FOOT & ANKLE
ASSOCIATES OF WYCKOFF

350 Franklin Ave., Suite 2 Wyckoff, NJ 07481 Phone: 201-891-4930 / Fax: 201-891-4715 www.WyckoffPodiatrist.com

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

Name Last_____ First_____ MI___ Nickname_____
Marital status: ❒ Single ❒ Married ❒Widow(er) ❒Divorced ❒Partner ❒Other
DOB_____ **Birth Sex**_____ **Social Security** # _____
Language_____ **Ethnic Group**_____ **Race**_____
Emergency Contact: Name _____Phone_____ Relationship to Patient:_____
Phone: Home _____Work _____ Mobile _____Preferred Phone _____
Is it OK to leave a message? ❒Yes ❒ No
E-Mail address _____ Opt-in to notifications? ❒Yes ❒ No
Address_____ City_____ State___ Zip_____
Employer_____ Occupation _____
Guarantor: Last Name_____ First_____ DOB _____
Contact Info if other than Patient: Last Name_____ First _____
City_____ State____ Zip_____ Phone _____
Primary Insurance: _____Effective date _____
Type (ex: HMO/PPO) _____Do you need a referral? _____ If so, please bring with you.
Policyholder _____Policyholder DOB _____Relationship_____
ID# _____Group #_____ Copay $ _____
Secondary Insurance: _____Effective date _____
Type (ex: HMO/PPO) _____Do you need a referral? _____ If so, please bring with you.
Policyholder _____Policyholder DOB _____Relationship_____
ID# _____Group #_____ Copay $ _____
Pharmacy _____Street_____ City_____ State _____
Primary Care Physician First Name _____ Last _____
City _____ State___ Date last seen: _____
How did you hear about our office? ❒Patient ❒Physician ❒Internet ❒Website ❒Other
Name of person who referred you? _____
Medical
What is the reason for your visit?
_____
How long have you had this condition? _____ Have you been treated for this condition? ❒Yes ❒No
If so, what treatment did you receive and when? _____
Are you taking any medications? ❒Yes ❒No If so, please list by name and dosage per day
_____
_____
_____
If you have too many to list here, please give a list to the receptionist.

Allergies

Are you **allergic** to any **medication**? ❒Yes ❒No If so, which one(s)? _____
Latex allergy or reaction? ❒Yes ❒No
Other **allergies**? ❒Yes ❒No If so, which one(s)? _____
Are you presently being, or have you ever been, treated for any of the following?

- ❒ Arthritis
- ❒ Chronic Back Pain
- ❒ Blood Clots
- ❒ Breathing Problems
- ❒ Cancer
- ❒ Diabetes
- ❒ Frostbite
- ❒ Gout
- ❒ Hepatitis
- ❒ Heart Disease
- ❒ High Blook Pressure
- ❒ History of Falling
- ❒ Kidney Disease
- ❒ Leg Cramps
- ❒ Numbness
- ❒ Phlebitis
- ❒ Poor Circulation
- ❒ Shortness of Breath
- ❒ Swollen Feet
- ❒ Stomach Ulcers
- ❒ Other

Patient Financial Responsibilities

PLEASE READ CAREFULLY

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.

1. 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.

2. 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.

3.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.

4. 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 of patient or guarantor _____ Today's date _____

Insurance billing approval

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.

Signature of patient or guarantor _____ Today's date _____
Print name _____