**Herskowitz Podiatry**
**2301 Evesham Road, Ste 302**
**Voorhees, NJ 08043**
**856-770-1313 Fax 856-770-1297**
**sjfootdocs@gmail.com**
**sjfootdoctors.com**

**Welcome to our office! Please fill out the following 5 pages. Thank you!**

Patient Name:_____
Gender: Male Female
Date of Birth:_____

E-mail:_____

Address:_____
City,
State and Zip Code _____,_____,_____

Home Phone:_____ (# To Confirm Appointment)
Cell Phone:_____

Primary Doctor:_____ Phone # _____
Referring Physician:_____Phone #_____

How did you hear about our office?_____
Emergency Contact Name & Number _____ # _____

Marital Status: M S DP W D
Are you currently working? _____
Are you currently a student?_____
Employer Name & Number _____

Insurance Company: _____
DO YOU NEED REFERRALS? YES NO
Policy Holder Name and Date of Birth:_____
Relationship to patient:_____

Please describe the reason for your visit today?_____
How long has it been bothering you? _____
Is your problem the result of trauma OR injury?_____
What activities aggravate your condition?_____
Is this conditioning worsening? Y N Is it constant? Y N
Have you received treatment for this condition?_____
Did this treatment give you relief? If yes, for how long?
What tests were performed and where? EX: XRAYS, CT Scans MRI? Y N
If yes where:_____

# PATIENT MEDICAL HISTORY

Height:_____ Weight:_____ BP:_____

Please describe any current medical problems:

_____
_____
_____
_____

Have you been diagnosed with Hepatitis or other communicable or blood disorders?Y__ N__
If yes, please list:_____

Please list your current medications:

_____
_____
_____
_____

Please list all allergies or adverse reactions to medications: _____
_____
_____

Do you smoke? Y__ N__ How much per day? _____
Do you drink? Y__ N__ How much per day? _____
Do you use illicit drugs? Y__ N__ Please describe:_____
Please list all surgeries or hospitalizations: _____
_____
_____
_____
_____

Please list your family's medical history (i.e. diabetes, stroke, etc.) _____
_____
_____
_____
_____

# OFFICE POLICY REGARDING INSURANCE ASSIGNMENT

Thank you for choosing our office for your health care. We are committed to providing you with quality care. We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. The following is a statement of our Financial Policy. We ask that you review it and sign it prior to treatment.

It is your responsibility to know the terms of your insurance policy. Please make sure you give us your current insurance information at each visit. A co-pay or payment in full, if required by your insurance company, is expected at the time of service or your appointment may be rescheduled. This applies to all visits including follow-up visits. You may need to check with your primary care physician for referrals or outside tests.

I understand and agree with all of the following policies and statements:

1. I understand I am required to pay my deductible and co-insurance at the time services are rendered. Acceptable methods of payment are cash, checks, Visa, and Master Card.
2. I understand that I am responsible for acquiring referrals prior to my appointment. If a referral was not issued, I will pay all fees for that date of service.
3. The physician's office does not guarantee that my insurance will pay for services. The office staff will make every attempt to receive verification and benefits of my policy. However, if my insurance claim is denied, I will be responsible for the full amount of my bill.
4. The physician's office will NOT enter into a dispute with my insurance company over my claim. I understand this is my responsibility and obligation.
5. If a payment plan is required, there will be a one and one half percent service charge per month. This shall be added to any balance remaining after 30 days from my initial visit. I also agree to pay all costs of collection of any balance, including attorney fees if applicable.
6. 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 $10.00 to $15.00. Forms will be completed as time permits usually within one week. Copies of medical records are available at $0.50 per page. All returned checks will be assessed an additional charge of $30.00 per check.
7. **The following checked statement is true**:
   ___Yes, I have been associated with a malpractice suit.
   ___No, I have never been associated with a malpractice suit.
8. I consent to evaluation and treatment by the doctor. If I have questions, I will ask the doctor prior to treatment.
10. In most cases, you will receive a reminder call 1 to 2 days before your visit. If you are unable to keep your appointment, kindly give us at least 24 hours notice. (You can leave a message with the answering service during non-business hours). I understand that if I miss an appointment without giving notice, I will be billed a **$25 fee**. This No-Show fee will NOT be billed to my insurance company.

By signing my name below, Herskowitz Podiatry will accept my insurance assignment.

_____ _____

Signature Date

# ACKNOWLEDGMENT OF RECEIPT
# OF
# NOTICE OF PRIVACY PRACTICES

(HIPAA AGREEMENT)

Herskowitz Podiatry

I acknowledge that I was provided a copy of the Notice of Privacy Practices. I had the opportunity to read and understand the Notice.

_____ _____/_____/_____

Patient's Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

**I am also giving my consent to discuss my treatment with the following individuals:**

_____

_____

_____

_____

## Authorization for Release of Case Records

I hereby authorize my primary physician, Dr._____,
to disclose to Dr. Herskowitz and associates 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

## Advance Directive

Do you have Advance Directives/Living Will? (For patients 18 & above)

☐ Yes ☐ No

## Cultural / Linguistic barriers to Care

Do you have any of the following? Check all that apply.

☐ Poor Vision ☐ Poor Hearing ☐ Language Barrier ☐ Religious/Cultural barriers
☐ None of the above

## Patient Advisory / Consent Form
## (Medicare Patients Only)

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. My doctor has told me that I do not have a qualifying medical condition. I understand that if I do not have pain or a qualifying medical condition, I must pay for the doctor for the services today and I will not be reimbursed by Medicare. The following best describes my situation:

☐ I have marked limitation of ambulation (walking) when the infected toenails become thickened or elongated.

☐ There is pain resulting from the thickening of infected toenails.

☐ The above two statements do not apply to me. I understand that I must pay for today's visit and I will not be reimbursed by Medicare because it is not a covered service.

_____ _____/_____/_____
Patient's Signature

# Pharmacy

Patients Name

_____

Pharmacy Name

_____

Phone

_____