FAMILY FOOT & ANKLE CENTER

of Central Jersey

PERSONAL INFORMATION:

Name _____ M / F S.S. # _____

Address _____

Home # _____ Cell # _____ Work # _____ Email Address _____

BIRTH DATE: ___/____/____ Race _____ Ethnicity _____ Language _____

Marital Status: M/D/S/W Employer _____ Occupation _____

Employer's Address _____

Emergency Contact _____ Phone _____

Family Physician _____ Phone _____

DATE LAST SEEN _____

Please Describe Your Foot/Ankle Problems _____

INSURANCE INFORMATION:

Primary Insurance Provider _____ Subscriber _____

Relationship to Patient _____ Subscriber's S.S. # _____ Subscriber's Birth Date _____

Group # _____ ID # _____

Address _____

SECONDARY INSURANCE INFORMATION:

Secondary Insurance Provider _____ Subscriber _____

Relationship to Patient _____ Subscriber's S.S. # _____ Subscriber Birth Date _____

Group # _____ ID # _____

Address _____

PHARMACY INFORMATION: _____

ADDRESS _____

PHONE NUMBER _____

Medical History

Have you ever been treated for (select all that applies):

☐ Corns/Calluses	☐ Warts	☐ Athlete's Foot
☐ Fungal Nails	☐ Ingrown Nails	☐ Neuroma
☐ Leg/Foot Ulcers	☐ Foot Numbness	☐ Bunions
☐ Broken Foot/Bone	☐ Broken Ankle	☐ Ankle Sprain
☐ Hammer/Mallet Toe	☐ Leg/Foot Cramp	☐ Flat Feet
☐ Arch pain	☐ High Arch Feet	☐ Knee Pain
☐ Lower Back Pain	☐ Heel Pain	☐ Rash
☐ In-Toeing	☐ Toe Walking	☐ Gait Problems

☐ Childhood Foot Problems

Do you get leg cramps after activity?

Does foot pain limit your desired activities?

Do you have any difficult walking?

Any pain in the calves or buttocks when walking?

Is the pain relieved by stopping & standing still?

List the sports and other actives in which you are involved:

_____

_____

_____

Patient Medical History: Have you ever been treated for:

☐ Stroke	☐ Heart Attack	☐ High Blood Pressure
☐ Phlebitis	☐ Vascular Disease	☐ Heart Condition
☐ Anemia	☐ Poor Circulation	☐ Eyes: Glaucoma
☐ Diabetes	☐ Kidney Disease	☐ Keloid/Thick Scar
☐ Gout	☐ Osteoporosis	☐ Alzheimer's
☐ Sciatica	☐ Lyme's Disease	☐ Rheumatic Fever
☐ Arthritis	☐ Headaches	☐ Hearing/Ear Disorder
☐ Epilepsy	☐ Nerve Disorder	☐ Psychiatric Disorder
☐ Asthma	☐ Lung Disease	☐ Tuberculosis
☐ Hepatitis	☐ Liver Disease	☐ Thyroid Problem
☐ Dark Urine	☐ Chronic Light Stool	☐ Weight Loss
☐ Cancer	☐ Stomach Ulcer	☐ None of the above

Other: _____

Surgical History: Surgical procedures and complications:

_____

_____

_____

Past Family & Social History

List immediate family members who have had:

Diabetes _____ Foot Problems _____

Arthritis _____ Heart Attack _____

Stroke _____ High Blood Pressure _____

Cancer _____ Birth Defects _____

# of Childbirths _____ Are you currently pregnant?

Are you slow to heal after cuts

Any abnormal bruising, bleeding or scarring?

Do you smoke now?

Did you ever smoke?

If you quit, what year did you do so? _____

Alcohol use? ☐ None ☐ Rarely ☐ Moderately ☐ Daily ☐ Quit

Recreational Drugs?

Are you currently taking any medications?

Are you taking Insulin?

List medications, dose & purpose below:

_____

_____

_____

_____

_____

_____

Are you taking your medications as prescribed?

Allergies: Is there a history of skin reaction or other outward reaction or sickness following an injection, oral or topical administration of:

Latex, Adhesive tape	☐	Penicillin	☐
Other antibiotics	☐	Empirin, Tylenol	☐
Aspirin, Advil, Aleve, Motrin	☐	Celebrex	☐
Other pain remedies	☐	Morphine	☐
Codeine	☐	Other narcotics	☐
Novocaine	☐	Other anesthetics	☐
Sulfa drugs	☐	Shrimp, Iodine or Merthiolate	☐

Clearly list additional medication, drugs, foods, etc.

_____

_____

_____

_____

Review of Systems: Are you currently experiencing any of the following:

General:	☐ Decreased Strength	☐ Weight change	☐ Decreased exercise tolerance	
Head:	☐ Headaches	☐ Vertigo	☐ Injury	
Eyes:	☐ Abnormal vision	☐ Double vision	☐ Diminished vision	☐ Increased drainage ☐ Pain
Ears:	☐ Change in hearing	☐ Tinnitus	☐ Bleeding	☐ Vertigo
Nose:	☐ Nose bleed	☐ Obstruction	☐ Discharge	☐ Inflammation of mucous membrane
Mouth:	☐ Dental difficulties	☐ Gum bleeding	☐ Use of dentures	
Neck:	☐ Stiffness	☐ Pain	☐ Tenderness	☐ Noted masses
Chest:	☐ Shortness of breath	☐ Wheezing	☐ Cough	☐ Spitting up blood
Heart:	☐ Chest pains	☐ Palpitations	☐ Fainting	☐ Breathlessness
Abdomen:	☐ Difficulty Swallowing	☐ Appetite change	☐ Vomiting	☐ Bowel habit changes ☐ Tarry Stool ☐ Pain
Neurologic:	☐ Weakness	☐ Tremor	☐ Seizures	☐ Changes in mentation ☐ Lack of muscle control
Psychiatric:	☐ Depressive symptoms	☐ Change in sleep habits		☐ Changes in thought content

FINANCIAL INFORMATION

All insurances including Medicare Replacement Plans: Family Foot and Ankle Center/Dr. Holli Alster will submit your claims to all other insurance companies providing:

At each visit we receive a copy of all current insurance identification cards.
Our patient Information Form is current and currently completed.
Our Financial Policy is signed.

If we have not heard from your secondary insurance within 60 days, you will be billed directly. In that event you must contact the insurance company directly to find out why your claim has not been paid. **It is the patient's responsibility to give us their current insurance information.** If we do not have a copy of your current insurance card, or have received incorrect or old insurance information, all charges will become the patient's responsibility. **All uncollected co-pays and co-insurances from prior visits will be due at the time of your next appointment**, as specified in your insurance contract and mandated by your carrier in our participation provider agreement. For your convenience Family Foot and Ankle Center accepts cash, all major credit cards, debit cards and personal checks. Payment is expected at each visit. You will receive a billing statement for all personal balances due. If we have not received a response from you by phone or received a payment or letter regarding your unpaid balance within 90 days, your account will be sent to our collections department. **Traditional Medicare Insurance:** Our office participates with Medicare. This means that we will send your claim to Medicare and we will adhere to Medicare's allowable amount fee schedule. Once you have met your annual deductible Medicare will pay us 80% of the allowable fee and you will be responsible for the remaining 20%. If you have a secondary insurance this amount will then be sent on to them and you will be billed for any remaining balance after the payment. Medicare has strict guidelines concerning their coverage routine foot care such as trimming nails or paring corns and calluses. The doctor will be able to determine if your routine foot care is or is NOT covered by Medicare. **Should you have a non-covered service such as this performed, you will be asked to pay for that service at the time of your appointment. We will also ask you to sign Medicare's Advanced Beneficiary's Notice (ABN) indicating you were informed that Medicare will not be paying for that particular service.** The ABN will be provided at the time of visit.

No Insurance:

If you do not have health insurance, charges for the day's medical service are due at the time of service.

Patient Authorization: ***I have read and agree to the below statements***

I authorize any holder of medical information about me to release to the Health Care Financing Administration or my insurance and its agents, any information needed to determine these benefits or the benefits payable for related services.

I give permission to the Doctor to access medical history from pharmacies, to examine, treat and perform general procedures, as she deems necessary in the diagnosis and/or treatment of my condition. I understand there are no guarantees associated with any working diagnosis or treatment.

Patient signature : _____ **Date:** _____

Print: _____ **Date:** _____

Referrals/Authorizations:

It is the patient's responsibility to obtain referrals if your insurance requires one. We will do all we can to assist you, but it is ultimately your responsibility. If a required referral is NOT in place PRIOR to your appointment, we may reschedule the appointment until it is received or you will be responsible for the cost of the visit.

Missed Appointment Policy:

Family Foot and Ankle Center reserves the right to charge a patient for a missed appointment. If you can not make your scheduled appointment, please provide 24hours notice. A charge for a missed appointment is NOT a charge for service itself. One missed appointment, or severe weather problems will NOT result in a patient being charged. **Consecutive missed appointments or repeated missed appointments will be assessed at a fee of $50.00 for each missed appointment.** Habitually missed appointments could lead to a patient being discharged from the practice.

Collections:

Family Foot and Ankle Center will attempt to make payment terms that meet your needs. If we do not hear from you by phone, mail or partial payment within 90 days of a statement being send, you may be referred to a collection agency. In the event your account is assigned to collection, the patient agrees to be responsible for a 32% collection fee, as well as all court costs and attorney fees,

I understand that if a custom DME product is ordered for me, such as orthotics or special shoes, or I receive an air cast, night splint surgical shoe, ankle brace or powersteps that they are non-refundable and non-returnable. If my insurance denies them for any reason, I understand it is ultimately my responsibility and I will pay for the product(s) I have received.

I understand that Family Foot and Ankle Centers financial policy is in effect for the entire time I am a patient not just for the date that I sign the policy. If Family Foot and Ankle Center has any changes, our office will have you fill out another form at that time.

I authorize Family Foot and Ankle Center/Dr. Holli Alster, to release information regarding my medical history and treatments to my insurance company in order for them to be paid. I also authorize payments for services to be paid directly to Family Foot and Ankle Center/Dr. Holli Alster from my insurance company.

I understand that unpaid balances must be paid prior to asking a follow up appointment. I understand that I will speak with an office staff to initiate a payment plan if my balance is overdue.

I acknowledge by signing my name below, as the patient or guardian of the patient, that I have read and initialed all of the above financial disclosures and understand and will comply, I have asked questions, if necessary, and I have had those questions answered and I understand.

Print: _____ Date:_____

Signature:_____Date:_____