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

WHO SHOULD WE CONTACT IN CASE OF EMERGENCY: _____ 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 REFEERED TO THE OFFICE?
____ PHYSICIAN ____ FAMILY _____ FRIEND _____ INSURANCE WEBSITE ____ DR BASS' WEBSITE
____ INTERNET ____ FACEBOOK ____ SETS _____ MAX FITNESS ____ OTHER_____
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WHO IS RESPONSIBLE FOR THE BILL (IF OTHER THAN PATIENT)? ____ SELF

NAME: _____

HOME ADDRESS: _____

HOME PHONE #: _____

INSURED/CARD HOLDERS EMPLOYER:_____

WORK ADDRESS:_____ PHONE #:_____
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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): _____
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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)
_____High Cholesterol
_____Heart Trouble
_____Circulation issues
_____Asthma
_____Kidney Disease
_____Liver Disease or Hepatitis
_____Epilepsy
_____Thyroid Conditions
_____Syncope (Fainting issues)
_____Other (please list): _____

Have you had any serious **ILLNESSES** or **OPERATIONS**? Yes____ No____
If yes, what type and when? (Please list)

ILLNESS OR OPERATIONS	**Date**
_____	_____
_____	_____
_____	_____

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, <u>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</u>. I also understand that payment is not dependent upon my insurance.

SIGNATURE: _____ **DATE**: _____
Signature of Patient or Legal Guardian

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 (2017-2018)? Yes __ No __
(2016-2017)? 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 main 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 finically 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, you 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: _____