Roselle Podiatry Group
776 E. 3rd Avenue Suite 2
Roselle, NJ 07203
Patient Information Forms

Please print clearly & fill out form completely.

Today's Date: _____

PATIENT INFORMATION

Last Name: _____ First: _____ Middle: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Birthdate: _____ Age: _____ □ Male □Female Email Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact: _____ Phone No: _____ Relationship: _____

Employer Name: _____ Employer Address: _____

Marital Status: □ Single □Married □Divorced □Separated □Widow □Other

Social Security No: _____ Ethnicity: □White □African American □Hispanic □Asian □Other

INSURANCE INFORMATION

Insurance Name: _____ Policy ID: _____ Group#: _____

Policy Holder's name: _____ birthdate: _____ relationship: _____

2nd Insurance Name: _____ Policy ID: _____ Group#: _____

Policy Holder's Name: _____ birthdate: _____ relationship: _____

Policy Holder's social security no: _____ (if different than patient)

Responsible Party Information- *Please complete if the party responsible for payment is not the Patient or the Policy Holder.*

Responsible Party's Name: (Last/First)_____

Responsible Party's SSN & Birthdate: _____ Relationship to Patient: _____

Responsible Party's Address: _____

Primary Care Physician: _____ Address: _____

When was your last visit with your primary doctor? (Date) _____

Preferred Pharmacy: _____ Address: _____

How did you hear about our office? □Doctor □Patient □Internet □Friend □Other: _____

May we leave voicemail on your home/cell phone to confirm appointments? □ Yes □ No

PODIATRY HISTORY

What is the chief concern for which you came to be treated?

_____

When did you notice the problem? _____ Any other concerns? _____

Have you seen a podiatrist before? □ Yes □ No If yes, please list:

Name: _____ last visit : _____

Please indicate which foot problem(s) you now have or had:

Ankle Pain □Yes □No	Arthritis □Yes □No	Athlete's Foot □Yes □No
Corns and Calluses □Yes □No	Cramps in legs □Yes □No	Cramps in feet □Yes □No
Numbness in feet □Yes □No	Gout □Yes □No	Heel Pain □Yes □No
Ingrown Toenails □Yes □No	Plantar Warts □Yes □No	Arch Problems □Yes □No
Tired feet □Yes □No	Swelling in ankles/feet □Yes □No	Varicose Veins □Yes □No

MEDICAL HISTORY

Do you have any allergies? □Yes □No if yes, please check all that apply

Adhesive YES NO	Anti-Inflammatory YES NO	Aspirin YES NO	Codeine YES NO
Demerol YES NO	Iodine YES NO	Latex YES NO	Anesthetics YES NO
Morphine YES NO	Penicillin YES NO	Seafood/shellfish YES NO	Sulfa/sulfer YES NO
Food allergy: YES NO	Dairy YES NO	Other:	

Please mark yes or no to indicate if you have had any of the following:

AIDS/HIV YES NO	ARTHRITIS YES NO	ASTHMA YES NO
CANCER YES NO	CIRCULATORY YES NO	DIABETES YES NO
KIDNEY DISEASE YES NO	HEART DISEASE YES NO	LOW/HIGH BLOOD PRESSURE YES NO
HIGH CHOLESTEROL YES NO	LIVER DISEASE YES NO	BLEEDING ISSUES YES NO
PSYCHIATRIC YES NO	STROKE YES NO	VARICOSE VEINS YES NO
GOUT YES NO	TOBACCO USE YES NO	ALCOHOL USE YES NO
DRUG USE YES NO	EPILEPSY YES NO	TUBERCULOSIS YES NO
NEUROPATHY YES NO	STROKE YES NO	OTHER:

Surgeries/Hospitalizations Y / N Women Only: Are you pregnant? Y / N if yes, due date: _____

What is your height _____ weight _____ Shoe size _____ was your blood pressure normal? Y / N _____

Have you had orthotics before? Y / N Cortisone shots Y / N Foot Surgery Y / N when? _____

Is this injury work related? Y / N Was your injury due to an auto accident? Y / N if yes, what state _____

Do you smoke cigarettes? Y/N Quit? When:_____ Do you drink alcohol? Y/N Ocassionally __

I hereby assign the policy rights and benefits to the doctor, and authorize direct payment for professional services rendered. I further authorize the doctor to release any information concerning my examination or treatment to my insurance company. I agree to be personally responsible for any unpaid balance, co-payment or co-insurance to the doctor. If I receive payments in error, I will sign them directly over the doctor. I hereby authorize the doctor to treat me for correction and alleviation of the above mentioned complaints and conditions.

Patient Signature: _____ **Date:** _____

(or parent if patient is a minor)

Roselle Podiatry Group
776 E. 3rd Avenue Suite 2
Roselle, NJ 07203

MEDICATION LIST

Patient Name: _____ birthdate: _____

Please check box ONLY if the patient takes no medicines
□ No medications

Please list all medications prescribed by your doctor, or over the counter medications as well as vitamins, herbs & eye drops.

Medication Name	Dosage	How many times per day?

Do you give our office permission to review your prescription history? Y / N
Do you accept and agree to e-prescribing? Y / N (prescriptions will be sent electronically to your pharmacy, it is fast & safe.

TO OUR MEDICARE PATIENTS

MEDICARE REQUIRES WRITTEN NOTIFICATION OF THE FOLLOWING:

If you are being treated for routine care, which includes cutting and grinding of mycotic, painful toenails and/or you have a systemic condition (such as diabetes or peripheral vascular disease) which requires professional foot care, Medicare will only pay for these services if it has been 63 days or more since you've been last treated. The doctor will inform you if you qualify for coverage based on Medicare's strict criteria.

If you are seen less than 60 days apart from your last visit for routine foot care, (cutting and grinding of nails) MEDICARE will deny the service and you will be fully responsible for payment.

Please remember this Medicare ruling when scheduling an appointment. When possible, please ask our receptionist when you are due for an appointment for cutting and grinding of your nails.

Also, as of January 1, 1996, Medicare may deny certain routine foot care procedures. If any services are denied, the patient is responsible for our total fee and will be billed accordingly.

I have read the above and understand the Medicare ruling regarding routine foot care.

PATIENT SIGNATURE: _____ **DATE:** _____

Roselle Podiatry Group

Financial Policies

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our Professional relationship. Please ask if you have any questions about our fees, or your financial responsibility. The patient or responsible party is responsible for seeing that the entire bill is paid in full. Responsible parties will be responsible for any collection fees, interest, and other expenses necessary to collect on any account, including court costs, should legal action be necessary to collect payment.

We will ask to see your insurance card on your first visit and will scan your card into our system as needed to keep our information current. We will ask this information at every visit, in order to ensure that no change in benefits or carrier has occurred. Please notify us if your insurance carrier or policy has changed. Billing of insurance is a courtesy we provide to our patients and is not required by law.

PLEASE READ AND INITIAL EACH LINE BELOW ACKNOWLEDING YOU HAVE READ ALL POLICIES.

_____ **CO-PAYMENTS:** Your insurance **REQUIRES** that we collect your designated co-pay at the time of service. Please be prepared to pay the co-pay at each visit. We will not bill you for your co-pay.

_____ **DEDUCTIBLES AND CO-INSURANCE:** We may collect your deductible and co-insurance at the time of service. RPG will bill your insurance company. Patient responsibility portions of your bill are to be paid within 90 days.

_____ **SELF-PAY/UNINSURED:** Self-Pay account shall exist if a patient has no insurance coverage or no evidence of insurance coverage. For new patients, a payment of **$** _____ is required on the day of your visit before being seen by our podiatrist. If you are unable to pay the amount required, you will not be seen.

_____ **REFERRALS:** If your insurance plan requires a referral from your primary care physician it is your responsibility to obtain it before your appointment and have it with you at the time of your appointment. If you do not have your referral, **YOU WILL BE REQUIRED TO RESCHEDULE.**

_____ **RETURNED CHECK FEES:** Any returned check from your bank for non-payment (insufficient funds) shall result in the patient's account being accessed a $**30.00** fee per check returned.

_____ **NO SHOW FEE:** You will be charged a **$25.00** fee if you fail to cancel your appointment with 24 hours of your scheduled appointment or do not show for your appointment.

_____ **SURGERY CANCELLATION FEE:** Any surgeries cancelled within 7 business days of the scheduled surgery date will incur a cancellation fee of **$500.00** (Fee will be waived if surgery is canceled due to a death in the family, illness or if the patient is not cleared for surgery)

RESPONSIBLE PARTY SIGNATURE: _____ **DATE:** _____

Patient Name (if different from responsible party): _____

NO SHOW & CANCELATION POLICY

Cancellation of an Appointment

In order to be respectful of the podiatric needs of our community, please be courteous and call promptly if you are unable to attend your appointment. This time will be reallocated to someone who is in urgent need of treatment. This is how we can best serve the needs of our community. If it is necessary to cancel your appointment, we require that you call 24 business hours in advance. Appointments are in high demand, and your early cancellation will give another patient the possibility to have access to timely podiatric care.

No show Policy

A "no show" is someone who misses an appointment without calling to cancel the appointment 24 hours in advance. (for example, you appointment is at 3pm on Tuesday. You will need to call us by 3pm on Monday, the day before your appointment) No shows inconvenience those individuals who need access to medical care in a timely manner. A failure to show at the time of your appointment will be recorded in your chart as a no-show, a fee of $25.00 will be billed to your account and sent to your home. This fee covers administrative tasks associated with your appointment. This fee is not covered by your insurance. This fee will need to be paid in full before scheduling any further appointments. 3 (three) no shows in a 12 month period of time will result in discharge from our practice.

By signing below, you understand and agree to our no show and cancellation policy.

_____ _____

Patient Signature (or parent if patient is minor) Date

Roselle Podiatry Group
776 E. 3rd Avenue Suite 2
Roselle, NJ 07203

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of Notice of Privacy Practices or have had the opportunity to receive a copy of Notice of Privacy Practices from Roselle Podiatry Group. In this notice I was advised of how health information about me may be used or disclosed by Roselle Podiatry Group.

_____ _____

Name of patient (Print) Patient Date of Birth

_____ _____

Signature of patient or Personal Representative Date

_____

Print Name of Personal Representative (if person signing is other than the patient)

_____

Personal Representative's Authority to Act. (parent, guardian, power of attorney stating relationship to the individual making the request.

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because: (Please specify reason below):

A copy of our privacy practices will be given upon request.