ARE YOU BEING TREATED FOR OR HAVE YOU BEEN TREATED FOR THE FOLLOWING?

_____AIDS/HIV	_____DIABETES	_____RADIATION TREATMENT
_____ANEMIA	_____EYE PROBLEMS	_____RASH
_____ANGINA/CHEST PAIN	_____GOUT	_____RESPIRATORY DISEASE
_____ANKLE/FOOT SWELLING	_____HEADACHES	_____RHEUMATIC FEVER
_____ARTHRITIS	_____HEART DISEASE	_____STROKE
_____ARTIFICIAL VALVES OR JOINTS	_____HEPATITIS/JAUNDICE	_____THYROID DISEASE
_____BACK PROBLEMS	_____HIGH BLOOD PRESSURE	_____TUBERCULOSIS
_____BLEEDING DISORDERS	_____KIDNEY PROBLEMS	_____ULCERS-LOWER LIMB
_____CANCER	_____LIVER DISEASE	_____ULCERS-STOMACH
_____CHEMICAL DEPENDENCY	_____NEUROPATHY	_____VARICOSE VEINS
_____CHEST PAIN	_____LIVER DISEASE	_____WEIGHT LOSS-SUDDEN
_____CIRCULATORY PROBLEMS	_____PHLEBITIS	_____RSD
_____CRAMPS OF FOOT/LEG	_____PSYCHIATRIC CARE	_____

OTHER NOT LISTED:_____

ARE YOU ALLERGIC TO OR HAVE YOU EVER REACTED TO ANY OF THE FOLLOWING?

_____ASPIRIN _____TAPE/BANDAIDS _____SULFA DRUGS _____CODEINE _____SEAFOOD

_____PENICILLIN _____IODINE _____LOCAL ANESTHESIA _____SEDATIVES _____NONE

OTHER NOT LISTED_____

WHO MAY WE THANK FOR REFERRING YOU?_____

APPOINTMENTS

IF YOU ARE UNABLE TO KEEP AN APPOINTMENT PLEASE CALL THE OFFICE TO RESCHEDULE AT LEAST 24 HOURS IN ADVANCE.

VERIFICATION OF BENEFITS

YOU AS THE POLICYHOLDER ARE PRIMARILY RESPONSIBLE FOR KNOWING YOUR BENEFITS. YOU ARE RESPONSIBLE FOR SUPPLYING US WITH YOUS CORRECT INSURANCE INFORMATION AND ANY REFERRALS THAT YOUR HEALTH INSURANCE POLICY REQUIRES.

WORKERS COMPENSATION

WE REQUIRE WRITTEN APPROVAL/AUTHORIZATION FROM YOUR EMPLOYER AND/OR WORKER'S COMPENSATION CARRIER AND CASE MANAGEMENT INFORMATION PRIOR TO YOUR INITIAL VISIT. IF YOUR CLAIM IS DENIED, YOU WILL BE RESPONSIBLE FOR PAYMENT IN FULL.

REQUIRED PAYMENTS

ANY CO-PAYMENT, DEDUCTIBLES, OR COINSURANCE, FEES FOR NON-COVERED SERVICES OR OUTSTANDING BALANCES MUST BE PAID AT THE TIME OF SERVICE.

RETURNED CHECKS

THERE IS CURRENTLY A FEE OF $25 FOR ANY CHECKS RETURNED BY THE BANK.

PAYMENTS

UNLESS OTHER ARRANGEMENTS ARE APPROVED BY AFANJ IN WRITING, THE BALANCE ON YOUR STATEMENT IS DUE AND PAYABLE WHEN THE STATEMENT IS ISSUED, AND IS PAST DUE IF NOT PAID BY THE END OF THE MONTH.

AUTHORIZATION OF TREATMENT

I GIVE PERMISSION TO THE DOCTORS AT ANKLE & FOOT ASSOCIATES OF NORTH JERSEY TO ADMINISTER TREATMENT AND PERFORM SUCH PROCEDURES AS THEY HAVE DEEMED NECESSARY IN THE TREATMENT OF MY MEDICAL CONDITION.

SIGNATURE_____ DATE:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES BY AFANJ AND THAT I HAVE READ OR HAD THE OPPORTUNITY TO READ THE NOTICE.

SIGNATURE_____ DATE:_____

PLEASE LIST ANY PERSON WITH WHOM WE MAY DISCUSS OR RELEASE YOUR MEDICAL INFORMATION AND THEIR RELATIONSHIP TO YOU. PLEASE DO NOT LIST ANY DOCTORS.

_____

_____

MEDICAL INFORMATION RELEASE

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO MY INSURANCE COMPANY NECESSARY TO PROCESS MY CLAIM. I ALSO AUTHORIZE THE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO MY PHYSICIAN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBILE FOR CHARGES NOT COVERED BY MY HEALTH INSURANCE.

SIGNATURE_____ DATE:_____

MEDICAID/FAMILY CARE PATIENTS ONLY

I HAVE A MEDICAID BASED INSURANCE. I HAVE DISCLOSED ANY ADDITIONAL INSURANCE COVERAGE THAT I MAY HAVE. IF ADDITIONAL INSURANCE IS DISCOVERED BY THE STATE OF NEW JERSEY I REALIZE THAT I WILL BE LIABLE FOR SERVICES RENDERED BY AFANJ. AFANJ MAY BILL ME IF THE INSURANCE PAYMENT IS RECALLED BY THE MEDICAID CARRIER AND COMPLETE PAYMENT IS NOT MADE BY THE PRIMARY CARRIER. I ALSO UNDERSTAND THAT I WILL BE RESPONSIBLE FOR PAYMENT IF I DO NOT PRESENT PROPER INSUJRANCE INFORMATION OR REFERRALS AT THE TIME OF THE VISIT.

SIGNATURE_____ DATE:_____

ANKLE & FOOT ASSOCIATES OF NORTH JERSEY

PLEASE PRINT-PATIENT INFORMATION

NAME_____ _____
LAST FIRST MIDDLE

ADDRESS_____
STREET CITY STATE ZIP

PHONE: HOME ( )_____ CELL ( )_____ WORK ( )_____

DATE OF BIRTH_____ AGE_____ SSN_____

SEX: MALE OR FEMALE MARITAL STATUS: SINGLE MARRIED WIDOWED PARTNERED

PRIMARY CARE PHYSICIAN_____ PHONE_____

EMPLOYER_____ OCCUPATION_____

EMERGENCY CONTACT_____ PHONE:_____
NAME/RELATIONSHIP

POLICYHOLDER INFORMATION:

NAME_____
LAST FIRST MIDDLE

ADDRESS_____
STREET CITY STATE ZIP

DATE OF BIRTH_____ AGE_____ SSN:_____

SEX: MALE OR FEMALE RELATIONSHIP_____

MEDICAL HISTORY

WHAT IS YOUR MAIN CONCERN TODAY? _____

WHEN DID SYMPTOMS APPEAR OR ACCIDENT OCCUR?_____

HAVE YOU SEEN A PODIATRIST BEFORE?_____NAME_____

HAVE YOU HAD PRIOR SURGERY? _____NO _____YES

WHAT?_____WHEN?_____

WHAT?_____WHEN?_____

DO YOU TAKE MEDICATION?____NO ____YES IF YES, PLEASE LIST?_____

_____

_____

DO YOU SMOKE? _____NO_____YES

FAMILY MEDICAL HISTORY_____

_____

HEIGHT_____ WEIGHT_____ SHOE SIZE_____ ARE YOU PREGNANT? ____NO ____YES