAT APPLY)*

	Diabetes	*Hypertension*	*Heart Disease*	*Stroke*	*Cancer*	*Migraine*	*Other:*
Father							
Mother							
Brother							
Sister							

I authorize payment of medical benefits to Dr. Jay Bhuta PC for any services furnished by the practice. I understand that I am responsible for any balance due that my Insurance does not pay.

I hereby give permission to Dr. Jay Bhuta and staff to administer treatment and to perform such procedures that may be deemed necessary in the diagnosi and/or treatment of my foot and ankle disorder. I also give permission to Dr. Jay Bhuta and staff to access my medication history as provided by my insurance company.

***** if you are unable to keep your appointment, please contact our office 24 hours prior to your scheduled appointment to avoid the $25.00 cancellation fee*****

_____ _____

Signature ***Date***

HOW TO GET MORE INFORMATION OR REPORT A PROBLEM If you have questions and/or would like additional information, you may contact our office at (732-532-3668). If you feel your privacy rights have been violated, you can file a complaint with our office or with the Secretary of Health and Human Services. You will not be penalized for filing a complaint.

I, _____, acknowledge receipt of Dr. Jay Bhuta PC Notice of Privacy Practices.

Patient Signature: _____Date:_____

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We are dedicated to providing the best possible care and services to you and regard your complete understanding of our financial policies as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

As our patient, you are responsible for all authorizations and referrals needed to seek treatment in this office. If you do not have a valid referral your appointment will be rescheduled and or you will be responsible for payment.

Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept cash, check, and all credit cards.

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claims for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.

We have made prior arrangements with insurers and other health plans to accept and assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.

If you have insurance coverage with a plan with which we do not have prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.

All health plans are not the same and do not cover the same service. In the event that your health plan determines a service to be "not covered" or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges to any service rendered.

Patients are encouraged to contact their plans for clarification of benefits prior to services rendered. You must inform the office of all-insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.

There are certain elective surgical procedures that we require prepayment. You will be informed in advance if your procedure is one of those. In the event, payment will be due one week prior to the surgery.

Any outstanding balance for which the patient is responsible is due within 30 days of billing. Any account that has gone 60 days without payment is subject to immediate collection process. I agree that if my account is referred to an outside agency/attorney for collection, I will be responsible for an additional Collection Fee of $50 or 35% of the balance owed,whichever amount is greater. There is a service fee of $35.00 for all returned checks, which is payable by cash or money order. Your insurance company does not cover this fee. Our office charges a $25 no show fee if you do not call our office to cancel your appointment. I understand that if the insurance carrier notifies the office subsequent to my visit that my insurance was not valid at the time of service, payment for services will be due upon receipt. If the balance is not paid within 30 days I understand that my account could be forwarded to our Collection Agency and Iunderstand that additional collection fees stated above will apply.

I have read the above and understand the patient financial policy.

Signature of Patient/Responsible Party: _____

Printed Name: _____ Date: _____

Witness:_____Date:_____

Printed Name: _____

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Patient Consent for My Provider to
File an Appeal on my Behalf with my Health Insurance Plan

Provider Name:	**Provider Plan ID Number:**
Provider Address:	
Description of services that may be appealed:	**Date(s) services were provided:**

I agree to allow this health care provider to file an appeal on my behalf with the following health plan if there is a question about coverage for the services listed below.
I understand that:

1. If I consent, I will not be able to file my own appeal concerning these same services, nor will any representative I appoint, unless this consent is rescinded in writing.
2. I have a right to rescind this consent at any time. My legal representative has the right to rescind this consent at any time.
3. This consent shall be automatically rescinded if my health care provider does not file an appeal, or stops appealing my case.

I have read this consent or have had it read to me, and it has been explained to my satisfaction.

I understand the information in the consent form, and grant my consent to this provider to file an appeal on my behalf.

Print Patient Name:	**Patient Date of Birth:**	**Health Insurance Company**:
Patient Address:	**Patient Insurance ID Number:**	
Patient Signature:	**Signature Date:**	

The above named enrollee is unable to sign this consent form because of the following reasons and I consent for the above named enrollee:

Print Representative Name:	**Relationship to the Patient:**
Representative Signature:	**Signature Date**:

Print Witness Name:	**Witness Signature:**	**Signature Date:**