Patient's Name _____ Date _____

Email Address _____

What is the best way to contact you?

___ Home Phone
___ Cell Phone
___ Business Phone

Do you have a living will?

___ Yes
___ No

To comply with federal regulations, we are required to ask you to fill out the following items:

Please indicate your *Race:*

___ White/Caucasian
___ African American
___ Asian
___ Hispanic
___ Other: _____
___ I prefer not to disclose

Please indicate your *Ethnicity:*

___ Hispanic or Latino
___ Not Hispanic or Latino
___ Unknown/Unreported

Preferred Language (if other than English): _____

Preferred Pharmacy: _____
(Please indicate city, state, phone number and cross streets if known)

RELEASE OF MEDICAL INFORMATION/PRIVACY PRACTICE:

In connection with the medical care provided to me at the office of Dr. Leslie Aufseeser, except as otherwise prohibited by law, by my signature below, I hereby grant permission for Dr. Aufseeser's office staff and my treating doctor to release medical records information to my health care insurers (including Medicare, Medicaid) my current professional care givers and/or other potential healthcare providers. This information may include any disease or drug/alcohol history.

*SIGNATURE:*_____ *DATE:*_____

*PRINTED NAME:*_____ *RELATIONSHIP:*_____

I ACKNOWLEDGE I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND HAVE READ (OR HAD THE OPPORTUNITY TO READ IF I CHOSE) AND UNDERSTAND THE NOTICE

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2. DESIGNATION OF CERTAIN RELATIVES, CLOSE FRIENDS, OTHER CAREGIVERS:

I agree that the practice may disclose certain of my health information to a family member, closed personal friend or other caregiver, since such 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. I may be contacted in the following manner - please check all that apply:

a) Home Telephone Number
___OK to leave message with detailed information
___Leave message with call back numbers only

b) Written communication:
___OK to mail to home address
___OK to mail to my work/office

c) Work Telephone Number
___OK to leave message with detailed information
___Leave message with call back numbers only

d) Fax communication
___OK to fax to this number:_____
Other:_____

The following person(s) are authorized to receive my patient Health information:

Print name:_____ Relationship:_____
Print name:_____ Relationship:_____
Print name:_____ Relationship:_____

The Privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for, Patient Health Information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the patient/parent/guardian. Healthcare entities must keep a record of Patient Health Information disclosures. Uses and disclosures for Treatment, Payment, and Health Care Operations may be permitted without prior consent.

LESLIE S. AUFSEESER, D.P.M.
Diplomate, American Board of Podiatric Surgery
1700 Madison Avenue
Lakewood, NJ 08701

Telephone: (732) 367-5151

SIGNATURE ON FILE

- ☐ I authorize use of this form on **all** my insurance submissions.
- ☐ I authorize release of information to all my **Insurance Companies.**
- ☐ I understand that **I am responsible** for my bill, co-pay or deductible and any uncovered expenses.
- ☐ I authorize my doctor to act as **my** agent in helping me obtain payment from my Insurance Companies.
- ☐ I authorize payment direct to my doctor.
- ☐ I permit a copy of this authorization to be used in place of the original.

Name (Please Print) _____

Signature _____ Date _____

DR. LESLIE S. AUFSEESER
1700 MADISON AVE.NUE
LAKEWOOD, NJ 08701
732-367-5151 732-905-5160 (FAX)

PATIENT LIABILITY AGREEMENT

I understand that I am financially responsible for All bills incurred while under the care of DR. LESLIE S. AUFSEESER. In the event that My account is not paid, I shall be liable for any and All costs of collection, including, but not limited To an additional fee of $40.00 if my account is Forwarded to a collection agency for collection.

I further understand that there shall be 1.5% interest Charged per month on any outstanding balance. In Addition, I further understand that if legal proceedings Are necessary to collect the amount due, I will also be Responsible for paying attorney's fee plus court costs.

By signing below, I hereby indicate that: 1) I have read This contract, 2) I understand the terms of the contract, And 3) I agree to the terms of this contract.

_____
PATIENT/GUARDIAN

_____
RELATIONSHIP DATE