FOOT & ANKLE ASSOCIATES OF WYCKOFF

Podiatric Medicine and Surgery

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Welcome to our office.
We appreciate your expression of confidence in choosing our office for your foot care.

Name_____
FIRST M.I. LAST
DOB ___/___/_____ Gender_____ Social Security #:_____/_____/_____
Address_____City_____State____Zip_____
Phone: Home_____ Work_____ Mobile_____
E-Mail address: _____
Primary Care Physician: First name_____ Last_____
Date last seen:_____ City:_____
Hispanic/Latino Origin? Yes No (circle one) Primary language _____ Race_____
Marital status: ❒ Single ❒ Married ❒Widow(er) ❒Divorced ❒Partner ❒Other
Employer_____Occupation_____
Employer Address_____
How did you hear about our office? ❒Patient ❒Physician ❒Internet ❒Website ❒Other
Name of person who referred you? _____

Person to notify in case of emergency:

_____ _____
Name DOB Relation to Patient

_____ _____
Phone-home Mobile

HIPAA PRIVACY PRACTICES

A copy of the HIPAA Notice of Privacy Practices is available upon request. By signing, I acknowledge that I have read, or been given the opportunity to read, if I so choose, and understand the Notice.

Signature_____ Today's date_____

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Insurance

Primary Insurance _____ Effective date _____

Policyholder _____ Policyholder DOB_____ Relationship _____

ID# _____ Group #_____ Copay $_____

Secondary Insurance _____ Effective date _____

Policyholder _____ Policyholder DOB_____ Relationship _____

ID# _____ Group #_____ Copay $_____

For those services rendered for which we will be billing the insurance company, a signed release is necessary allowing us to collect directly from the insurance company for your care. Please read and authorize:

> "I request that payment of my insurance benefits be made directly to Foot & Ankle Associates of Wyckoff for any services rendered to me by Foot & Ankle Associates of Wyckoff. I authorize release to the insurance company and its agents any information needed to determine these benefits payable for related services."
>
> I have read and understand the above statements and information. With my signature, I am agreeing to these.

_____ _____

Print name **Signature**

_____

Today's date

FOOT & ANKLE ASSOCIATES OF WYCKOFF

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Medical History

What is the reason for your visit? _____

_____

How long have you had this condition? _____

Have you previously been treated for this condition? ❒Yes ❒No

If so, what treatment did you receive and when? _____

Are you taking any medications? ❒Yes ❒No

Please list by name and dosage per day:

_____

_____

Are you **allergic** to any **medication**? ❒Yes ❒No Which one(s)? _____

Are you presently being, or have you ever been, treated for any of the following:

❒ ARTHRITIS
❒ BACK PAIN
❒ BLOOD CLOTS
❒ BREATHING PROBLEMS
❒ CANCER
❒ DIABETES
❒ FROSTBITE
❒ GOUT
❒ HEPATITIS
❒ HEART DISEASE
❒ HIGH BLOOD PRESSURE
❒ HISTORY OF FALLING
❒ KIDNEY DISEASE
❒ LEG CRAMPS
❒ NUMBNESS
❒ PHLEBITIS
❒ POOR CIRCULATION
❒ SHORTNESS OF BREATH
❒ SWOLLEN FEET
❒ STOMACH ULCERS

OTHER (Please list) _____

_____

Pharmacy _____ Location_____

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Patient Financial Responsibilities
PLEASE READ CAREFULLY

1. It is the patient's responsibility to know and understand their particular insurance policy and their benefits. We will not be responsible for misunderstandings in coverage. If you have any questions about your insurance coverage, it would be to your advantage to contact your insurance carrier prior to any care.

2. Managed Care (HMO) patients are responsible for acquiring completed referral forms per visit from their Primary Care Physician. If you have a referral for multiple visits, it is your responsibility to know when it runs out and when you will need a new one. Failure to comply may result in denial of insurance claim and will be the responsibility of the patient or guarantor for all charges incurred.

3. If the patient does not have insurance, he/she will be required to pay at the time of the visit unless previous arrangements have been made.

4. This office does NOT participate with the following insurances: Aetna, Aetna Medicare HMO, AmeriChoice, AmeriHealth, Community plans, Emblem Health, First Health/Coventry, GHI, Horizon Medicare Blue HMO, IDA, MagnaCare, Medicaid, Meritain Health. If you have a question about a specific insurance company please ask the receptionist. We will submit these to the insurance company as a courtesy but the patient or guarantor is responsible for the full amount.

5. I hereby authorize and guarantee payment for all services rendered. Although fees for services are due and payment may be expected at the time services are rendered, if I have been granted a grace period for payment of fees, I acknowledge that payment is due and expected at the time the first billing statement is received. In the event that my account becomes delinquent for more than 30 days, I also agree to pay a finance charge, if applicable, of 1.5% per month on any balance due, as well as all reasonable collection costs not to exceed 50%, court costs, attorney fees, interest fees and any other fees accrued with the collection of this account.

6. P**lease note: There will be a $40 charge for appointments not cancelled or rescheduled within 24 hours of appointment time.**

By signing below, you acknowledge that you have read, understand, and agree to all of the above.

_____ _____

Signature of patient or guarantor Today's date

_____

Print name