

# FEET 'N BEYOND OF NEW JERSEY, P.A.

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## PATIENT REGISTRATION FORM

(PLEASE PRINT CLEARLY)

DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

AGE: \_\_\_ SEX: M F PRIMARY LANGUAGE: \_\_\_\_\_ RACE: \_\_\_\_\_ ETHNICITY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ CELL PHONE: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_ (WILL NOT BE SHARED)

EMPLOYER: \_\_\_\_\_ WORK PHONE: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

PRIMARY CARE DOCTOR: \_\_\_\_\_ DATE LAST SEEN \_\_\_\_\_

PHONE: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ADDRESS: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_

PHARMACY: \_\_\_\_\_ LOCATION: \_\_\_\_\_ PHONE: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

WHO IS RESPONSIBLE FOR PAYMENT? \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ WHO REFERRED YOU TO US? \_\_\_\_\_

### **INSURANCE INFORMATION**

PRIMARY INSURANCE COMPANY NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ PHONE: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

INSURED NAME: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ EMPLOYER \_\_\_\_\_

ID # \_\_\_\_\_ GROUP # \_\_\_\_\_

SECONDARY INSURANCE COMPANY NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ PHONE: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

INSURED NAME: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ EMPLOYER \_\_\_\_\_

ID # \_\_\_\_\_ GROUP # \_\_\_\_\_

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## **MEDICATIONS**

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

<u>MEDICATION NAME</u>	<u>DOSE</u>	<u>HOW OFTEN DO YOU TAKE?</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE LIST ALL PRIOR SURGERIES:

<u>TYPE OF SURGERY</u>	<u>DATE</u>	<u>TYPE OF SURGERY</u>	<u>DATE</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

<u>REASON FOR HOSPITALIZATION</u>	<u>DATE</u>	<u>REASON FOR HOSPITALIZATION</u>	<u>DATE</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## **SOCIAL HISTORY**

MARITAL STATUS:  SINGLE  MARRIED  PARTNERED  SEPARATED  DIVORCED  WIDOWED

USE OF ALCOHOL:  NEVER  NO LONGER USE  HISTORY OF ALCOHOL ABUSE  
 CURRENT USE - TYPE \_\_\_\_\_  RARE  OCCASIONAL  MODERATE  DAILY

USE OF TOBACCO:  NEVER  QUIT - HOW LONG AGO? \_\_\_\_\_  SMOKE \_\_\_ PACKS/DAY FOR \_\_\_ YEARS

USE OF RECREATIONAL DRUGS:  NEVER  QUIT - HOW LONG AGO? \_\_\_\_\_ TYPE \_\_\_\_\_  
 CURRENT USE - TYPE \_\_\_\_\_  RARE  OCCASIONAL  MODERATE  DAILY

## **FAMILY HISTORY**

DO YOU HAVE A FAMILY HISTORY OF:  DIABETES: TYPE 1 OR TYPE 2  CANCER  HEART DISEASE

HIGH BLOOD PRESSURE  STROKE  CORONARY ARTERY DISEASE  BLEEDING DISORDER

RHEUMATOID ARTHRITIS  OTHER \_\_\_\_\_

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## YOUR MEDICAL HISTORY

ALLERGIES:  MEDICATIONS \_\_\_\_\_  
 ANESTHESIA \_\_\_\_\_  FOODS \_\_\_\_\_  
 TAPE  LATEX  SHELLFISH  IODINE  OTHER \_\_\_\_\_  
 NONE KNOWN

REACTION: \_\_\_\_\_

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES: TYPE 1 OR TYPE 2 (CIRCLE)	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS: _____								

## CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? \_\_\_\_\_

HOW LONG AGO DID THIS PROBLEM FIRST START? \_\_\_\_\_ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM:  BEGIN ALL OF A SUDDEN  GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN OR SYMPTOM?

NO PAIN  SHARP  DULL  ACHING  BURNING  
 RADIATING  ITCHING  STABBING  OTHER \_\_\_\_\_

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT:  STAYED THE SAME  BECOME WORSE  IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE?  WALKING  STANDING  DAILY ACTIVITIES

RESTING  DRESS SHOES  HIGH HEELS  FLAT SHOES  ANY CLOSED TOE SHOE  
 RUNNING  OTHER \_\_\_\_\_

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? \_\_\_\_\_

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? \_\_\_\_\_

WAS THIS PROBLEM CAUSED BY AN INJURY?  YES  NO (DESCRIBE) \_\_\_\_\_

IF YES, WAS IT A WORK-RELATED INJURY?  YES  NO

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## PATIENT CONSENTS

**E-PRESCRIBING** IS DEFINED BY A PHYSICIAN ABILITY TO ELECTRONICALLY SEND AN ACCURATE, ERROR FREE, AND UNDERSTANDABLE PRESCRIPTION DIRECTLY TO YOUR PHARMACY. CONGRESS HAS DETERMINED THAT THE ABILITY TO ELECTRONICALLY SEND PRESCRIPTIONS IS AN IMPORTANT ELEMENT IN IMPROVING THE QUALITY OF PATIENT CARE. E-PRESCRIBING GREATLY REDUCES MEDICATION ERRORS AND ENHANCES PATIENT SAFETY. THE MEDICARE MODERNIZATION ACT 2003, LISTED STANDARDS THAT HAVE TO BE INCLUDED IN AN E-PRESCRIBING PROGRAM. THESE INCLUDE: (1) FORMULARY AND BENEFIT TRANSACTIONS, WHICH GIVES THE PRESCRIBER INFORMATION ABOUT WHICH DRUGS ARE COVERED BY A DRUG BENEFIT PLAN; (2) MEDICATION HISTORY TRANSACTIONS, WHICH PROVIDES THE PHYSICIAN WITH INFORMATION ABOUT MEDICATIONS THE PATIENT IS ALREADY TAKING TO MINIMIZE ADVERSE DRUG EVENTS.

I AUTHORIZE **FEET 'N BEYOND OF NEW JERSEY, P.A.** TO VIEW MY EXTERNAL PRESCRIPTION HISTORY VIA ELECTRONIC E-PRESCRIBING SERVICES. I UNDERSTAND THAT PRESCRIPTION HISTORY FROM MULTIPLE, OTHER UNAFFILIATED, PROVIDERS, INSURANCE COMPANIES, PHARMACIES AND PHARMACY BENEFIT MANAGERS MAY BE VIEWABLE BY THE PROVIDERS AND STAFF OF **FEET 'N BEYOND OF NEW JERSEY, P.A.**, AND IT MAY INCLUDE PRESCRIPTIONS BACK IN TIME FOR SEVERAL YEARS AND MAY INCLUDE PRESCRIPTIONS TO TREAT HIV, SUBSTANCE ABUSE AND PSYCHIATRIC CONDITIONS. IF APPLICABLE, I UNDERSTAND THAT MY PRESCRIPTION HISTORY WILL BECOME PART OF MY RECORD AT THIS PRACTICE. UNDERSTANDING ALL OF THE ABOVE, I HERBY PROVIDE INFORMED CONSENT TO **FEET 'N BEYOND OF NEW JERSEY, P.A.** TO ENROLL ME IN THE E-PRESCRIBE PROGRAM. THIS CONSENT WILL REMAIN ENFORCED UNTIL REVOKED OR CHANGED.

**MEDICAL PHOTOGRAPHY/VIDEOGRAPHY** I CONSENT FOR MEDICAL PHOTOGRAPHS, AUDIO RECORDINGS OR VIDEOS TO BE MADE OF ME OR MY CHILD (OR PERSON FOR WHOM I AM THE LEGAL GUARDIAN). I UNDERSTAND THAT THE INFORMATION MAY BE USED IN MY MEDICAL RECORD, FOR PURPOSES OF MEDICAL TEACHING, PUBLICATION OR ADVERTISEMENT. BY CONSENTING TO THESE I UNDERSTAND THAT I WILL NOT RECEIVE PAYMENT FROM ANY PARTY. REFUSAL TO CONSENT WILL IN NO WAY AFFECT THE MEDICAL CARE I WILL RECEIVE. IF I HAVE ANY QUESTIONS OR WISH TO WITHDRAW MY CONSENT IN THE FUTURE, I MAY CONTACT THE OFFICE. I WAIVE THE RIGHT OF PRIOR APPROVAL AND HEREBY RELEASE THE PRACTICE FROM ANY AND ALL CLAIMS FOR DAMAGES OF ANY KIND BASES ON THE USE OF MY MEDIA INFORMATION CONTAINED.

I CERTIFY, TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

I GIVE PERMISSION TO THE DOCTORS AT **FEET 'N BEYOND OF NEW JERSEY, P.A.**, TO ADMINISTER AND PERFORM ANY DIAGNOSTIC, THERAPEUTIC AND/OR OPERATIVE PROCEDURES AS MAY BE DEEMED MEDICALLY NECESSARY IN DIAGNOSIS AND/OR TREATMENT OF MY CONDITION.

PATIENT/MINORS UNDER THE AGE OF 18, WILL NOT BE TREATED WITHOUT A PARENT OR LEGAL GUARDIAN PRESENT. IF ANOTHER FAMILY MEMBER, CARETAKER OR FRIEND, OVER THE AGE OF 18 WILL BE PRESENT; WRITTEN CONSENT FROM THE PARENT/LEGAL GUARDIAN STATING AS SUCH MUST BE PRESENTED AT THE TIME OF THE APPOINTMENT. THANK YOU.

\_\_\_\_\_  
PRINT NAME OF PATIENT

\_\_\_\_\_  
PRINT PARENT/LEGAL GUARDIAN

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
SIGNATURE PARENT/LEGAL GUARDIAN

\_\_\_\_\_  
DATE

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**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

**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 SSN (required): \_\_\_\_\_  
Print Name: \_\_\_\_\_ Last four digits SSN (required): \_\_\_\_\_  
Print Name: \_\_\_\_\_ Last four digits 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 Number:** \_\_\_\_\_

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: \_\_\_\_\_

**Other:** \_\_\_\_\_

\_\_\_\_\_  
Name of Patient (Printed)                      Signature of Patient/Parent/Guardian

\_\_\_\_\_  
Witness signature                      Date

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# FINANCIAL POLICY FOR FEET 'N BEYOND OF NEW JERSEY, P.A.

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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 with certain insurance plans, please check with our office when you call for appointment and we might need your insurance information to better assist you with the coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. If you are not insured or not having up to date of your insurance information, we do offer Self Pay rates so you would not have to delay your care.

**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 coinsurance, which is 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.

**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. Our office will inform you the detail cost prior any treatment rendered.

**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. If you do not have a valid referral at the time of your visit, your appointment will be rescheduled.

**CLAIM SUBMISSION:** We will submit in-network claims **ONLY** 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. 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 with interest accruing on balance. It is also your responsibility to pay for the interest accrued if sent 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. 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.

**SELF PAY RATES:** These Self Pay rates are available if you do not have health insurance or out-of-network benefits. Payment in full is due at the time of service. Please note: If you choose to use your out-of-network benefits, these rates will not be applied to you.

**PAYMENT OPTIONS:** We accept the following payment methods: **credit cards, debit cards, checks, CareCredit or FHA/HSA funds.** An additional \$25.00 will be added to your statement if the check is returned for insufficient funds.

I have read the above policy regarding my *financial responsibility* to **Feet 'N Beyond of New Jersey, P.A.** for medical services provided. I agree to pay **Feet 'N Beyond of New Jersey, P.A.** 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 **Feet 'N Beyond of New Jersey, P.A.** 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: \_\_\_\_\_

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