

FEET 'N BEYOND OF NEW JERSEY, P.A.

REGISTRATION (please print)

Tel: 908-576-0880

Facsimile: 908-576-0881

Date ____/____/____ Home Phone (____) _____ Cell Phone (____) _____

May we leave message on your home phone ____Yes ____No and/Or On your cell phone ____Yes ____No

PATIENT'S INFORMATION __DR. __MR. __MRS. __MISS

Name _____ Birthday ____/____/____

Address _____ City _____

State _____ Zip _____ Email _____

Ethnicity African American Asian Caucasian Hispanic other: _____

Marital Status Married Divorced Widow Single Minor

Employer name/School _____ Occupation _____

Employer/School Phone# _____

Primary Doctor _____ Phone (____) _____

Primary Doctor's address _____

When was the last date you saw your doctor ____/____/____ *please approximate*

In case of emergency who should be notified? _____ Phone (____) _____

How did you hear about us? __ Newspaper (Weekly, Reporter, Record) __ Insurance __ PCP Referral
__ Friend/Family (name _____) __ other: _____

The reason(s) that bring you to the foot doctor today is/are _____

How long have you had this problem? ____ Days ____ Weeks ____ Months ____ Years

Was this problem treated? __ Yes __ No, If yes, what was done? _____

Past Medical & Podiatry history (please check all that applies to indicate if you or patient has the following)

__ AIDS/HIV __ Anemia __ Arthritis __ Asthma __ Back problems/pain __ Bleeding Disorder

__ Bruise easily __ Circulation problem __ Diabetes __ Eye/Ear problem __ Heart disease/attack(s)

__ Heart bypass __ Hepatitis __ High blood pressure __ Kidney disease __ Leg cramps __ Liver disease

__ Lung disease __ Tuberculosis __ Other _____

Current Medications _____

Do you have any allergies to medications or food? __ Yes __ No, If yes, what are you allergic to? _____

Shoe Size _____ Weight _____ Height _____ Surgeries you have had _____

MEDICAL DOCUMENTATION POLICY

Under the Privacy Act and regulation by HIPAA: This office can not release any records regarding your treatments and/or medical status. There are situations; however, such as emergencies or legal proceedings where your medical records are needed...our office would like to know what you would like us to do in such situations.

Please choose below: ****

___ DO NOT release my medical records to anyone (including my family) under any circumstances which includes emergencies, legal proceedings, hospitalizations etc... (I will obtain my records in person by filling out a request)

___ I allow this office to release my medical records to my spouse and/or family without me being present—please provide us family members' name and their relation to you on the line provided below. *(Only the names listed will be allowed to access)*

___ I allow this office to release my medical records to my attorney (provide Law firm's name and contact person phone #) _____

****** Medical Documentation Release Policy: Feet 'N Beyond of New Jersey, P.A. reserves the right to hold and delay any request for a patient's medical records for 3 to 10 business days for review and/or consultation of our legal experts.**

CONSENTS FOR TREATMENTS AND PHOTOGRAPH

I certify that the above information is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of any medical conditions within the doctor's scope of practice.

I agree to allow Feet 'N Beyond of New Jersey, P.A. to take pictures of my feet, lower leg and/or ankles. I also understand that these pictures may be used for any of the following purposes: historical reference, diagnostic, teaching, research, and/or presentations. I also understand that my face, name, and any other personal information will not be disclosed.

Patient/Authorized Signature _____

Date _____

INSURANCE INFORMATION

To provide accuracy in insurance billing submission, please provide the information below:

Primary Insurance Company: _____

Coverage Holder Name : Self other: _____ Relationship: _____

Secondary Insurance Company: _____

Coverage Holder Name : Self other: _____ Relationship: _____



FINANCIAL POLICY FOR FEET 'N BEYOND OF NEW JERSEY, P.A.

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high 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% of 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 co-payments and deductible must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment 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 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 your 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 up to three notices for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account may be forwarded to collections. 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, Debit, VISA/MasterCard/AMEX/Discover. An additional \$25.00 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 to our office to be applied to your balance.

I have read the above policy regarding my *financial responsibility* to **Feet 'N Beyond of New Jersey, P.A.** for medical services provided. I agree to pay **Feet 'N Beyond of New Jersey, P.A.** any balance unpaid by my insurance carrier for myself or the below named person.

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.

PATIENT ACKNOWLEDGE OF NOTICE OF PRIVACY PRACTICES: By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have (or had the opportunity to read if I so chose) and understand the Notice and agree to its terms.

ASSIGNMENT OF BENEFITS

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **Feet 'N Beyond of New Jersey, P.A.** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, 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 physician 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 information and acknowledge I have read and provided with a copy of the Notice of Privacy Practices and understand and accept its terms:

PRINT Patient Name: _____ Signature: _____ Date: _____

FINANCIALLY RESPONSIBLE PARTY:

PRINT Name: _____ Signature: _____ Relationship to Patient: _____

