Foot and Ankle Care
of South Jersey
Dr. Jeffrey S. Rosenman
Treatment & Rehabilitation of the Foot and Ankle
The Pavilions of Voorhees • 2301 Evesham Rd. • Voorhees NJ 08043
(856) 429-5100, fax (856) 429-5800 • email: jrosenman@sjfoot.com • web: sjfoot.com

Patient Information

Patient Name _____ Todays Date _____/_____/_____

First Name Last Name Middle Initial

Birth Date _____-_____-_____ Age _____ Male Female

Month Day Year *Please Circle*

Social Security Number _____-_____-_____ Best Number to Reach You? Home Cell

Home Address _____ Home Phone No. (_____) _____

_____ Cell Phone No. (_____) _____

City State Zip

Email (required for portal acct) _____ Consent to Text you at the mobile number provided? YES NO

Check here if you DO NOT want a Portal Account ☐

Marital Status: Single Married Divorced Domestic Partner Widowed Other

How Were You Referred To Us? Google - Insurance Website - Phone Book - ZocDoc - Web Browsing - Physician

Your Primary Care Physician (MD, DO, PA, NP)? _____

Primary Care Providers Phone Number (_____)_____ Date Last Seen _____

Pharmacy (Name & Location) _____

Preferred Radiology & Laboratory (Name & Location) _____

Spouse/Parent/Guardian - Name & Phone Number _____

Emergency Contact Name, Phone #, Relationship _____

Employer Name & Phone Number _____

Your Occupation _____ Approximate Hours/Day Standing _____

Height _____ Weight _____ Most Recent Blood Pressure _____

Shoe Size _____ Type/style of most frequently worn shoe gear _____

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Insurance Information

Please Present All Insurance Cards

Primary Insurance

Name of Insurance Carrier _____

Identification Number _____ Group Number _____

Relation to Patient _____

Policy Holders Name _____ **Policy Holders** Date of Birth ___/___/___
MM DD YYYY

Is a Referral Required for Specialist? YES NO

Secondary Insurance

Name of Insurance _____

Identification Number _____ Group Number _____

Relation to Patient _____

Policy Holders Name _____ Policy Holders Date of Birth ___/___/___
MM DD YYYY

Release: *I hereby authorize the release of any information acquired during my examination which said insurance company may request.*
Responsibility & Assignment: *I also assign and request payment of medical benefits to the above stated physician for medical services. I also understand that I am financially responsible for payment of my bill. As a courtesy, we will bill your insurance company.*

Signature: _____

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Patient Medical History

Please describe in detail the reason for your visit _____

_____

Please describe your pain? (please circle) Aching Throbbing Sharp Pins & Needles Electrical Numbness Dull

When did your problem begin? ____/____/_____ What activities aggravate your problem? _____

Any prior treatments/self or other? (please describe) _____

Please list your past surgical history _____

Diabetic Patients: Most recent blood sugar reading (fasting/a.m.): _____ HbA1C (if known) _____

Date Last Seen by Podiatrist (or MD/DO if not seen by Podiatrist): _____

Please list your current medications: _____

_____

Allergies _____

_____

Please list any medical problems you have: _____

_____

_____

Do you currently smoke? YES NO If YES, how much do you currently smoke? _____

Have you ever smoked? YES NO If YES, how many years did you smoke for? _____

Alcoholic beverages? NONE OCCASIONAL MODERATELY HEAVY QUIT? When? _____

Any non-prescribed or illicit Drugs (current or prior history)? YES NO _____

Have you ever had a serious illness or Test Positive for MRSA? YES NO _____

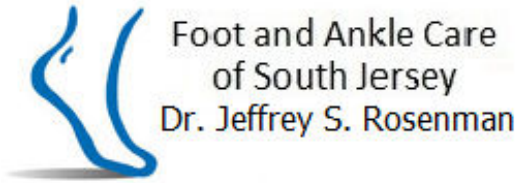
Have you ever been hospitalized? YES NO If yes, please explain: _____

What type of Diet do you follow? _____ Your Exercise Level? _____

Do you have a living will/advanced directive? YES NO

Please list <u>your family's</u> medical history (i.e. diabetes, stroke, heart disease, high blood pressure, migraines, etc.)

_____



ACKNOWLEDGEMENT 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 and/or had the opportunity to read and understand the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent/Authorized representative (if applicable)

_____

Signature

I authorize Foot and Ankle Care of South Jersey to obtain any protected health information from health care professionals who are involved in my care. I understand that this information is strictly confidential and solely used for the purpose of my medical care.

_____

Initials

Foot and Ankle Care
of South Jersey
Dr. Jeffrey S. Rosenman

Office Policies

Thank you for choosing Foot and Ankle Care of South Jersey. We will strive to give you the excellent professional care you deserve as our patient.

We want to make your experience at Foot and Ankle Care of South Jersey a pleasurable one. Please be aware of the procedures and policies of this office as stated below. Should you have any questions or do not understand something, please ask one of our staff members.

Co-Payments

All copayments will be collected at the time of check-in. Your insurance company requires that you pay your co-pay at the time of your visit. Patients who fail to do this are in direct violation of the contract with their insurance company. If you are unable to pay your co-pay at the time of your visit, we will be happy to reschedule your appointment.

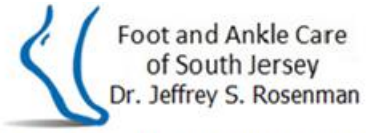
Referrals

Patients will be advised if a referral is requited for their next scheduled visit. It is the responsibility of the patient to obtain this referral from their primary care physician prior to the visit. If you do not have your referral with you at the time of check-in, we will be glad to reschedule your appointment or contact your primary care provider as a courtesy to obtain the referral for you. Please understand that if we contact your provider for you, this will likely delay your appointment time, which we have no control over.

Foot and Ankle Care of South Jersey is NOT obligated to call you primary care physician to obtain a referral for you.

_____ _____

Patient Signature Date



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CANCELLATION/MISSED APPOINTMENT POLICY

(Please read this carefully to avoid a broken appointment fee)

Your appointment time has been set aside for you. This time is unavailable to other patients. Therefore, we require at least 24 hours advanced notice if you must cancel your appointment. For all "no call/no show" or cancelled appointments with less than 24 hours notice, there will be a $50.00 broken appointment fee. Appointment reminder calls and/or texts/emails are a courtesy. It is your responsibility to remember your appointment. If you receive a reminder call and wish to reschedule, you must contact the office within 24 hours.

I have read and understand the cancellation/missed appointment policy.

Patients Signature _____

If patient is a minor, please enter parent or guardians information below.

Name _____ Relationship _____

Parent/Guardian Signature _____

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Authorization to Release Medicare Records

I hereby authorize my primary care physician to disclose (if necessary) to Foot and Ankle Care of South Jersey any information which they have obtained by examination. By signing this, I release them of any consequence.

Primary Care Physician: _____

Patient Signature: _____ Date: _____

Acknowledgement of Receipt of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices. I was given the opportunity to read and fully understand the notice.

_____ _____

Patient's Name (Please Print) Date

_____

Parent or Authorized Representative

_____

Signature

Office Policy Regarding Insurance Assignment

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY!

Co Payments, Referrals and Co-Insurance

All copayments are collected at the time of check-in. Your insurance company requires that you pay your co pay at the time of your visit. If you are unable to pay your copay, we will be happy to reschedule your appointment.

I understands that I am solely responsible for acquiring referrals from my primary doctor PRIOR to my appointment and knowing how many visits have been issued. If a referral was not issued, your office visit and treatment are considered NOT COVERED by your insurance; therefore, you will be responsible for the cost of your visit. Foot and Ankle Care of South Jersey is NOT obligated to call your primary care provider to obtain a referral on your behalf.

For all Medicare patients: We are a participating practice with Medicare, which means, we will accept the amount that Medicare approves for our services. Medicare pays 80% of their established rate for services. You as the patient are responsible for the remaining 20% of the fees either through secondary insurance or self-payments. Medicare also has a deductible each year that must be met before payment for services is rendered. Acceptable forms of payment are cash, check, credit card and debit//HAS/FSA cards.

Foot and Ankle Care of South Jersey is required to process your insurance claims with your primary insurance carrier. We will bill any secondary insurance as a courtesy to you, the patient. Please let us help you receive the maximum benefit from your insurance companies. Have a current copy of your insurance cards/s so we may copy them for your record. If you change your health insurance during your treatment, please provide us with the updated information promptly. If you have questions about our insurance policy, feel free to ask them at the time of your visit, or call during normal business hours.

It is our policy to bill your insurance companies for reimbursement, however, we shall allow no more than sixty (60) days for payment. After this period, patient will be billed for any outstanding balances on account.

The office will NOT enter a dispute with your insurance company over any claim. It is your responsibility to contact your insurance company and review your claim.

The following statement applied to me:

_____ Yes, I have been associated with a medical malpractice suit.

_____ No, I have never been associated with a medical malpractice suit.

I have fully read and understand the Office Policies regarding Insurance Assignment:

_____ _____ _____

Name (Please Print) Signature Date

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HIPAA

I understand that I have certain rights to privacy regarding my protected health information (PHI). These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent, I authorize Foot and Ankle Care of South Jersey (FACSJ) to use and disclose my PHI to carry out:

- Treatment
- Obtaining Payment
- Day-today healthcare operations of the office

I have also been informed of and given the right to review and secure a copy of the Notices of Privacy Practices, which contains a more complete description of the uses and disclosures of your PHI and your rights under HIPPA. Additional information can also be obtained at the office upon request. I understand that FACSJ reserves the right to change the terms of this notice from time to time, consistent with the states' latest policies and laws. You may contact FACSJ at anytime to obtain the current copy of this notice.

I understand that I have the right to request restrictions on how my PHI is used and disclosed to carry out treatment, payment/s and health care operations, but that FACSJ is not required to agree to these/those requested restrictions. However, if in agreement, both are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date revoked will not affect this consent.

Print Patient Name_____Date_____

Signature_____

Relationship if unable to sign or signing on behalf of a minor_____