Podiatry Center of New Jersey

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www.PodiatryCenterNJ.com

Medicine of the Foot and Ankle

Foot Orthotic Therapy

Ankle-Foot Orthotic Therapy

Biomechanics of the Lower Extremities

Gait Analysis

Surgery of the Foot and Ankle

Arch and Heel Pain

Sports Medicine

Shoe Therapy

Children's Foot Disorders

Trauma of the Foot and Ankle

Nail and Skin Disorders

Welcome to Podiatry Center of New Jersey!

Thank you for selecting our office for your foot and ankle health care needs! We have prepared this packet of information and patient forms in order to help make your visit a convenient and pleasant experience.

Prior to your appointment, please contact your insurance company to clarify your coverage requirements.

Here are a couple of important points to keep in mind to make your visit easier:

Payments: Co-pays and self-pay items are due at the time of service. You are also responsible for services applied to your deductible, if using insurance. You may request an estimate for costs at the end of your appointment.

Referrals: If your insurance requires a referral to see a specialist, you cannot assume that your referral has been approved unless you have received written confirmation from your insurance company. If you are not sure your referral has been approved, please contact your insurance company before your appointment.

Prior to your appointment, please complete the following forms:

- Registration Form
- Health History Forms (2)
- Review of Symptoms Form
- Financial Policy
- Patient Consent for Use and Disclosure of Protected Health Information

When you come for your appointment, please bring the following:

- The completed forms listed above
- Medical Insurance card
- Written referral, if required by your insurance company
- Medication List
- Previous x-rays and medical records, if applicable
- Shoes (bring a sample of the more common shoes that you wear
  - including athletic and walking shoes)

Note: As you will be receiving advice on the proper shoes for your feet, we recommend that you not purchase any new shoes before your visit.

Please be prepared to pay for the following at the time of your visit:

- Co-payment
- Deductible (if not fully paid for this year)
- If no insurance, the full cost of the visit
- Unless you are paying your portion in full at the time of service, we strongly recommend keeping a credit card on file.

For your convenience, we accept Cash, Checks, Visa, MasterCard, Discover, and American Express.

Our entire staff is here to help you in whatever manner we can. We look forward to serving you in the near future.

Information:
We are located at 510 Hamburg Tpke. Suite 108 in Wayne, NJ.
Directions and more information can be found at **www.PodiatryCenterNJ.com.**

This form can be filled out in the office during your initial visit. If you wish to save time in the office during your initial visit you may fill out this form ahead of time. You have the option of filling this form out by hand and bringing it with you. OR you can fill this form out on your computer and either print it and bring it with you, or save the information and email it to podiatrycenternj@gmail.com.

IF YOU CHOOSE TO FILL THIS FORM OUT AND EMAIL IT BEFORE YOUR INITIAL VISIT YOU MUST DOWNLOAD THE NEWEST VERSION OF ADOBE IN ORDER for the information to be saved digitally.

Podiatry Center of New Jersey

Patient Registration

Patient Information

Patient Full Name: **Last** **First** **M.I.** ☐ **M** ☐ **F**

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

By what name do you preferred to be addressed?

Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner ☐

Patient's Address

City **State** **Zip**

Preferred Phone ☐ Home ☐ Cell ☐ Work

Alternative Phone ☐ Home ☐ Cell ☐ Work

E-mail Address (required for access to your online patient portal)

Social Security # **Birth Date**

I would like automated reminders by: ☐ Email ☐ Phone ☐ Text (Choose up to 3)

Employer **Occupation**

Emergency Contact/Relationship **Phone**

Insurance

Patient is: ☐ **Subscriber** ☐ **Spouse** ☐ **Dependent**

Name of insured (if other than self) **Birth Date** **SSN**

Name of insured's employer **Insured's work phone number**

Name of person responsible for paying the bill (the Guarantor): ☐ **Same as patient** ☐ **Same as insured**

Guarantor's Address ☐ **Same as patient** ☐ **Same as insured**

Guarantor's Telephone

L&I Injury

If injured on the job, fill this portion out.

Date of Injury **Type of Injury** ☐ Work ☐ Auto ☐ Other

Has a claim been filed? ☐ **Yes** ☐ **No** **Claim#:** **Where was claim filed?**

Cause of injury

Lower Extremity Medical History, Referral Information, Doctors and Pharmacies

Name: _____ **Date**: _____

What is the chief complaint(s) that brings you to our office for medical treatment? (Include foot, ankle, leg, knee, hip and back complaints: _____

Symptoms of Current Problem (circle or fill in your answer)

Which Side : Right Left Both **Type of Pain :** Dull Achy Throbbing Burning Sharp Shooting

Area of Pain : Bottom of Heel Back of heel Arch Ball of foot Big toe Top of foot Ankle No Pain

Other/Details: _____

On set : Slow Sudden Traumatic **Has pain gotten** : Better Worse Stayed the Same

How long has this been a problem for you?: Days Weeks Months Years

What aggravates condition? Walking Running Standing Shoes Activities First steps after rest

Other: _____ **Severity** : Mild Moderate Severe

What have you tried for the pain? Changing shoes Anti-inflammatory meds Decreasing activities Ice Heat Prefabricated Arch Supports Custom Orthotics Stretching Injections Physical Therapy Surgery Antibiotics Other OTC Meds Padding Massage Acupuncture Soaking

Other:_____

After it starts, how long does pain last? _____

Have you ever had a similar pain ? (describe, including treatments received) _____

How did you hear about our office?

Relative Friend Google Bing Other Web Search Facebook Yelp

Insurance Company Mail Phone Book TV Other: _____

From My Doctor (name/specialty/city):_____

Who is your primary care physician and what other doctors treat you regularly?

Primary Care Physician: _____ MD DO PN

Date last seen: _____ I don't have a primary care physician

Other doctors and their specialties: _____

List your primary pharmacy (name and location) - This is where we will send any prescriptions

Primary pharmacy (include city and street): _____

Pharmacy Phone Number: _____

NAME: _____ DATE: _____

Past Medical History, Social and Family History

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General

What is your weight: _____

What is your height: _____

What is your shoe size: _____

Allergies and Drug Intolerance

- ☐ Adhesive/Tape
- ☐ Aspirin
- ☐ Codeine
- ☐ Iodine
- ☐ Local Anesthetics
- ☐ Penicillin
- ☐ Seafoods
- ☐ Sulfa
- ☐ Other: _____
- ☐ No Known Allergies

Medications

List all medications **WITH DOSES** you are taking:

Surgeries, Injuries, Illnesses

List surgeries, serious injuries, and illnesses not previously listed:

General Medical History

Mark "yes" or "no" to indicate if you or a family member have any of the following:

Personal			Family	Relation
○ yes	○ no	Anemia	☐ yes	
○ yes	○ no	Arthritis: Type: _____	☐ yes	
○ yes	○ no	Artificial Heart Valve or Joints	☐ yes	
○ yes	○ no	Asthma	☐ yes	
○ yes	○ no	Back Problems	☐ yes	
○ yes	○ no	Bleed easily	☐ yes	
○ yes	○ no	Cancer	☐ yes	
○ yes	○ no	Chemical Dependency	☐ yes	
○ yes	○ no	Chest Pain	☐ yes	
○ yes	○ no	Circulatory Problems	☐ yes	
○ yes	○ no	Diabetes	☐ yes	
○ yes	○ no	Epilepsy	☐ yes	
○ yes	○ no	Fibromyalgia	☐ yes	
○ yes	○ no	Gout	☐ yes	
○ yes	○ no	Heart Disease	☐ yes	
○ yes	○ no	Hemophilia	☐ yes	
○ yes	○ no	Hepatitis	☐ yes	
○ yes	○ no	High Blood Pressure	☐ yes	
○ yes	○ no	HIV Positive	☐ yes	
○ yes	○ no	Kidney Problems	☐ yes	
○ yes	○ no	Leg Cramps	☐ yes	
○ yes	○ no	Liver Disease	☐ yes	
○ yes	○ no	Lung/Respiratory	☐ yes	
○ yes	○ no	Menopause	☐ yes	
○ yes	○ no	Mental Illness	☐ yes	
○ yes	○ no	Phlebitis / Clots	☐ yes	
○ yes	○ no	Psoraisis	☐ yes	
○ yes	○ no	Rheumatic Fever	☐ yes	
○ yes	○ no	STD	☐ yes	
○ yes	○ no	Stroke	☐ yes	
○ yes	○ no	Thyroid Problems	☐ yes	
○ yes	○ no	Tuberculosis	☐ yes	
○ yes	○ no	Ulcers—Stomach	☐ yes	
○ yes	○ no	Weight Change	☐ yes	

Mental / Emotional

- ○ yes ○ no Eating Disorder
- ○ yes ○ no Anxiety
- ○ yes ○ no Depression
- ○ yes ○ no Psychiatric
- ○ yes ○ no Alcoholism

Exercise and Orthotics

In what athletic activities do you participate?

days per week exercising? _____

Do you wear store-bought arch supports? ○ yes ○ no

Do you wear custom orthotics? ○ yes ○ no

If yes, who made them: _____

How old are the orthotics: _____

Social History

Your occupation?

Do you smoke? ○ yes ○ no

Are you a past smoker? ○ yes ○ no

How Much? packs/day _____

Years Smoked: _____

Drink Alcohol?: ○ yes ○ no

How Much: _____

Recreational Drugs? ○ yes ○ no

What: _____

Pregnant or possibly pregnant? ○ yes ○ no

The US HITECH Act requires us to ask the following questions:

Preferred Language: ○ English ○ Other: _____

Race:
- ☐ American Indian or Alaska native
- ☐ Asian ☐ Asian Indian
- ☐ Black/African American
- ☐ European
- ☐ Native Hawaiian/Pacific Islander
- ☐ White
- ☐ Other: _____
- ☐ **Decline**

Ethnicity: ○ Hispanic/Latino ○ Not Hispanic/Latino ○ Other: _____ ○ **Decline**

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Review of Symptoms

Check all that you are currently experiencing.

GENERAL
- Fever
- Chills
- Sweats
- Weight Loss
- Weight Gain
- Other_____

EYES
- Please circle right, left or both
- Vision changes R L Both
- Eye injury R L Both
- Eye irritation R L Both
- Other_____

EARS/Nose/Throat
- Please circle right, left or both
- Hearing loss R L Both
- Earache R L Both
- Smell Disorder
- Balance problem
- Sore Throat
- Other_____

CARDIOVASCULAR
- Chest Pain
- Irregular beat
- Heart Valve problems
- Edema
- Other_____

RESPIRATORY
- Cough
- Difficulty sleeping
- Wheezing
- Other_____

GASTROINTESTINAL
- Nausea
- Vomiting
- Diarrhea
- Abdominal pain
- Other_____

GENITOURINARY
- Pain with urination
- Frequent urination
- Difficulty starting or maintaining urination
- Other_____

MUSCULOSKELETAL
- Muscle cramps or aches
- Joint pain or swelling
- Back pain
- Other_____

CIRCULATION
- Leg cramps
- Blood Clots
- Other_____

NEUROLOGICAL
- Headaches
- Seizures/Stroke
- Numbness/Tingling
- Other_____

PSYCHOLOGICAL
- Depression
- Anxiety
- Other

ENDOCRINE
- Cold intolerance
- Heat intolerance
- Excessive thirst or urination
- Other_____

HEMATOLOGICAL
- Abnormal bruising
- Abnormal bleeding
- Other_____

SKIN
- Rash
- Itching
- Suspicious lesions
- Other_____

I have answered the above questions to the best of my ability. By typing your name below, you are signing this document electronically. You agree your electronic signature is the legal equivalent of your manual signature on this Agreement.

Signature/e-Signature:_____ Date:_____/_____/_____

*Note: Your e-signature does act as your real signature

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I authorize the Podiatry Center of New Jersey to DISCLOSE and OBTAIN, all medical records for the purposes of treating me. This includes but is not limited to disclosing and obtaining medical records from Hospitals, Doctors, Laboratories, Radiology centers, Wound care clinics, Family members. I may change this authorization at any time in writing.

I acknowledge the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Name (Please print) Date

_____ _____

Signature Parent or Authorized Representative (if applicable)

SUMMARY OF NOTICE OF PRIVACY PRACTICES

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization.

In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;

FINANCIAL POLICY ASSIGNMENT OF BENEFITS

We Accept Visa, MasterCard, American Express and Discover

Podiatry Center of New Jersey

Thank you for choosing us as your podiatric physicians. We are committed to your treatment being successful. As part of our service, we try to contain the cost of health care. In an effort to do this, we have implemented a **FINANCIAL POLICY** which we request you read and sign prior to any treatment.

PAYMENT FOR SERVICES: Payment for services is due at the time that those services are provided to you, and we expect that all charges we present to you at a visit will be paid at the time of the visit. This includes copay amounts, program deductibles, earlier charges that remain unpaid, and charges for services that we believe are not covered by, or are left over as your responsibility to pay after coverage by, insurance or government programs. **If we are billing insurance, the day's charges are an estimate**; you may be refunded or additionally billed after we hear from your insurance company. Payments may be made by *cash, check or credit/debit card*. There will be a $25.00 charge for *returned checks. Delinquent accounts* will be referred for collection at the discretion of the office manager. **CO-PAYS AND UNPAID**

BALANCES DUE AT TIME OF VISIT: Please be prepared to pay all co-payments and unpaid balances at the time of service. We do not send bills out for co-payments, so your visit will have to be re-scheduled if you are not prepared to pay the co-payment.

INSURANCE: Our office will submit a claim to your insurance company as a courtesy. To do this we must have *complete and accurate* insurance information and a copy of your identification card or claim form. Your insurance policy is a contract between you and your insurance company; therefore you are responsible for payment whether or not your insurance company pays. **It is your responsibility to contact your insurance company regarding *pre- authorizations, obtaining required referrals, second opinions, etc***. Failure to do so may reduce the amount of benefits paid by your insurance, and the balance will then become your responsibility to pay.

NO INSURANCE: If you do not have insurance or the doctor is not a participating provider with your insurance plan, please be prepared to fully cover the fees for each visit at the time of treatment.

BILLING COMMUNICATIONS: We may present charges to you by written statement via the mail or email following a visit. We expect that each charge will be paid in full by return mail, in the office, or online via our patient portal the first time it is presented to you. We may contact you regarding billing and office announcements, using any form of contact provided to us.

DEDUCTIBLES: If you have an annual deductible which has not yet been paid in full, then any charges incurred up to that amount may be due at the time of your visit.

MINOR PATIENTS: The adult or the parent (custodial guardian) accompanying a minor is responsible for payment of services. For unaccompanied minors, non-emergency treatment will be denied unless prior authorization from the parent or guardian has been made for the charges and treatment.

SUPPLIES: For your convenience we make some supplies available for purchase in the office. If you choose to purchase these items, payment is due at time of purchase.

ASSIGNMENT OF BENEFITS: I authorize my insurance benefits to be paid directly to the doctor. I understand that the doctor's office will bill my insurance as a courtesy and that I am responsible at the time of service for all co-payments, deductible, unpaid balances and non- covered services. I authorize the release of information required to process my claims. (If not signed, payment is due at time of service).

I have read and agree to the terms set forth in the above financial policy. I am financially responsible for any balance due. I agree to make all payments for any co-payments, charges due within my current deductible and any unpaid balance from previous visits at the time of my appointment. I agree to the Assignment of Benefits.

Patient or Guardian Signature: _____ **Date:** _____

Print Name: _____

Podiatry Center of New Jersey

No-show and On-time Appointment Policy

We have developed this no-show and on-time appointment policy to best meet the needs of our patients. We welcome your feedback and suggestions and will make updates to this policy as needed.

At Podiatry Center of New Jersey, LLC we respect your time and pride ourselves on keeping our appointment schedule on time. One of the ways we do this is by giving each patient ample time to meet with their doctor.

At a busy podiatric practice it is often impossible to predict what a day will bring. A sudden emergency such as a fracture or an infection throws our well-planned schedule into chaos. On the rare occasion we have to cancel an appointment, we will call and explain and reschedule as soon as possible.

Unpredictable traffic jams or a toddler who throws a tantrum can cause our patients to be late or miss an appointment altogether. We understand that sometimes being late is unavoidable and usually a quick phone call to the office explaining your tardiness or last-minute cancellation is sufficient.

Late Arrivals
When a patient arrives late for an appointment, if the schedule allows, we will see the patient. There may be a lengthy wait, however, as we will see all on-time patients first. If there isn't any flexibility in that day's schedule, the patient will be
asked to wait if it is for urgent care or to reschedule if the problem is not urgent.

No-Shows
If you must miss an appointment please call us as soon as you know you cannot make it. Patients who habitually do not show and do not contact us take time away from other patients and will be asked to find another provider.

A $30 no-show fee will be applied to patients that do not show up for a scheduled appointment.

Walk-ins
If you have an urgent problem, we will likely work you into an already busy schedule. In this situation, be aware that there may be a wait but we are committed to seeing you that day.

Usually we will see you within 30 minutes of your scheduled appointment time, but occasionally the wait may be longer.