# PATIENT INFORMATION & HEALTH RECORD

In order to help us render the proper podiatric services to you please complete this form in its entirety. We thank you for your cooperation.

Today's Date _____ Social Security Number _____ - ____ - _____

Sex ○M ○F Date of Birth ____/___/_____ Home Phone (____) _____ - _____

Email _____ Cell Phone (____) _____ - _____

Name _____ Marital Status S M W D

Address _____ Apt/Unit # _____

Town _____ State _____ Zip _____

Employer _____ Occupation _____

Employer Address _____ Town _____ State ____ Zip_____

Work Phone (____) _____ - _____ Extension _____

Spouse's Name _____ Date of Birth ___/___/____ Home Phone (___) ____ - _____
(or if a child, responsible parent's/guardian's name)

In Case of emergency, contact _____ Phone (____) _____ - _____

Nearest Relative _____ Phone (____) _____ - _____
(not living with you/significant other)

Family Physician _____

Physician's Address _____ Phone (____) _____ - _____

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## INSURANCE INFORMATION

Name of Card Holder _____ Relationship to Patient _____

Name of Insurance Company _____

Insurance Address _____ Town _____ State ____ Zip_____

Insurance Phone (____) _____ - _____ Employer of Card Holder _____

Policy # on Card _____ Group # (if any) _____
(Include any prefixes ex - "XWG", "R", "C", without them, your claim will be rejected by your Ins. Co.)

DOB of Card Holder ____/___/_____

## SECONDARY INFORMATION

Name of Card Holder _____ Relationship to Patient _____

Name of Insurance Company _____

Insurance Address _____ Town _____ State ____ Zip_____

Insurance Phone (____) _____ - _____ Employer of Card Holder _____

Policy # on Card _____ Group # (if any) _____
(Include any prefixes ex - "XWG", "R", "C", without them, your claim will be rejected by your Ins. Co.)

DOB of Card Holder ____/___/_____

Were you referred by (circle one) Friend Physician Phone book Website
(If by a friend, please give us their name. If by phone book or website, let us know which one)

Name of person/ad _____ Other/Not Listed _____

Describe Your Foot Problem _____

Have you had previous surgery? ---SELEC Type of procedure(s) _____

Name of Doctor Who Performed Surgery _____

Date of Surgery (approx.) _____

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HEALTH INFORMATION

Height _____ Weight _____ Age _____

Please check of any of the following for which you have been or are being treated:

| | | | |
|---|---|---|---|
| _____ | Arthritis | _____ | HIV |
| _____ | Rheumatic Fever | _____ | Epilepsy/Seizure |
| _____ | Scarlet Fever | _____ | Asthma |
| _____ | Hypertension | _____ | Emphysema |
| _____ | Cardiac Disease/High Cholesterol | _____ | Glaucoma/Cataracts |
| _____ | Peripheral Vascular/Arterial Disease | _____ | Sexually Transmitted Disease |
| _____ | Tuberculosis | _____ | Renal Disease (Kidney) |
| _____ | Gout | _____ | Polio, Cerebral Palsy, Muscular Dystrophy |
| _____ | Cerebral Accident (Stroke) | _____ | Phlebitis/Thrombosis/Blood Clots |
| _____ | Diabetes (Insulin or Pill) | _____ | Thyroid |
| _____ | Liver Disease (Hepatitis) | _____ | Anemia/Bleeding Disorder |

Other (Please State) _____

Allergies: Are you allergic to any of the following? Please circle any that may apply.

| | |
|---|---|
| Penicillin | Asprin |
| Novocain/Local Anesthetics | Barbiturates |
| Iodine/Dyes | Caffeine |
| Tetracycline | Sulfa Drugs |
| Codeine | Cortisone |
| Adhesive Tape | Other _____ |

Are you taking any medication(s)? ---SELEC
If yes, please provide a detailed list below.

_____

Are you currently under a doctor's care? ---SELEC

Have you had previous surgery or hospitalization for any other conditions? ---SELEC
If yes/ please provide approximate dates ____/___/_____ ____/___/_____

# OUR FINANCIAL POLICY

We are pleased that you have chosen us as your pediatric care provider. We are committed to your treatment being successful and are certain you will be happy with the care provided by our staff. The following is a statement of our Financial Policy, and we ask you to read and sign PRIOR to any treatment.

ALL patients must complete our patient information record before being examined by the doctor.

## REGARDING INSURANCE

As a convenience to our patients, we submit claims to your insurance company on your behalf. We cannot bill your insurance company unless you bring all insurance information (this may include referrals). Patients who are enrolled in an HMO or POS program must present a referral prior to being seen by the doctor if required. Failure to do so will result in a rescheduling of the appointment. WE CANNOT RELY ON THE PCP's office to fax it to us. If we do not nave the referral and you choose to be seen by the doctor, payment in full for the visit/treatment will be required at the time of the visit. NO backdated referrals will be accepted!

We do require that all co-pays, deductibles and services not covered by your insurance be paid at the time of service. (This may include post-operative supplies, orthopedic appliances, and medications considered “over the counter" items). Any credit card/HSA transactions are subject to a 2% surcharge.

Your insurance policy is a contract between you and your insurance company. In the event that your insurance company has not paid your account within 45 days, the responsibility to pay the balance will automatically be transferred to you. Please be aware that some or all services provided by our doctors may not be covered and not considered reasonable or necessary under the Medicare Program and/or other insurance plans. Any non-covered services or amounts not paid by your insurance company are due within 30 days of the billing date. A rebilling fee of S10 per month may be added to the unpaid balance of your bill that is 30 days or more past due.

Again, we bill your insurance company as a courtesy. The insurance industry is changing every day; we will make every effort to assist you, however, it is ultimately the patient's responsibility to know and be aware of his/her coverage, deductibles, co-pays, and limitations. If your insurance should change or if any information pertaining to yourself, your employer, and/or your dependents should change, please notify us as soon as possible to avoid any delays in processing.

## USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. However, each individual insurance carrier has its own "fee schedule".

## MISSED APPOINTMENTS

Please help us serve you better by keeping scheduled appointments. If you are unable to keep an appointment, we require that you notify the office at least 24 hours in advance.

Thank you for reviewing our Financial Policy. Please let us know if you have any questions.

I have read the Financial Policy; I hereby authorize Hoboken Ankle & Foot Center, PA to apply for benefits on my behalf for services rendered by Drs. Llpkin and Granata. I request payments to be made directly to Hoboken Ankle & Foot Center, PA. I certify that the information given is true and correct to the best of my ability. I further authorize the release of necessary information, including medical information for this or any other related claim to my insurance company. I permit a copy of this authorization to be used in place of the original. I hereby give permission to Hoboken Ankle & Foot Center, PA to examine and treat my feet medically-and orthopedically.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Co-responsible Party Date

# ACKNOWLEDGMENT OF RECEIPT

OF

# NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of 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

HOBOKEN ANKLE & FOOT CENTER

WILLIAM J. LIPKIN, D.P.M.*
MARK GRANATA, D.P.M.• t
• Fellow of American College of Foot & Ankle Surgeons
• Board Certified by American Board of Foot & Ankle surgery
t · Fellow of American Collage of Foot & Ankle Orthopedics
t • Board Certified In Podiatric Orthopedics & Primary Medicine

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Tel: (201) 656-4608
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# Appointment Cancellation Policy

Patient's name:_____ Date of birth:_____

We understand that there are times when you must miss an appointment due to emergencies, traffic situations, or obligations for work or family. However, when you do not call to cancel an appointment or inform us of any tardiness, you may be preventing another patient from getting much needed treatment The situation may *also* arise where another patient fails to cancel their appointment and we are unable to schedule you for a visit or you may experience a normal than usual timeframe to have an appointment scheduled with us.

If an appointment is not cancelled at least 24 hours in advance and you do not arrive for your appointment, you will be charged a $45.00 fee. No further appointments will be scheduled for you until the $45.00 cancellation fee is paid. This fee will not be reimbursed by your insurance company, nor will it be credited toward a future appointment This will apply to all commercial,government (federal/state) and uninsured patients.

Since we understand that illness or other problems can occur, and sometimes without anywarning, we will not charge you for your first missed or non-cancelled appointment.

1bis policy is in effect for all appointments at all our office locations. Please acknowledge tha tyou have had the opportunity to review this policy by signing below.

Thank you for your understanding and cooperation.

_____ _____
Patient signature (or parent/guardian if patient is a minor) Date

_____ _____
Witness (or staffmember's signature if none present) Date

# COVID-19 SCREENING HANDOUT

REVISED DATE: 4/21/2020

## OUR PATIENTS' SAFETY IS OUR PRIMARY GOAL.

## PLEASE ANSWER THE QUESTIONS BELOW TO DETERMINE IF YOU PRESENT A COVID-19 RISK.

| | | |
|---|---|---|
| Have you traveled in the past 14 days?<br>Where? _____ | □ YES | □ NO |
| Have you had contact with a person who has traveled within the last 14 days? | □ YES | □ NO |
| Have you had contact with a person who has been diagnosed with the Coronavirus disease? | □ YES | □ NO |
| Have you tested positive for COVID-19?<br>If so, when? _____ | □ YES | □ NO |

Have you had any of the following symptoms in the past 14 days? (Check Boxes that Apply)

- □ Fever
- □ Chills/Repeated Shaking with Chills
- □ Muscle Pain
- □ Recent Onset Cough
- □ Shortness of Breath
- □ Other Acute Respiratory Symptoms
- □ Sore Throat
- □ New Loss of Taste or Smell