COMPREHENSIVE FOOT & ANKLE CENTER OF SOUTH JERSEY

PATIENT INFORMATION FORM

Date: _____

Patient Name: _____ Date of Birth:_____ Age: _____ Sex:☐M☐F☐GNC

Home Address: _____ City/State: _____ Zip: _____

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____ Which is preferred:_____

E-Mail - _____ MAY WE LEAVE A MESSAGE/ TEXT/ EMAIL? ☐ YES ☐ NO

Race/ Ethnicity: _____

Legal Guardian or Healthcare Power of Attorney- Name: _____ Relationship: _____ Phone #:_____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Primary Care Doctor: _____ Phone #: _____ Date of Last Visit: _____

Referring Doctor: _____ Phone #: _____

Pharmacy: _____ Location: _____ Phone #: _____

Is there a family member you would like for us to share medical information?

YES - Name(s): _____ NO ☐

Who is responsible for payment? Name: _____ Relationship: _____

Address: _____ City/State: _____ Zip: _____ Phone #: _____

How did you hear about us?☐Doctor referral☐ Friend/family referral☐ Insurance provider☐Google☐Other _____

INSURANCE INFORMATION

PRIMARY Insurance Company Name: _____

Address: _____ City/State: _____ Zip: _____ Phone # of insured: _____

Name of insured: _____ Date of Birth of insured: _____ Employer : _____

Insurance ID #: _____ Group # : _____

SECONDARY Insurance Company Name_____

Address: _____ City/State: _____ Zip: _____ Phone # of insured: _____

Name of insured: _____ Date of Birth of insured: _____ Employer : _____

Insurance ID #: _____ Group # : _____

FINISHED WITH THIS FORM? Save to your device and **EMAIL** to **generalinfo@sjfootankle.org** or **PRINT** and bring to your visit.

PATIENT NAME: _____

YOUR MEDICAL HISTORY

ALLERGIES: ☐ DRUG ALLERGIES _____

☐ ANESTHESIA _____ ☐ FOODS _____

☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER _____ ☐ NONE KNOWN

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

	Y	N		Y	N		Y	N
ACID REFLUX	☐	☐	FIBROMYALGIA	☐	☐	NEUROPATHY	☐	☐
ANEMIA	☐	☐	GOUT	☐	☐	OPEN SORES	☐	☐
ARTHRITIS	☐	☐	HEART ATTACK	☐	☐	PNEUMONIA	☐	☐
ASTHMA	☐	☐	HEART DISEASE/ FAILURE	☐	☐	RHEUMATIC FEVER	☐	☐
BACK TROUBLE	☐	☐	HEPATITIS	☐	☐	SICKLE CELL DISEASE	☐	☐
ABNORMAL BLEEDING	☐	☐	HIV/AIDS	☐	☐	SKIN DISORDER	☐	☐
BLOOD CLOTS	☐	☐	HIGH BLOOD PRESSURE	☐	☐	SLEEP APNEA	☐	☐
BLOOD TRANSFUSION	☐	☐	KIDNEY DISEASE	☐	☐	STOMACH ULCERS	☐	☐
BRONCHITIS/EMPHYSEMA	☐	☐	LIVER DISEASE	☐	☐	STROKE	☐	☐
CANCER	☐	☐	MIGRAINE HEADACHES	☐	☐	THYROID DISEASE	☐	☐
DIABETES: TYPE 1 OR TYPE 2 (CIRCLE)	☐	☐	MITRAL VALVE PROLAPSE	☐	☐	TUBERCULOSIS	☐	☐
OTHER CONDITIONS:								

PLEASE LIST ALL **MEDICATIONS** YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME **DOSE** **HOW OFTEN DO YOU TAKE?**

_____

_____

_____

_____

_____

_____

_____

PLEASE LIST ALL **PRIOR SURGERIES**:

TYPE OF SURGERY DATE TYPE OF SURGERY DATE

_____ _____

_____ _____

_____ _____

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF **ALCOHOL**: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE

☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF **TOBACCO**: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE _____ PACKS/DAY FOR _____ YEARS

RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____ CURRENT USE - TYPE _____

☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

EMPLOYER: _____ OCCUPATION: _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ☐ CHILDREN–AGE(S) _____ ☐ PET(S)–WHAT KIND? _____

☐ ELDERLY OR DISABLED FAMILY MEMBER ☐ OTHER _____

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES: TYPE 1 OR TYPE 2 ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE ☐ STROKE

☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS ☐ OTHER _____

FINISHED WITH THIS FORM? SAVE IT TO YOUR DEVICE AND **EMAIL** TO **GENERALINFO@SJFOOTANKLE.ORG** OR **PRINT** AND BRING TO YOUR VISIT

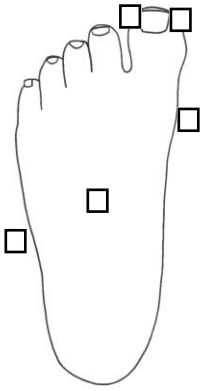
PATIENT NAME: _____

CURRENT PROBLEM

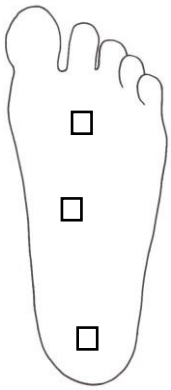
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

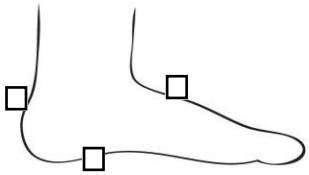
LEFT FOOT



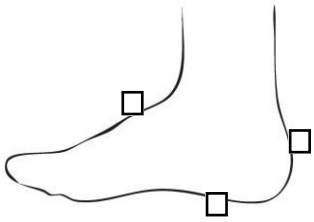
TOP OF FOOT



BOTTOM OF FOOT

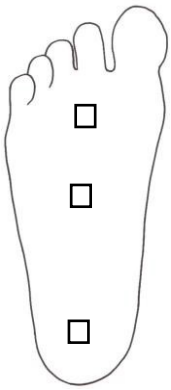


INSIDE OF FOOT

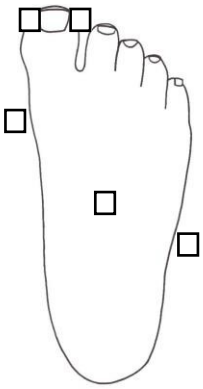


OUTSIDE OF FOOT

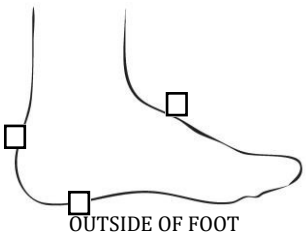
RIGHT FOOT



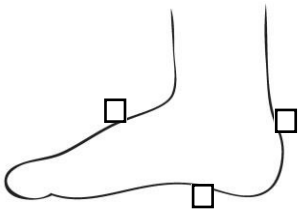
BOTTOM OF FOOT



TOP OF FOOT



OUTSIDE OF FOOT



INSIDE OF FOOT

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS ☐ WEEKS ☐ MONTHS ☐ YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING ☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)

(NO PAIN) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 *(WORST PAIN POSSIBLE)*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES ☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE ☐ RUNNING ☐ OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) _____ ☐ NO

WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____

PRINT NAME OF PATIENT, PARENT OR GUARDIAN

_____ _____

SIGNATURE DATE

FINISHED WITH THIS FORM? SAVE IT TO YOUR DEVICE AND **EMAIL** TO **GENERALINFO@SJFOOTANKLE.ORG OR PRINT** AND BRING TO YOUR VISIT

COMPREHENSIVE FOOT & ANKLE CENTER OF SOUTH JERSEY

COMPLIANCE ASSURANCE NOTIFICATION

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability & Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the government rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect. Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation properly.

Thank you for being one of our highly valued patients.

HIPAA COMPLIANCE PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

Terms of this notice may change, if so, you will be notified at your next visit to update your signature.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA law allows for the use of information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected health information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice as the right to restrict the use of the information, but the practice does not have the right to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? ☐ **YES** ☐ **NO**

May we leave a message on your answering machine at home or your cell phone? ☐ **YES** ☐ **NO**

May we discuss your medical condition with any member of your family? ☐ **YES** ☐ **NO**

If, YES, please name the members allowed:

_____

This consent was signed by: _____

(PRINT NAME)

Signature: _____ **Date: _____**

COMPREHENSIVE FOOT & ANKLE CENTER OF SOUTH JERSEY

277 White Horse Pike	2301 E. Evesham Rd	69 Haddonfield Berlin Rd	900 NJ 168
Suite 101	Suite 508	First Floor	Suite A-2
Atco, NJ 08004	Voorhees, NJ 08043	Cherry Hill, NJ 08034	Turnersville, NJ 08012
(P) 856.768.7850	(P) 856.768.7850	(P) 856.858.0180	(P) 856.768.7850
(F) 856.768.7853	(F) 856.768.7853	(F) 856.869.3080	(F) 856.768.7853

FINANCIAL POLICY

Thank you for choosing Comprehensive Foot & Ankle Center of South Jersey as your foot care provider. We are committed to providing you with quality and affordable health care. Please read the following office payment policy and feel free to ask us any questions that you may have. Once you accept this policy, kindly sign in the space provided. A copy will be provided to you upon request.

1. INSURANCE - We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. CO-PAYMENT & DEDUCTIBLES - All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-pays and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. NON-COVERED SERVICES - Please be aware that some and perhaps all of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. PROOF OF INSURANCE - All patients my complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. If required, obtaining the proper referral from your primary care physician is your responsibility. Patients presenting to our office without a valid referral will be asked to pay in full. This payment will be held for 48 hours and will become non-refundable if the proper referral is not obtained by then.

5. CLAIMS SUBMISSION - We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefits is a contract between you and your insurance company.

6. COVERAGE CHANGES - If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

7. NONPAYMENT - Invoices are sent out every 30 days. Your prompt payment will assist us in keeping the cost of healthcare down. If your account is over 90 days past due (4 statements), your account will be referred to our collection agency.

8. FEES - Our fees are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

9. You agree, in order for us to service your account or collect monies you may owe, Comprehensive Foot & Ankle Center of South Jersey and/or our agents may contact your by telephone at any telephone number associated with your account, including wireless telephone numbers, which may results in charges to you. We may also contact you by sending your text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/ artificial voice messages and/or use of automatic dialing devices, as applicable.

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

Signature _____ Date _____

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(F) 856.768.7853	(F) 856.768.7853	(F) 856.869.3080	(F) 856.768.7853

E-PRESCRIBING CONSENT FORM

E-Prescribing is defined by a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a 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 (MMA - 2003) listed standards that have to be included in an e-prescribe program.

These include:

- Formulary and benefit transactions - gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions - provides the physician with information about medications the patient is already taking to minimize the number of adverse reactions.

I authorize Comprehensive Foot & Ankle Center of South Jersey to view my external prescription history via electronic prescribing services. I understand that my prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies, and pharmacy benefit managers may be viewable by my provider and staff at Comprehensive Foot & Ankle Center of South Jersey. This may include prescriptions that date back in time for several years as well as prescriptions to treat HIV, substance abuse, and psychiatric conditions, if applicable. I understand that my prescription history will become part of my Comprehensive Foot & Ankle Center medical record.

Understanding all of the above, I hereby provide informed consent to Comprehensive Foot & Ankle Center of South Jersey to enroll me in the e-Prescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

This consent will remain enforce until revoked or changed.

_____

Patient Name (PLEASE PRINT)

_____ _____

Signature Date

COMPREHENSIVE FOOT & ANKLE CENTER OF SOUTH JERSEY

277 White Horse Pike
Suite 101
Atco, NJ 08004

2301 E. Evesham Rd
Suite 508
Voorhees, NJ 08034

69 Haddonfield-Berlin Rd
First Floor
Cherry Hill, NJ 080334

900 NJ Route 168
Suite A2
Turnersville, NJ 08012

Dear Patients,

Welcome to Comprehensive Foot & Ankle Center! We are pleased to have you as a patient and look forward to providing you with the highest quality of healthcare services. To ensure clarity and transparency regarding your financial responsibility for the medical services you receive, we have outlined the following financial responsibilities and terms of payment:

Insurance Information:

- It is your responsibility to provide accurate and up-to-date insurance information at the time of registration. This includes presenting your insurance card and any relevant documentation.

Co-Payments, Deductibles, and Co-Insurance:

- If your insurance plan requires co-payments, deductibles, or co-insurance, you are responsible for making these payments at the time of your visit. These payments are due regardless of the ultimate coverage or reimbursement provided by your insurance.

Verification of Insurance Coverage:

- While we will make reasonable efforts to verify your insurance coverage, it is ultimately your responsibility to ensure that our services are covered by your insurance plan. Any services not covered by your insurance plan will be your financial responsibility.

Non-Covered Services:

- Some services or procedures may not be covered by your insurance plan. You are responsible for all charges associated with non-covered services, and payment is due upon receipt of the bill.

Billing Statements:

- You will receive 3 billing statements detailing the services provided and the associated charges. Please review this statement carefully and contact our **Billing Department at 718-888-0841** if you have any questions or concerns.

Payment Due Date:

- Payment for any outstanding balance is due within 30 days from the date of the billing statement. We offer various payment options, including online payments, by mail, or in person at our clinic.

Collections Policy:

- Failure to make timely payments may result in your account being sent to collections. We reserve the right to report unpaid balances to credit bureaus and seek legal action for unpaid debts.

Updating Contact Information:

- Please keep us informed of any changes to your contact information, including address, phone number, or insurance coverage, to ensure accurate billing and communication.

By signing below, you acknowledge that you have read and understand your financial responsibilities as outlined above. You agree to adhere to the terms and conditions of payment for the medical services provided by Comprehensive.

Patient's Signature: _____ Date: _____

If you have any questions or need clarification regarding your financial responsibility, please do not hesitate to contact our **Billing Department at 718-888-0841.**

Thank you for choosing Comprehensive for your healthcare needs. We are committed to providing you with exceptional care, and we appreciate your cooperation in fulfilling your financial obligations.

Sincerely,

Comprehensive Foot and Ankle Center of South Jersey

P: 856-768-7850
F: 856-768-7853
www.southjerseyfootandankle.com