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350 Franklin Ave., Suite 2
Wyckoff, NJ 07481
P: 201-891-4930 / F: 201-891-4715
WYCKOFFPODIATRIST.COM

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 Relationship to Patient

_____________________________________ _____________________________________

Phone-home Mobile

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

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)? ___________________________
Latex allergy or reaction? ❒Yes ❒No Other allergies? ___________________________________
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________________________

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.

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

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______________

=

Notifier: FOOT & ANKLE ASSOCIATES OF WYCKOFF	Medicare Identification Number:
Patient Name:	

Medicare Advance Beneficiary Notice of Noncoverage (ABN)

Note: If Medicare doesn't pay for the item below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the service/product below.

Code	Reason MC may not pay	Estimated Cost
□ L3000	Non-covered service	$450
□ L4350 (Ankle brace)	Less than 5 years since last device	$90
□ L4361 (CAM walker)	Less than 5 years since last device	$325
□ L4397 (Night splint)	Less than 5 years since last device	$200
□ L_____	Less than 5 years since last device	$_______
□ 11721	Less than 61 days since last nail cutting	$65
□ 11719	MC does not pay for non-diseased nails	$60
□ 11055, 11056, 11057	MC does not pay for corns and callouses	$90-$125
□ Shoes	Non-diabetic shoes are non-covered	$_______
□ Surgical shoe	Non-covered service	$20
□ Deductible	Annual Medicare deductible required	Individual

WHAT YOU NEED TO DO NOW:

Read this notice, so you can make an informed decision about your care.

- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the service/product listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

☐ I want the service/product listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. **If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.**

☐ I want the service/product listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**

☐ I don't want the service/product listed above. I understand with this choice I am not responsible for payment, and **I cannot appeal to see if Medicare would pay.**

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You may also receive a copy.

I. Signature:	J. Date:

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