



Richard L. Corbin, DPM, FACFAS
*Diplomate, American Board of Podiatric Surgery
Fellow, American College of Foot & Ankle Surgeons*

Matthew F. Wachtler, DPM, AACFAS
Associate, American College of Foot & Ankle Surgeons

Samantha L. Sheppard, DPM, AACFAS
Associate, American College of Foot & Ankle Surgeons

Patient Name: _____ **Today's Date:** _____

Reason for today's visit: _____

Allergies to medication: _____

Current medications: _____

Past Medical History, Medical Conditions:

Past Surgical History: _____

Family Medical History of Cancer, Heart Disease, Diabetes or other medical conditions

Father: _____

Mother: _____

Brother: _____

Sister: _____

Do you smoke cigarettes (circle): Yes No
- How many packs per day: _____ For how many years: _____

Do you drink alcohol (circle): Never Occasionally Daily

Patient Signature: _____



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ACKNOWLEDGEMENT OF RECEIPT NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided an opportunity to read (if I chose to) a copy of the notice of Privacy Practices and understood the notice.

Patient Name (please print)

Date

Parent of Authorized Representative (if applicable)

Signature



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INSURANCE

Although I have health insurance, I am aware that this is no guarantee of payment. If my insurance company denies payment, I understand that I am ultimately responsible for this bill.

If my insurance requires a referral, it is solely my responsibility to obtain the referral before my office visit. If I do not obtain the referral prior to the visit, payment for the visit is my responsibility.

I am responsible to notify the office of any and all changes in my health insurance and present updated cards in coordination. If I do not provide accurate information, I am responsible for payment of office visit.

Print Patient Name

Patient Signature

Date



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HIPPA Consent Form

I, _____, understand that under the Health Portability and Accountability Act 1996 (HIPAA) I have certain rights to privacy regarding my health information. I also understand that Garden State foot & Ankle Specialist originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, test results, diagnoses, treatments and any plans for future care and treatment at Garden State foot & Ankle Specialist.

I understand that this information can be used as:

- A basis for planning my care and treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- A means of communication among the many health professionals who contribute to my care.
- A means by which a third-party payer can verify that services billed were actually provided and obtain payment from third party payers.
- A tool for routine healthcare operations such as assessing quality and receiving the competence of healthcare professionals.

I prefer to have notification of my healthcare information by the following methods. Please check all applicable:

- _____ Home telephone
- _____ If I am not available, you may leave a message with a family member
- _____ Detailed message on answering machine
- _____ Work phone with direct contact only
- _____ Cell phone

My health information may also be discussed with the following people upon their request:

Name: _____

Relationship: _____

 Patient Signature

 Date



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Name _____

Medicare # _____

"I request that payment of authorized Medicare benefits be made on my behalf to the name of provider of service and (or) supplier for any service furnished to me by that provider of service and (or) supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services."

Beneficiary Signature

Date

Name _____

Medicare # _____

Secondary Policy # _____

"I request that payment of authorized secondary benefits be made on my behalf to the name of provider of service and (or) supplier for any service furnished to me by that provider of service and (or) supplier. I authorize any holder of medical information about me to release to the secondary insurer and its agents any information needed to determine these benefits or the benefits payable for related services."

Beneficiary Signature

Date



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Medicare has specific rules covering payment for mycotic (fungal) toenails. In order for Medicare to cover the debridement (cutting) of nails, one must have pain associated with the condition and/or have a medical condition such as Diabetes or poor circulation. If I have been told by my doctor that I do not have a qualifying condition, I must pay the doctor for the services today and I will not be reimbursed by Medicare. The following best describes my situation. However, if I was seen by my doctor within 61 days for mycotic nail treatment, I must pay for that service and Medicare will not reimburse me.

- I have marked limitation of ambulation (walking) when the infected toenails become thickened.
- There is pain resulting from thickening and dystrophy of the infected toenails.
- The above two statements do not apply to me. I understand I must pay for today's visit and Medicare will not reimburse me if I elect to have my toenails cut today.

Signature of Patient

Date