

AFFILIATED FOOT AND ANKLE CENTER, LLP

Patient: _____ Date _____
(Full name)

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

Home Phone: (_____) _____ Date of Birth: _____ Age: _____

E-mail address (will not be shared in any way): _____

Sex: M F Occupation: _____ Cellular #: (_____) _____

Employer: _____ Work Phone: (_____) _____

Business Address: _____

Spouse's Full Name: _____ Occupation: _____

Your Pharmacy: _____ Town: _____ Phone #: _____

Emergency Contact - Name: _____ Phone: (_____) _____



SS#: _____ Medicare #: _____

Primary Ins. Co.: _____ Policy #: _____

Name of Insured: _____ Group #: _____

Soc. Sec. # of Insured: _____ D.O.B of Insured: ___/___/___ Relationship: _____

Secondary Ins. Co.: _____ Policy #: _____

Name of Insured: _____ Group #: _____

Soc. Sec. # of Insured: _____ D.O.B of Insured: ___/___/___ Relationship: _____

Referred by: _____ Date of Last Physical : _____ By Whom: _____

Family M.D. _____ Address: _____



What is your foot problem(s): _____

Shoe Size: _____ Have you ever worn custom made arch supports (orthotics) Y N Do you smoke? Y N

Illnesses: (Check those which apply):
 Poor Circulation Heart Disease Liver Disease Diabetes Arthritis Anemia Kidney
Problem Hepatitis Lung Problems Back Problems Bleeding Disorders Asthma Gout
 High Blood Pressure Rheumatic Fever Stroke Back Pain Neck Pain Numbness in Feet

Allergies to Medications: (Check those which apply):
 Penicillin Aspirin Codeine Adhesive Tape Iodine
 Sulpha Sea Food Local Anesthetic Other: _____

Medication Taking: (Prescription and non-prescription) _____

Prior Surgery or Illnesses: _____

I hereby give my permission to the doctors at Affiliated Foot and Ankle Center, LLP to perform diagnostic, therapeutic and/or operative procedures as may be deemed necessary in diagnosis and/or treatment of my feet and/or ankles.

PATIENT SIGNATURE: _____ DATE: _____

FINANCIAL POLICY FOR AFFILIATED FOOT AND ANKLE CENTER, LLP

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 or VISA/Mastercard. 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 Affiliated Foot and Ankle Center, LLP for medical services provided. I agree to pay Affiliated Foot and Ankle Center, LLP any balance unpaid by my insurance carrier for myself or the below named person.

Assignment of Benefits

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **Affiliated Foot and Ankle Center, LLP** 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.

PRINT Patient Name: _____

Signature: _____

FINANCIALLY RESPONSIBLE PARTY:

PRINT Name: _____

Signature: _____

Relationship to Patient: _____ Date: _____

Podiatric Pain Analysis Survey

Affiliated Foot & Ankle Center, LLP

PODIATRIC MEDICINE • FOOT & ANKLE SURGERY • SPORTS MEDICINE
Dr. Alison DeWaters • Dr. Varun (Ben) Gujral • Dr. Jasen Langley • Dr. Hal Ornstein
4645 Hwy 9 North, Howell NJ 07731 • 2163 Oak Tree Road, Suite 108, Edison NJ 08820
300 Overlook Road, Monroe NJ 08831 • 32 Tennyson Street, Carteret, NJ 07008

Name: _____

Phone: _____ Age: _____

Please check any of the following conditions you are currently experiencing or suffering from:

- | | |
|---|---|
| <input type="checkbox"/> Flat Feet | <input type="checkbox"/> Pain in feet or legs at rest |
| <input type="checkbox"/> Poor coordination | <input type="checkbox"/> Pain in feet or legs with exercise or activity |
| <input type="checkbox"/> Heel or Arch Pain | <input type="checkbox"/> Feet/Toes feel numb |
| <input type="checkbox"/> Leg pain (shin splints) | <input type="checkbox"/> Foot/Toes/Legs burn |
| <input type="checkbox"/> Achilles tendon pain | <input type="checkbox"/> Difficulty/Pain with brisk walking or running |
| <input type="checkbox"/> "Toe-in" or "Toe-out" gait (walking) | <input type="checkbox"/> Discoloration of toes/foot |
| <input type="checkbox"/> Ankle swelling or stiffness | <input type="checkbox"/> Pain legs occurs at the same distance every time |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Coldness in the legs or feet that is uncomfortable |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Non / Poor healing sore on the leg or foot |
| <input type="checkbox"/> Ankle instability (easy twisting injuries) | <input type="checkbox"/> Do your legs feel heavy, tired, restless, or achy |
| <input type="checkbox"/> Have you had a Deep Vein Thrombosis (DVT) and are experiencing pain, swelling, | |
| <input type="checkbox"/> Change in skin color, cellulites, or non-healing ulcers? | |

Please answer the following about the above conditions:

Do the above conditions disrupt your lifestyle and activities of daily living? Yes / No

Is this condition causing or are you suffering with any of the following:

- | Tingling/Numbness in: | Pain radiating into: | Weakness of the: | Difficulty with: |
|--------------------------------------|--------------------------------------|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Legs R / L | <input type="checkbox"/> Ankle R / L | <input type="checkbox"/> Legs R / L | <input type="checkbox"/> Standing |
| <input type="checkbox"/> Ankle R / L | <input type="checkbox"/> Feet R / L | <input type="checkbox"/> Ankle R / L | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Feet R / L | <input type="checkbox"/> Toes R / L | <input type="checkbox"/> Foot R / L | <input type="checkbox"/> Sitting |
| | | | <input type="checkbox"/> Bending |
| | | | <input type="checkbox"/> Lifting |
| | | | <input type="checkbox"/> Kneeling |

How long have you been suffering with this condition? Days / Weeks / Months / Longer

Is this condition affecting your ability to perform daily tasks? Yes / No

Would you like to get rid of or reduce this problem? Yes No

There may be treatment options or solutions for the pain you are experiencing. Please let us know what you would like to do today.

- I would like to discuss the above conditions with the Doctor so I can make an educated decision about my health.
- If it were available, I would be interested in receiving treatment for this condition in this office.
- If available, I would be open to have a medical test to further evaluate my problem.

Patient Signature

Physician Signature

Office Policies Regarding Managed Care Insurance Plans

We understand that the many changes in the health care system have made it quite confusing for our patients. The following are guidelines that have been established by the insurance companies to allow reimbursement for services we provide:

- You are responsible for obtaining and bringing referrals at the time service is rendered.
- Be aware that referrals may be for one visit or more. This is clearly indicated on the referral form.
- Referrals do expire. Most are good for either sixty or ninety days. This is also indicated on the referral form.
- A consultation report will be sent to your primary care doctor after the first visit and follow-up reports will be provided as necessary.
- You are responsible for your co-pay at the time your treatment is rendered.
- If you do not have a referral for a visit, you are responsible for full payment.
- Primary care physicians have indicated that they can not be called with a patient in the office for a referral for that particular visit. Referrals must be obtained before your visit to our office. Primary care physicians often need several days to provide you with a referral.

We are always available to help you with any questions regarding your insurance and treatment in our office. Thank you.

Our Patient's Bill of Rights

As patient and physician, ours is more than a relationship, it's a partnership. To ensure this, we have lived by the following principles:

- A patient has the right to know what his or her condition is and what trouble it is likely to cause.
- A patient has a right to have the condition explained in real terms, not medical terms.
- A patient has the right to know our qualifications and experiences.
- A patient has the right to consult other doctors without us being insulted or angry that the patient wants another opinion.
- A patient has a right to understand our fees.
- We will spend a patient's money wisely as possible. We will look for and recommend the most cost effective way of solving our patient's problems.
- We will not recommend surgery unless the patient needs help that only surgery can provide.
- If a patient feels that we have not provided them with our best efforts, please make this known. We can not guarantee results of treatment, but we can guarantee you our best efforts to treat you honestly and fairly.
- If a patient has financial problems, our office is committed to making arrangements so proper, necessary care is always provided.
- Considerate, respectful care at all times and under all circumstances with recognition of your personal dignity.
- Personal and informational privacy, within the law.
- Confidentiality of records and disclosures. Except when required by law, you have the right to approve or refuse the release of records.
- The opportunity to participate in decisions involving your health care, unless contraindicated by concerns about your health.
- Impartial access to treatment regardless of race, color, sex, national origin, religion, handicap or disability.
- Know the identity and professional status of individuals providing service to you.

Affiliated Foot and Ankle Center, LLP.

4645 Route 9 North - Howell, NJ 07731

(732)905-1110 Fax (732)905-7885

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Affiliated Foot and Ankle Center, LLP. (the “Practice”), in accordance with the federal Privacy Rule, 45 CFR parts 160 and 164 (the “Privacy Rule”) and applicable state law, is committed to maintaining the privacy of your protected health information (“PHI”). PHI includes information about your health condition and the care and treatment you receive from the Practice and is often referred to as your health care or medical record. This Notice explains how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI.

HOW THE PRACTICE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The Practice, in accordance with this Notice and without asking for your express consent or authorization, may use and disclose your PHI for the purposes of:

(a) **Treatment** – To provide you with the health care you require, the Practice may use and disclose your PHI to those health care professionals, whether on the Practice’s staff or not, so that it may provide, coordinate, plan and manage your health care.

(b) **Payment** – To get paid for services provided to you, the Practice may provide your PHI, directly or through a billing service, to a third party who may be responsible for your care, including insurance companies and health plans. If necessary, the Practice may use your PHI in other collection efforts with respect to all persons who may be liable to the Practice for bills related to your care. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.

(c) **Health Care Operations** – To operate in accordance with applicable law and insurance requirements, and to provide quality and efficient care, the Practice may need to compile, use and disclose your PHI. For example, the Practice may use your PHI to evaluate the performance of the Practice’s personnel in providing care to you.

**OTHER EXAMPLES OF HOW THE PRACTICE MAY USE YOUR
PROTECTED HEALTH INFORMATION**

(a) **Advice of Appointment and Services** – The Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment reminders may be used by the Practice: a) a postcard mailed to you at the address provided by you; and b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone.

(b) **Family/Friends** – The Practice may disclose to a family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person’s involvement with your care or the payment for your care. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

(i) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment, that you do not object to the use or disclosure.

(ii) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person’s involvement with your care.

**OTHER USE & DISCLOSURES WHICH MAY
BE PERMITTED OR REQUIRED BY LAW**

The Practice may also use and disclose your PHI without your consent or authorization in the following instances:

(a) **De-identified Information** – The Practice may use and disclose health information that may be related to your care but does not identify you and cannot be used to identify you.

(b) **Business Associate** – The Practice may use and disclose PHI to one or more of its business associates if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies.

(c) **Personal Representative** – The Practice may use and disclose PHI to a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) **Emergency Situations** – The Practice may use and disclose PHI for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible: The Practice may also use and disclose PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(e) **Public Health Activities** – The Practice may use and disclose PHI when required by law to provide information to a public health authority to prevent or control disease.

(f) **Abuse, Neglect or Domestic Violence** – The Practice may use and disclose PHI when authorized by law to provide information if it believes that the disclosure is necessary to prevent serious harm.

(g) **Health Oversight Activities** – The Practice may use and disclose PHI when required by law to provide information in criminal investigations, disciplinary actions, or other activities relating to the community’s health care system.

(h) **Judicial and Administrative Proceeding** – The Practice may use and disclose PHI in response to a court order or a lawfully issued subpoena.

(i) **Law Enforcement Purposes** – The Practice may use and disclose PHI, when authorized, to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena, or if the Practice believes that your death was the result of criminal conduct.

(j) **Coroner or Medical Examiner** – The Practice may use and disclose PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

(k) **Organ, Eye or Tissue Donation** – The Practice may use and disclose PHI if you are an organ donor to the entity to whom you have agreed to donate your organs.

(l) **Research** – The Practice may use and disclose PHI subject to applicable legal requirements if the Practice is involved in research activities.

(m) **Avert a Threat to Health or Safety** – The Practice may use and disclose PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

(n) **Specialized Government Functions** – The Practice may use and disclose PHI when authorized by law with regard to certain military and veteran activity.

(o) **Workers’ Compensation** – The Practice may use and disclose PHI if you are involved in a Workers’ Compensation claim to an individual or entity that is part of the Workers’ Compensation system.

(p) **National Security and Intelligence Activities** – The Practice may use and disclose PHI to authorized governmental officials with necessary intelligence information for national security activities.

(q) **Military and Veterans** – The Practice may use and disclose PHI if you are a member of the armed forces, as required by the military command authorities.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

YOUR RIGHTS

You have the right to:

(a) Revoke any Authorization or consent you have given to the Practice, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

(b) Request special restrictions on certain uses and disclosures of your PHI as authorized by law. In general, this relates to your right to request special restrictions concerning disclosures of your PHI regarding uses for treatment, payment and operational purposes under Privacy Rule, Section 164.522(a) and restrictions related to disclosures to your family and other individuals involved in your care under Privacy Rule, Section 164.510(b). Except in certain instances, the Practice may not be obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.

(c) Receive confidential communications or PHI by alternative means or at alternative locations as provided by Privacy Rule Section 164.522(b). For instance, you may request all written communications to you marked "Confidential Protected Health Information." You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

(d) Inspect and copy your PHI as provided by federal law (including Privacy Rule, Section 164.524) and state law. To inspect and copy your PHI, you must submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request. In certain situations that are defined by law, the Practice may deny your request, but you will have the right to have the denial reviewed as set forth more fully in the written denial notice.

(e) Amend your PHI as provided by federal law (including Privacy Rule, Section 164.526) and state law. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

(f) Receive an accounting of disclosures of your PHI as provided by federal law (including Privacy Rule Section 164.528) and state law. To request an accounting, you must submit a written request to the Practice's Privacy Officer. The request must state a time period, which may not be longer than six (6) years and may not include dates before April 14, 2003. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a twelve (12) month period will be free, but the Practice may charge you for the cost of providing additional lists. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.

(g) Request special authorization to allow the Practice to use and disclose your protected health information (PHI) for purposes other than those enumerated in this Notice of Privacy Practices (NPP). This request must be made in writing to the Practice's Privacy Officer.

(h) Receive a paper copy of this Privacy Notice from the Practice (as provided by Privacy Rule Section 164.520(b)(1)(iv)(F)) upon request to the Practice's Privacy Officer, or from this Practice's web site www.footdoctorsnj.com.

(i) Complain to the Practice or to the Secretary of HHS (as provided by Privacy Rule Section 164.520(b)(1)(vi)) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

To obtain more information about your privacy rights or if you have questions you want answered about your privacy rights (as provided by Privacy Rule Section 164.520(b)(2)(vii)), you may contact the Practice's Privacy Officer as follows:

Affiliated Foot and Ankle Center, LLP
Attn: Privacy Officer
Address: 4645 Route 9 North, Howell, NJ 07731
(732) 905-1110 Fax (732) 905-7885

PRACTICE'S REQUIREMENTS

Affiliated Foot and Ankle Center, LLP.

4645 Route 9 North - Howell, NJ 07731

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(a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

(b) Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.

(c) Is required to abide by the terms of this Privacy Notice.

(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

(e) Will distribute any revised Privacy Notice to you prior to implementation.

(f) Will not retaliate against you for filing a complaint.

EFFECTIVE DATE

This Notice is in effect as of 04/14/03.

PATIENT HIPAA ACKNOWLEDGEMENT 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 health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name: _____

Last four digits of his/her SSN (required): _____

Print Name: _____

Last four digits of his/her SSN (required): _____

Print Name: _____

Last four digits of his/her SSN (required): _____

III. Request to Receive Confidential Communications by Alternative 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:

Written Communication Address:

 OK to leave message with detailed information

 OK to mail to address listed above

 Leave message with call back numbers only

E-mail me at: _____

Work Telephone Number:

Fax Communication:

 OK to leave message with detailed information

 OK to Fax at the number listed above

 Leave message with call back numbers only

E-mail me at: _____

Other: _____

Name of Patient (Print)

Signature

Date

Witness: _____

Date: _____