Dr. Morris Morin, DPM
Dr. Elena Blanco, DPM
125 Prospect Ave
Hackensack, NJ 07601

Date: ______________________________

Patient Information

Last name: ______________________ **First name:** ______________________ **M.I.:** ____________
Street address: ___________________________________ **Apt:** _______
City: ______________________________ **State:** _______________ **Zip code:** _______________
Home phone #: ______________________ **Cell phone #:** ______________________
Email address: _______________________________________
Race: _________________________________ **Preferred Language:** ___________________________
Sex: □ **Male** □ **Female** **Age:** ______ **Birthdate:** __________________ **SSN:** _________________
Marital status: □ **Married** □ **Widowed** □ **Single** □ **Minor** □ **Separated** □ **Divorce**
Family physician: ____ **Last visit date:** _______________
**** What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints)** ____
____

Insurance Information
****Please provide insurance cards & photo ID to receptionist****

Primary Insurance: ____
Member ID: ____ Group #: ___________________
Subscriber's Name: ___________________________________ Date of Birth: ________________
Patient's relationship to subscriber: □ Self □ Spouse □ Child □ Other __________________
Secondary Insurance (if applicable): ________________________________
Member ID: ____ Group #: ___________________
Subscriber's Name: ___________________________________ Date of Birth: ________________
Patient's relationship to subscriber: □ Self □ Spouse □ Child □ Other __________________

In Case of Emergency

Name: ____ Phone #: ____________________________
Relationship: ____________________________________

Pharmacy/Medications

Pharmacy: _______________________________________ Town, State: _________________________
Medications: ____
____

Allergies

□ Adhesive/Tape	□ Demerol	□ Penicillin
□ Anticoagulant/ Therapy	□ Iodine	□ Seafoods
□ Aspirin	□ Local Anesthetics	□ Sulfa
□ Codeine	□ Novocaine	□ Other: ________________

Medical History (Check ONLY that apply)

□ AIDS/HIV	□ Circulatory Problems	□ Kidney Problems
□ Allergies to Anesthetics	□ Corns and Calluses	□ Liver Disease
□ Allergies to Medicine/Drugs	□ Diabetes	□ Low Blood Pressure
□ Anemia	□ Ear Problems	□ Neuropathy
□ Ankle Pain	□ Eye Problems	□ Numbness in Feet or Legs
□ Angina	□ Fainting	□ Plantar Warts
□ Arthritis	□ Flat feet	□ Psychiatric Care
□ Artificial Heart Valves/Joints	□ Foot or Leg Cramps	□ Respiratory Disease
□ Asthma	□ Gout	□ Shortness of Breath
□ Athlete's Foot	□ Headaches	□ Sinus Problems
□ Back Problems	□ Heart Disease	□ Stroke
□ Bleeding Disorders	□ Heel Pain	□ Swelling in Ankles or Feet
□ Bunions	□ Hepatitis	□ Thyroid Problems
□ Cancer	□ High Blood Pressure	□ Tired Feet
□ Chemical Dependency	□ High Cholesterol	□ Ulcers
□ Chest Pain	□ Ingrown Toenails	□ Varicose Veins
□ Chronic Diarrhea	□ Jaundice	□ Weight Loss, unexplained

Surgical History

*Please list all surgeries you have had ____

____

____

Social History

Occupation ____

Patient Employer/School ____

Employer/School Address ____

Employer/School Phone Number (_____) ____________________

Cigarette/Tobacco Use: □ Yes □ No

If yes, how many cigarettes do you smoke per day? ____________________

Who may we thank for referring you? ______________________________________

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

____ ____________________

Signature of Patient, Parent, Guardian, or Personal Representative — Date

____ ____________________

Please print name of Patient, Parent, Guardian, or Personal Representative — Date

FINANCIAL POLICY for DR. MORIN

Financial Policy

Thank you for choosing Dr. Morris Morin as your foot care provider. We are committed to providing you with quality and affordable healthcare. Please review the following office payment policy and feel free to address any questions that you may have with our office staff. Your acceptance of this agreement requires that you kindly sign in the space provided below. A copy will be provided to you, upon request.

1. **Insurance.** We participate with most insurance plans. If you are not insured by a plan we participate with, payment in full will be expected at every visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and deductibles.** All co-payments must be paid at the time of service. Co-insurance and Deductibles are your financial responsibility, once the insurance has paid their part of the claim. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us to uphold the law by paying your co-payment at every 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 reasonably or medically necessary by Medicare or other insurers. Therefore, it is your responsibility to check with your insurance company regarding your coverage, or you will be responsible for any balance not covered by your insurance company.
4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card.
5. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you to receive your maximum benefits.
6. **Referrals.** It is your responsibility to obtain the proper referral from your Primary Care Physician, if your insurance requires it. Patients presenting to our office without a valid referral will be asked to pay in full. The payment will be held for 48 hours and will become non-refundable if the proper referral is not obtained.
7. **Claims Submission.** We will submit your claims and assist you in any way that we can reasonably help to 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 benefit is a contract between you and your insurance company.
8. **Nonpayment.** Invoices are sent out every 30 days. Your prompt payment will assist us in keeping the cost of your healthcare down. If your account is over 60 days past due, you will receive a letter requesting immediate payment. Partial payments will not be accepted, unless otherwise approved by our billing department. Please be aware that if a balance remains unpaid, that we will take legal action and the doctor is at liberty to send you a written notification of his discharge of care. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative podiatric care. During the 30-day period, our physician will only treat you on an emergency basis.
9. **Missed appointments.** Our policy requires 24 hour advance notice when canceling an appointment. A $50.00 fee may be incurred for frequent cancellations.
10. **Fees.** Our fees are representative of the usual and customary charges for our area.

Thank you for your understanding of our financial policy. Please let us know if you have any questions or concerns.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY AND AGREE TO ABIDE BY ITS GUIDELINES:

X	
SIGNATURE OF PATIENT **PARENT OR AUTHORIZED REPRESENTATIVE**	**DATE**

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MEDICAL INFORMATION RELEASE FORM
(HIPPA RELEASE FORM)

Patient Name: ________________________________ **Date of Birth:** ______________

I authorize the release of information including diagnosis, records, examination rendered to me and claims information. This information may be released to:

[ ] Spouse: ________________________________
[ ] Child(ren): ________________________________
[ ] Other: ________________________________
[ ] Information is not to be released to anyone

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided with a copy of the notice of Privacy Practices and that I have read (or have had the opportunity to read if I so chose) and understand them.

Patient name: ________________________________ Date of Birth: ______________
Signature: ________________________________ Date: ______________

TEXT MESSAGING AND EMAIL CONSENT

Our practice has a mobile text messaging and email communication service. This service will be used for phone calls, text, and email reminders to patients regarding upcoming appointments. We always strive to maintain the confidentiality of your information and will continue to do so while using this system. To help us do this, **it is important that you let us know if you change your mobile number or email address in the future.**

If you give us consent to communicate with you by mobile text messaging and/or email as outlined above, please fill in your details below. **If you decide you no longer wish to receive messages through this service, please inform us.**

Patient name: ________________________________

Date of birth: ________________________________

Mobile number: ________________________________

Email address: ________________________________

□ **Opt out of electronic communication service.**

Morris R. Morin, D.P.M.
Elena Blanco, D.P.M.
125 Prospect Avenue
Hackensack, NJ 07601

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OF

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____ ____________________

Patient Name (Print) Date

____

Parent or Authorized Representative (if applicable)

____

Signature