<u>Prime Foot and Ankle Specialists</u>

19 Maple Ave Ste A	2301 East Evesham Road #210,	1130 Blackwood Clementon Rd	17 White Horse Pike 10A
Woodbury Heights, NJ 08097	**Voorhees**, NJ 08043	**Pine Hill**, NJ 08021	**Haddon Heights**, NJ 08035
Phone: 856-384-1333	Phone: 856-770-1313	Phone: 856-783-3366	Phone: 856-546-8989
Fax: 856-384-1297	Fax: 856-770-1297	Fax: 856-782-1648	Fax: 856-546-8905

Welcome to our office! Thank You for choosing Prime Foot and Ankle Specialists!

Patient's Name:________________________________ **Date of Birth**:______/______/_______

Gender: ☐ **M** ☐ **F** **Email**: ____

Address:____

City:___________________________________**State**:_________**Zip**:______________________

Cell Phone: (________) _______________________**Home Phone**: (_______) ________________

Alternate Phone Number:(_____)______________ **Work Phone**: (______) ________________

Primary Doctor:_______________________________**Address:**__________________________

Primary Doctor's Phone: (______)_______________**Date Last Seen**:_____/______/_______

Pharmacy: _________________________ **Location**:___________________________________

How did you hear about our office? ☐ Google/Internet ☐ Primary Care:________________

☐ Friend/Relative:______________________ ☐ Other: ______________________________

Emergency Contact's Name:______________________**Phone Number**: ________________

<u>Insurance Information:</u>

Insurance Company:___________________ **Policy Number:** ______________________________

Primary Policy Holder's Name:____

Policy Holder's D.O.B _____/_____/_____ **Social Security #**________-________-_______

Policy Holder's Relationship to Patient:____

Secondary Insurance:___________________ **Policy Number:** ____________________________

Tertiary Insurance: _______________________ **Policy Number:**___________________________

Please circle all **Allergies** or adverse reactions to medications: ☐ No Known Drug Allergies

☐ Penicillin ☐ Sulfa Drugs ☐ Ibuprofen ☐ Aspirin ☐ Food/Others:__________________

Please circle your **Current Medications**: ☐ Atorvastatin 10/20/40/80mg ☐ Albuterol ☐ Levothyroxine 25/50/75/100/125 mcg ☐ Lisinopril 2.5/5/10/20/30/40 ☐ Amlodipine 5/10mg ☐ Omeprazole ☐ Metformin 500/1000 mg ☐ Gabapentin 100/300mg ☐ Losartan25/50/100mg

Others:____

Please circle your **Medical History**: ☐ Diabetes type I/ Type II ☐ Hypertension ☐ Depression ☐ Cholesterol ☐ Heart Disease ☐ Psychotic Disorder ☐ CHF ☐ Prostate Disorder ☐ MI ☐ PE ☐ DVT ☐ PoorCirculation ☐ varicose veins ☐ clotting disorder ☐ Thyroid Disease

Others: ____

Please list all **Surgeries or Hospitalizations**: _______________________________________
____

Please list your **Family's Medical History** ____

Height: __________ **Weight**: ____________ **Most Recent Blood Pressure:** ______________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Do you **Smoke** ? YES ☐ NO ☐ How much per day? ______________________

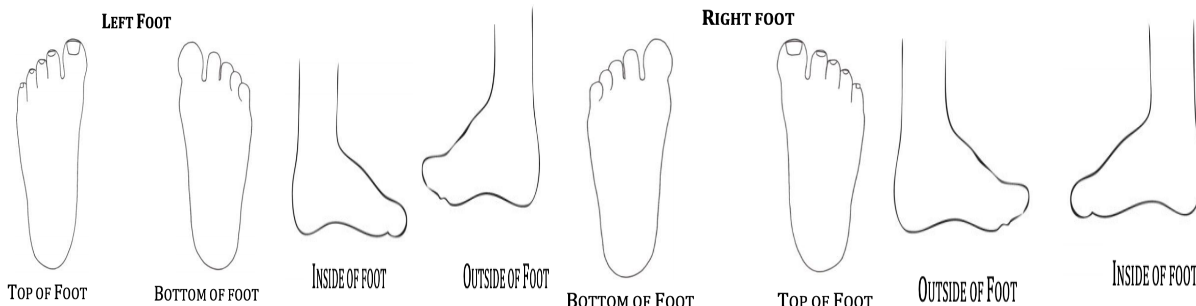
Do you **Drink** ? YES ☐ NO ☐ How much per day? ______________________

Do you use **Illicit Drugs**? YES ☐ NO ☐ Please describe:_________________________

Occupation: ____________________________**Employer**:___________________________

What Specific problem brings you to our office today?______________________________
____

Where is the pain/problem located? **Left** ☐ **Right** ☐ **Foot** ☐ **Ankle** ☐ **Leg** ☐



Authorization for Release of Case Records

I hereby authorize my **Primary Physician, Dr.**____________________________________,
to disclose to **Prime Foot and Ankle Specialists** any information which they may have acquired by examination of my physical or mental condition. I hereby release them of any Consequence.

____ ______/_______/_____

Patient's Signature **Date**

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Practice's *Notice of Privacy Practices*

By subscribing to my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

II. Designation of Certain Relative, close Friends and other Caregivers as my Personal Representative :

I agree that the practice may disclose certain of my health information to a personal Representative of my choosing, since such a person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Names: ____

III. As provided by the Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed on Page 1 (including, cell/work/home phone number and email address). I also agree that it is OK to leave a message with detailed information regarding my health records. I also agree that practice may send and may share my email for marketing purposes.

IV. E-PRESCRIBING CONSENT

E-Prescribing is defined by a Physician's ability to electronically send an accurate, error free, and understandable prescription directly to your pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-prescribing greatly reduces medication errors and enhances patient safety. The Medicare modernization act of 2003, listed standards that have to be included in an e-prescribing program. These include (1) Formulary and benefit transactions which gives the prescriber information about which drugs are covered by a drug benefit plan (2) Medication history transactions, which provides the physician with information about medications the patient is already taking to minimize adverse drug events. I authorize **Prime Foot and Ankle Specialists**, to view my external prescription history via electronic E-prescribing services. I understand that prescription history from multiple, other unaffiliated, provedier, insurance companies, pharmacies and pharmacy benefit managers may be viewable by the providers and staff of **Prime Foot and Ankle Specialists**, and it may include prescriptions back in time for several years and may include prescriptions to treat HIV, substance abuse and psychiatric conditions. If Applicable, I understand that my prescription history will become part of my record at this practice. Understanding all of the above, I hereby provide informed consent to **Prime Foot and Ankle Specialists** to enroll me in the E-prescribe program. This consent will remain enforced until revoked or changed.

V. I certify, to the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I Understand that it is my responsibility to inform the doctor and office staff of my changes in medical status.

VI. I give permission to the doctors at **Prime Foot and Ankle Specialists** to administer and perform any diagnostic, therapeutic and operative procedures as may deemed medically necessary in diagnosis and treatment of my condition.

VII. Patients/Minors under Age of 18 will not be treated without a Parent or Legal Guardian present.

I have read, understood and agreed to the above terms and conditions.

____________________________________ ______/_______/______

Patient/Parent/Guardian **Signature** **Date**

FINANCIAL POLICY – Please Read Carefully!

Thank you for choosing **Prime Foot and Ankle Specialists** as your provider. We are committed to providing you with quality and affordable health care and to being transparent with our billing process. Please read the following policy. Feel free to ask us any questions that you may have. When you have accepted the policy, please **sign** in the space provided. A copy will be provided to you upon request.

It is my responsibility to provide up-to-date insurance information prior to my appointment and each time my insurance changes.
Office must maintain a copy of my Insurance and ID Cards as protection for me against fraud.
If I do not have insurance that the office participates in or I fail to provide up-to-date insurance information for a plan office to participate in, I will need to pay in full for all charges.
It is my full responsibility to know and understand the details of my insurance policy including, but not limited to, in vs.out of network, co-pays, deductibles, co-insurance and non-covered services.
Coverage & benefits quotes I am given are provided in good faith from what office/staff has been told by my insurance, but are in no way a guarantee of payment or coverage. It is my responsibility to contact my insurance company with questions I have on my coverage.
If required, it is my responsibility to obtain a proper referral. Failure to do so will result in my paying in full for all charges. This payment will be held for 48 hours and will become non-refundable if proper referrals are not presented by that time.
All anticipated patient responsible charges must be paid at the time of service, this includes co-pays, co-insurance, deductibles and non-covered services. If it is not known that a service is non-covered until after the appointment, I will be billed for that service.
Services associated with my visit will be promptly sent to insurance for claim processing. After my insurance has processed the claim(s), I will receive a statement listing charges that are my responsibility. I agree to pay in full within 30 days of the statement date.
Office will NOT enter into a dispute with my insurance company over my claim. I understand this is my responsibility and obligation.
If there is an outstanding balance on my or my family's account(s), I will need to pay in full at the time of check-in.
Unpaid balances past 30 days are subject to a $10 repeat statement fee.
Unpaid balances past 60 days may be sent to a collection agency and fees associated with that agency will be added to my balance.
Office will submit my claims and assist me in any way reasonable to help get my claims paid. My insurance company may need me to supply certain information directly. It is my responsibility to comply with their request.Failure to do so, will result in my paying in full for all charges
Cancellations must be made 24 hours in advance. Failure to do so will result in a $35 fee.

Appointments not canceled,and not kept are deemed ‘No-shows’ and will incur a $50 fee.
After 3 No-shows and/or late cancellations, I will be required to leave a non-refundable deposit for future appointments. The deposit will be applied to any balance due at kept appointments.
The office staff will submit requested documentation on my behalf to my insurance company. The charge for completing medical forms (disability, leave of absence, etc.) is $25.00. Forms will be completed as time permits usually within 7 business days. Copies of medical records are available at $1.00 per page. All returned checks will be assessed an additional charge of $30.00 per check.

I have read and understand the payment policy and agree to abide by its guidelines:

____

Print name of patient or responsible party

____ ________________

Signature of patient or responsible party Date