Wayne Foot & Ankle Center, P.A. "We Care"

Patient last Name:	First Name:			Middle Initial:
Date of Birth:	Age:		SSN:	
Marital Status:	Single:	Married:	Widowed:	Divorced:
Address:		**City:**		**Zip code:**
Email Address:				
Home Phone # :		Cell Phone #:		
Employer:	Occupation:		Work #:	
Employer Address:				
Race:	**Ethnicity:** Hispanic/ Not Hispanic		**Prefer Language**:	
Primary Care Physician:	Last appointment date:		PCP Phone #:	
Spouse's Name/ Parent or Guardian Name if a Minor:				
Pharmacy Name, Address, & Phone#:				
Medical Insurance Information				
Primary Insurance:				
Primary Policy Holder's Name:	Date of Birth:		Relationship to Patient:	
Policy Holder's Address:				
Policy Holder's Phone #:		Employer Name:		
Member ID:	Group ID:		SSN:	
Secondary Insurance:				
Primary Policy Holder's Name:	Date of Birth:		Relationship to Patient:	
Policy Holder's Address:				
Policy Holder's Phone #:		Employer Name:		
Member ID:	Group ID:		SSN:	
Emergency Contact Information				
Person To Notify in Case of Emergency:			Relationship to Patient:	
Home #:	Cell #:		Work #:	
Referred By:				
☐ Physician:	☐ Patient:		☐ Family member	
☐ Insurance Co:	☐ Other:		☐ Online	

I understand that the above information is correct to the best of my knowledge. I also understand that it is my responsibility to inform Wayne Foot and Ankle Center of any changes to my medical status. I hereby consent and authorize Wayne Foot and Ankle Center and staff to perform any services deemed appropriate by attending physician(s) to make a thorough diagnosis. I also authorize Wayne Foot and Ankle Center, and staff, to perform any procedures, forms of treatment, medication and therapy in connection with my diagnosis and treatment plan, I understand that payment for services, procedures and treatment forms is solely and ultimately my responsibility. I understand that payment for services is due at the time that services are rendered, unless other financial arrangements have been made. I hereby authorize and request that all payments be made directly to Wayne Foot and Ankle Center. **There will be a $45 fee for returned checks.**

Signature: _____ **SIGN HERE**

Print Name: _____ **Todays Date:** _____/____/_____

Wayne Foot & Ankle Center, P.A. "We Care"

Patient's Name: _____ **Date of Birth:** ____/____/____

My Primary foot or ankle problem today is: _____

What is your height? _____Feet____Inches____ Shoe Size? _____

Medications			
Medication Name	For what Medical Condition?	**Medication Name**	For what medical condition?
1.		**5.**	
2.		**6.**	
3.		**7.**	
4.		**8.**	

Attach additional sheet if necessary

Medical History

Have you ever had any of the following? (Circle all that apply)

Seasonal allergies	Epilepsy/Seizures	Skin Ulcer
Stomach Ulcers	Heart Problems	Anemia
Arthritis	Hepatitis or Liver Disease	Stroke
Thyroid Disease	High Blood Pressure	Asthma
Bleeding Abnormality	HIV	Tuberculosis
Cancer/ Tumor	Kidney Disease	Neuropathy
Circulatory Problems	MRSA	Bunion
COPD	Sickle Cell	Callus (es)
Food Allergies	Skin Rash/ Hive	Diabetes

Other:_____

Allergies: Do you have any drug allergies or have you had any adverse reactions to any medication or anesthesia? ☐ Yes or ☐ No If so, what? _____
_____

Past Surgical Procedures / Hospitalizations

Are you Pregnant: ☐ yes ☐ No Are you Breastfeeding? ☐ Yes ☐ No

Family History

Parents:

Father Alive/ Deceased

Mother Alive/Deceased

Siblings: how many?

_____Brothers: Alive/ Deceased

_____ Sisters: Alive/ Deceased

Children: how many?

____Sons _____ Daughters

Wayne Foot & Ankle Center, P.A. "We Care"

Patient's Name: _____ **Date of Birth:** ____/____/____

Please note family history (Parents, siblings, children; living or deceased) for the following conditions

Disease//condition	No	Yes	Relationship to you:
Cancer			
COPD/Lung Disease			
Diabetes			
Heart Disease			
High Cholesterol			
Hypertension			
Stroke			
Other (specify):			

Social History

Do you currently smoke cigarettes? ___Yes
_____No (Never Smoked) ___No (**Former smoker**) if so, start date: _____ Quit date: _____
Number of yrs. You smoked? _____
Do you use any of these tobacco Products? ___Cigars ___Pipes ___Chewing Tobacco
Alcohol Use: ___ Never ___Rarely _____Socially _____Daily
Caffeine: __1-2 cups/ day ___3-4 cups/day __4+ cups/day
Do you use recreational drugs? ___Yes __ No If yes, what type? _____

ROS: Please Circle Any Symptoms you Have Had in the Past Month						
General:	Fever	Chills	Fatigue	Weight loss	weight Gain	Headaches
Allergy/ Immunology:	Seasonal Allergies	Congestion	Cough			
Ophthalmologic:	Corrective Lenses	Dry Eye	Red Eye	Glasses for Reading Only		
ENT:	Decreased hearing	Difficulty Swallowing	Nosebleed	Sinus Pain	Ringing in the ears	
Endocrine:	Diabetes	Difficulty Sleeping	Hair Loss			
Respiratory:	Asthma	Shortness of Breath	Wheezing			
Cardiovascular:	Chest Pain	Heart Murmur	Heart Disease	Irregular Heartbeat		
Gastrointestinal:	Abdominal Pain	Blood in Stool	Constipation	Heartburn	Nausea	
Hematology:	Anemia	Bleeding Problems	Easy Bruising			
Genitourinary:	Blood in Urine	Difficulty Urinating	Frequent Urination	Kidney Problems		
Musculoskeletal:	Arthritis	Back Problems	History of Gout	Leg Cramps	Sciatica	
Skin:	Dry Skin	Eczema	Skin Cancer			
Neurologic:	Balance Difficulty	Fainting	Seizures	Tingling/ Numbness	Tremors	
Psychiatric:	Anxiety	Depression				

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Patient's Name: _____ **Date of Birth:** ____/____/____

Payment Authorization Form

We are committed to meeting your healthcare needs and keeping your insurance and other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner for all patients, we ask that you adhere to our practice's financial policy. By signing below, you are agreeing to its terms.

1. I am ultimately responsible for payment of charges for services I receive from this practice including those covered by my insurance. As a convenience, this practice will submit claims for reimbursement with my insurance provider; however, all payment responsibility is ultimately mine.
2. Some immediate payment may be expected at the time of service. This may include a co-pay and additional payment if this practice determines that the cost of my visit today will not be reimbursed by my insurance provider. This often happens if my deductible is not yet satisfied.
3. This practice may deny service or charge a service fee for failure to pay a co-pay at the time of service.
4. It is my responsibility to provide my current address, telephone number, email address, and insurance information at each visit.
5. I agree to provide the above practice and/or its designated payment agent with my debit/credit card or AHC information.
6. I understand that my signature and payment information will be maintained on file digitally for future use by the practice. The applicable payment card or ACH information will be truncated and "tokenized" by the payment agent in order to help maintain the security of my payment information. Card or ACH Information will be obtained through a card swipe, manual entry from card, void check, or orally in person or over the phone.
7. If warranted, this practice may offer the option of paying my share of costs via an automated payment plan. I understand that I may incur some interest expense beyond my balance in exchange for this convenience. I can avoid interest charges by paying my bill immediately if required or by its due date.
8. I authorize the above practice and/or its designated payment agent to apply charges to my payment card and/or ACH account for all amounts owed to the practice for medical visits, procedures or supplies, including (I) amounts agreed as part of a payment plan, (II) copayments, (III) coinsurance (after application of insurance proceeds), (IV) amounts not covered by insurance and/or (V) fees (if applicable) charged by the practice for failure to keep a scheduled appointment or provide timely notice of appointment cancellation.
9. In the case of a patient balance that is not satisfied by a charge to my payment method or a payment plan, I may receive a monthly statement for any outstanding balance. I am responsible for paying this balance by its due date in order to avoid paying possible interest on the balance.
10. Transaction receipts will be maintained in the patient file or will be emailed to me if I provide and maintain a valid email address.
11. I authorize the above practice and/or its designated provider to send electronic account statements and invoices to my email address on file. I understand that it is my responsibility to maintain a current email address on file and that I will not receive a mailed copy of any electronic statement.

This authorization will remain in effect until I provide written notice of cancellation to the practice. Authorization for services already rendered cannot be cancelled or refunded. I agree to notify the practice in writing of any changes in my payment or other information.

_____ _____@_____ (_____)_____-_____

Name as it Appears on Card/Check **Email Address** Phone Number

_____ _____ _____ _____

Billing Address City State Zip Code

AUTHORIZED SIGNATURE: _____ **SIGN HERE**

DATE: _____/_____/_____

Wayne Foot & Ankle Center, P.A. "We Care"

Patient's Name: _____ **Date of Birth:** ____/____/____

Financial Policy

Thank you for choosing **Wayne Foot and Ankle Center** as your ankle and foot care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our financial policy is important to our professional relationship. Please understand that payment for services is part of that relationship. Payment will be due at the time services are rendered. In order to serve you better, we accept Cash, Check, Money Order, Care Credit, and all major Credit Cards. In our ongoing effort to make sure that all your medical needs are met, our staff is available to discuss our fees, policies, and your responsibilities with you. We ask that all responsible parties read and sign our financial policy as well as complete the patient information forms prior to your scheduled visit. As the responsible party, please understand and **initial the following**:

Initial _____ 1. Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Initial ---------- 2. Certain health insurances (HMO,POS, etc.) require that you obtain a referral or prior authorization from you Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if not obtained.

Initial --------- 3. Fees for services, which include, unpaid balances, deductibles, co-payments, co-insurances, and non-covered over the counter products are due at the time of service unless previous arrangements have been made with a billing coordinator. Absolutely no post-dated checks will be accepted. You understand and agree that if you fail to make payments for which you are responsible in a timely manner, such default will result in referral to a collection agency. You will be responsible for all costs of collecting monies owed, including collection agency fees.

Initial _____ 4. The charge for a returned check is **$35.00** payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check. Unpaid returned check fees and balances will be subject to collection placement.

Initial _____ 5. Our practice offers X- ray, Non- Invasive Vascular Studies, as well as custom orthotics. As with other professional services, we will bill your insurance for these services; however, should your insurance not cover the charges, you may ultimately be held financially responsible._

Initial _____ 6. Completion of Forms (e.g. Disability or Family Medical Leave) and Copies of Medical records are not a billable reimbursement by insurance carriers. Therefore, you are responsible for the $10.00 fee related to the completion of these documents. Payment is due when forms are presented for completion.

Initial _____7. Failure to pay your full balance within 60 days of the most recent statement will result in your account being turned over to collections.

This financial policy helps Wayne Foot and Ankle Center provide quality care to our valued patients. If you have any questions or need clarification regarding any of the above policies, please feel free to contact our billing department at 973-595-8900.

I UNDERSTAND THE ABOVE INFORMATION AND WILL BE RESPONSIBLE FOR THE PATIENT LISTED BELOW

Print Name of Patient:_____Date:_____

Signature of Patient or Responsible Party:_____ **SIGN HERE**

Name and Relationship if other than patient:_____

Wayne Foot & Ankle Center, P.A. We Care"

Patient's Name: _____ **Date of Birth:** ____/____/____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient Name (Please print :)_____Date:_____

Parent or Authorized Representative (if applicable):_____

Signature:_____ **SIGN HERE**

SUMMARY OF NOTICE OF PRIVACY PRACTICES

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization.

In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern, or complaint regarding our privacy practices, please inform your Doctor.

Wayne Foot & Ankle Center, P.A. "We Care"

Patient's Name: _____ Date of Birth: ____/____/____

Patients:

To ensure your privacy, please answer the following questions and notify the Front Office Staff whenever this information change.

1. Do we have permission to leave a message on the phone number(s) you have provided to us?

   YES ☐ or NO ☐

2. May we discuss your Medical Information with family and friends?

   YES ☐ or NO ☐

Please list names of people we can discuss your medical care with:

Name:_____ Phone #: ----------

Patient's Relationship to contact: ☐ Spouse ☐ Parent ☐ Child ☐ Friend

Name:_____Phone #

Patient's Relationship to contact☐ Spouse ☐ Parent ☐ Child ☐ Friend

Name:_____phone #: _____

Patient's Relationship to Patient: ☐ Spouse ☐ Parent ☐ Child ☐ Friend

3. If someone calls for you or asks for you while you are in our office, do we have permission to tell the individual you are here? YES ☐ or NO ☐

Patient Signature:_____ **SIGN HERE**

Patient Name (Printed):_____Date: _____