

**CENTRAL JERSEY FOOT & ANKLE CARE, PC**  
**ALAN L. BASS, DPM**  
**PATIENT INFORMATION SHEET**

NAME: \_\_\_\_\_  
(Last) (First)

HOME ADDRESS: \_\_\_\_\_  
(Street) (City) (State) (Zip)

HOME PHONE #: \_\_\_\_\_ CELL PHONE #: \_\_\_\_\_ SSN #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_ MARITAL STATUS: S M D W STUDENT

E-MAIL ADDRESS: \_\_\_\_\_ CONTACT BY:  PHONE  TEXT  EMAIL

PRIMARY LANGUAGE \_\_\_\_\_ RACE \_\_\_\_\_ ETHNICITY: Are you Hispanic or Latino? Y N

EMERGENCY CONTACT: \_\_\_\_\_ PHONE # \_\_\_\_\_

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**WHAT IS THE MAIN REASON FOR YOUR VISIT TODAY?**

=====  
**HAVE YOU SEEN ANOTHER PHYSICIAN FOR THIS PROBLEM?** YES \_\_\_\_ NO \_\_\_\_

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**HOW WERE YOU REFERRED TO THE OFFICE?**

\_\_\_\_ PHYSICIAN \_\_\_\_ FAMILY \_\_\_\_ FRIEND \_\_\_\_ INSURANCE WEBSITE \_\_\_\_ DR BASS' WEBSITE  
\_\_\_\_ INTERNET \_\_\_\_ FACEBOOK \_\_\_\_ SETS \_\_\_\_ OTHER \_\_\_\_\_

=====  
**WHO IS RESPONSIBLE FOR THE BILL (IF OTHER THAN PATIENT)? \_\_\_\_ SELF**

NAME: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

HOME PHONE #: \_\_\_\_\_

INSURED/CARD HOLDERS EMPLOYER: \_\_\_\_\_

WORK ADDRESS: \_\_\_\_\_ PHONE #: \_\_\_\_\_

=====  
**PRIMARY INSURANCE:**

INSURANCE COMPANY NAME: \_\_\_\_\_

NAME OF CARD HOLDER: \_\_\_\_\_

ID NUMBER: \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_

INSURED BIRTHDATE (IF DIFFERENT FROM PATIENT): \_\_\_\_\_

INSURED SOCIAL SECURITY # (IF DIFFERENT FROM PATIENT): \_\_\_\_\_

=====  
**SECONDARY INSURANCE:**

INSURANCE COMPANY NAME: \_\_\_\_\_

NAME OF CARD HOLDER (SELF, SPOUSE, PARENT): \_\_\_\_\_

ID NUMBER: \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_

INSURED BIRTHDATE (IF DIFFERENT FROM PATIENT): \_\_\_\_\_

INSURED SOCIAL SECURITY # (IF DIFFERENT FROM PATIENT): \_\_\_\_\_

**PATIENT HISTORY**

Generally speaking, are you in good health now? Yes\_\_\_\_ No\_\_\_\_

Height\_\_\_\_\_ Weight\_\_\_\_\_

Do you have a **PERSONAL** history of **Diabetes**? Yes\_\_\_\_ No\_\_\_\_

Is there any **FAMILY** history of **Diabetes**? Yes\_\_\_\_ No\_\_\_\_

Do you use tobacco products or smoke? Yes\_\_\_\_ No\_\_\_\_

If yes, how much? \_\_\_\_\_

Do you drink alcohol? Yes\_\_\_\_ No\_\_\_\_

If yes, how much? \_\_\_\_\_

Are you subject to prolonged bleeding? Yes\_\_\_\_ No\_\_\_\_

If yes, do you take a blood thinner?  
(i.e. Coumadin or Aspirin, please circle)

Do you have **ALLERGIES** to drugs, medicines or other substances? Yes\_\_\_\_ No\_\_\_\_

If yes, please list: \_\_\_\_\_

Are you being treated for or have you ever been treated for (please check all that apply):

- |  |                                  |
|--|----------------------------------|
| _____ High Blood Pressure (Hypertension) | _____ Liver Disease or Hepatitis |
| _____ High Cholesterol                   | _____ Epilepsy                   |
| _____ Heart Trouble                      | _____ Thyroid Conditions         |
| _____ Circulation issues                 | _____ Syncope (Fainting issues)  |
| _____ Asthma                             | _____ Other (please list): _____ |
| _____ Kidney Disease                     |                                  |

Have you had any serious **ILLNESSES** or **OPERATIONS**? Yes\_\_\_\_ No\_\_\_\_

If yes, what type and when? (Please list)

<b>ILLNESS OR OPERATIONS</b>	<b>Date</b>
_____	_____
_____	_____
_____	_____

**Do you have a PRIMARY CARE PHYSICIAN?** Yes\_\_\_\_ No\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

**Date last seen:** \_\_\_\_\_

Are you taking any **MEDICATIONS**? Yes\_\_\_\_ No\_\_\_\_

If yes, please list: \_\_\_\_\_

PHARMACY NAME: \_\_\_\_\_ LOCATION: \_\_\_\_\_ PHONE: \_\_\_\_\_

**I hereby give permission to Dr. Bass to examine and/or perform diagnostic tests, and treat my condition medically, surgically or orthopedically. The undersigned consents to and authorizes the administration and performance of medical care that may be in the judgment of the physician considered advisable and necessary, why may include the performance of certain blood tests for communicable diseases such as Hepatitis and HIV. Dr. Bass is authorized to furnish information, necessary to process claims, to an insurer, compensation carrier or welfare agency that may be providing financial acceptance for hospital care. I understand that although I have medical insurance, I am solely responsible for payment of medical bills. I agree to pay all fees billed to me immediately upon completion of all services unless other arrangements have been made in advance. I also understand that payment is not dependent upon my insurance.**

**SIGNATURE:** \_\_\_\_\_  
Signature of Patient or Legal Guardian

**DATE:** \_\_\_\_\_

The federal government is requiring all physicians to start collecting the information below.  
This office must comply with this program or be penalized for non-participation.  
We appreciate your cooperation

**ADDITIONAL PATIENT HISTORY INFORMATION**

**Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**For all patients**

Has the patient received a flu vaccination for this season? Yes \_\_\_ No \_\_\_

If No, what was the reason? \_\_\_ Patient allergy \_\_\_ Patient declined \_\_\_ Vaccine unavailable

**For those patients 65 years of age or older**

Do you have a living will or someone to make decisions on your behalf? Yes \_\_\_ No\_\_\_

Have you ever had a pneumonia vaccination? Yes \_\_\_ No \_\_\_

# PATIENT HIPPPA ACKNOWLEDGMENT AND DESIGNATION DISCLOSURE FORM

## I. Acknowledgement of Practice's Notice of Privacy Practices

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP) and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms

\_\_\_\_\_  
Name of Patient                      Date of Birth                      Signature of Patient/Parent/Guardian                      Date

## II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal representative

I agree that the practice may disclose certain of my health information to a personal representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case the Physician Practice will disclose only information that is directly relevant for the person's involvement with my healthcare or payment relating to my healthcare

Print Name: \_\_\_\_\_ Last 4 digits of his/her SSN (required) \_\_\_\_\_  
Print Name: \_\_\_\_\_ Last 4 digits of his/her SSN (required) \_\_\_\_\_  
Print Name: \_\_\_\_\_ Last 4 digits of his/her SSN (required) \_\_\_\_\_

## III. Request to Receive Confidential Communications by Alternate Means

As provided by Privacy Rule Section 164.522(b), I hereby request that the practice make all communications to me by the alternative means that I have listed below.

**Home Telephone Number:** \_\_\_\_\_

OK to leave message with detailed information

Leave message with call back numbers only

**Written Communication Address:** \_\_\_\_\_

OK to mail to address listed above

OK to email me at: \_\_\_\_\_

**Work Telephone Number:** \_\_\_\_\_

OK to leave message with detailed information

Leave message with call back numbers only

**Fax Communication:** \_\_\_\_\_

OK to fax to the number listed above

**Other:** \_\_\_\_\_

\_\_\_\_\_  
Name of Patient (Print)                      Signature                      Date

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**FINANCIAL POLICY FOR CENTRAL JERSEY FOOT AND ANKLE CARE, PC**

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

**INSURANCE:** We participate in most insurance plans. 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.

**MEDICARE:** We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However, that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any copayments, which are usually 20% for the allowed amount for an item or service

**SECONDARY INSURANCE:** Your medical claim will be forwarded to your secondary insurance (if any) after payment and /or explanation of benefits (EOB) is received from your primary insurance company.

**COPAYMENTS AND DEDUCTIBLES:** all copayments and deductibles must be paid at the time of services. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments or deductibles from patients can be considered fraud. Please help us in upholding the law by paying your copayment at each visit.

**SELF PAY:** Payment in full is due at the time of service if you do not have health insurance.

**NON-COVERED SERVICES:** Please be aware that some of the services that you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment of these services.

**REFERRALS/AUTHORIZATIONS:** We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of this visit. If you do not have a referral from your primary care physician at the time of a visit, you will be financially responsible for all services received due in full upon completion of the visit. Full credit will be given if a referral is presented to our office within 48 hours of this visit. You will also be given the option to reschedule your appointment

**CLAIM SUBMISSION:** We will submit you 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 benefit is a contract between you and your insurance company.

**PATIENT BILLING:** You will be sent a statement for any outstanding balance owed after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. **If a second or third statement is required, a \$10 rebilling fee will be added to your account for each subsequent statement. You will be sent up to three notices of your financial responsibility (coinsurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. If payment is not received after the third and last notice, your account will be forwarded to collections or small claims court, where additional fees will apply.** Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check or Visa/MasterCard/AMEX. An additional \$50.00 will be added to your statement if the check is returned for insufficient funds. In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it you our office to be applied to your balance.

**PRIVACY STATEMENT:** Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

**Assignment of Benefits**

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **Central Jersey Foot and Ankle Care, PC** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, copayments and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize **RELEASE OF MEDICAL INFORMATION** to my insurance carrier, or requested by physicians to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance and acknowledge I was provided with a copy of the Notice of Privacy Practices and understand and accept its terms. **I have read the above policy regarding my financial responsibility to Central Jersey Foot and Ankle Care, PC for medical services provided. I agree to pay Central Jersey Foot and Ankle Care, PC any balance unpaid by my insurance carrier for myself or the below named person.**

PRINT Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

**FINANCIALLY RESPONSIBLE PARTY**

PRINT Name: \_\_\_\_\_

Signature \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_