LAWRENCEVILLE FOOT CARE, LLC

DIVISION OF NEW JERSEY PODIATRIC PHYSICIANS & SURGEONS GROUP, LLC

Patient Name: _____ **Date: _____**

COVID-19 SCREENING	
Have you ever been tested for COVID-19? If so, what was the test date and result?_____	☐ Yes ☐ No
Do you have fever or have you felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No
Are you having shortness of breath or other difficulties breathing?	☐ Yes ☐ No
Do you have a cough?	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No
Have you experience recent loss of taste or smell?	☐ Yes ☐ No
Are you in contact with any confirmed COVID-19 positive patients?	☐ Yes ☐ No
Is your age over 60?	☐ Yes ☐ No
Do you have heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorders?	☐ Yes ☐ No
Have you traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐ Yes ☐ No

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PATIENT INFORMATION 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: _____ PHONE: (_____) _____-_____

ADDRESS: _____CITY/STATE: _____

WHO IS RESPONSIBLE FOR PAYMENT? _____RELATIONSHIP: _____

ADDRESS: _____CITY/STATE: _____ZIP: _____

PHONE: (_____) _____-_____ WHO REFERRED YOU TO US? _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

SECONDARY INSURANCE COMPANY NAME: _____

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YOUR MEDICAL HISTORY

ALLERGIES: ☐ MEDICATIONS _____

☐ ANESTHESIA _____ ☐ FOODS _____

☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER _____

☐ NONE KNOWN

REACTION: _____

When was your last Flu Vaccine? _____ (Month and Year)

If you're over 65 years old. When was your Pneumonia Vaccine_____ (Month and year)

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N		ABNORMAL BLEEDING	Y	N		ANEMIA	Y	N		ARTHRITIS	Y	N
ASTHMA	Y	N		BACK PROBLEM	Y	N		BLOOD CLOT	Y	N		COPD	Y	N
CANCER	Y	N		CORONARY ARTERY DISEASE	Y	N		DEMENTIA	Y	N		DEPRESSION	Y	N
DIABETES: TYPE 1 OR TYPE 2 (CIRCLE)	Y	N		EMPHYSEMA	Y	N		EPILEPSY	Y	N		FIBROMYALGIA	Y	N
GERD	Y	N		GLAUCOMA	Y	N		GOUT	Y	N		HIV	Y	N
HEART DISEASE/ FAILURE	Y	N		HEPATITIS	Y	N		HIGH CHOLESTEROL	Y	N		HYPERTENSION/ HIGH BLOOD PRESSURE	Y	N
KIDNEY DISEASE	Y	N		LIVER DISEASE	Y	N		HEART ATTACK (MI)	Y	N		MIGRAINE HEADACHES	Y	N
NEUROPATHY	Y	N		OPEN SORES	Y	N		PNEUMONIA	Y	N		POLIO	Y	N
PULMONARY EMBOLISM	Y	N		SKIN DISORDER	Y	N		SLEEP APNEA	Y	N		STROKE	Y	N
TUBERCULOSIS	Y	N		THYROID DISEASE	Y	N		STOMACH ULCERS	Y	N				
OTHER CONDITIONS:														

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF:

CORONARY ARTERY DISEASE	Y	N		CANCER	Y	N		HIGH CHOLESTEROL	Y	N		DIABETES	Y	N
HEART DISEASE (DISORDER)	Y	N		HYPERTENSION (HIGH BLOOD PRESSURE)	Y	N		HEART ATTACH (MI)	Y	N		RHEUMATOID ARTHRITIS	Y	N
STROKE	Y	N		THYROID DZ	Y	N								

MEDICATIONS

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

MEDICATION NAME (IF A LIST IS AVAILABLE, PLEASE PROVIDE THE LIST TO THE FRONT DESK INSTEAD)

_____ _____

_____ _____

_____ _____

_____ _____

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

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE
_____		_____	
_____		_____	

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
_____		_____	
_____		_____	

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

SHOE SIZE: _____.

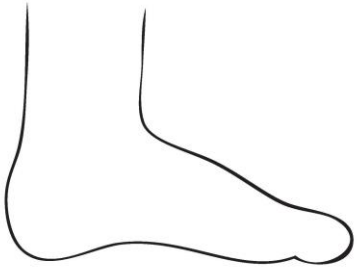
CURRENT PROBLEM

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

LAWRENCEVILLE FOOT CARE, LLC

DIVISION OF NEW JERSEY PODIATRIC PHYSICIANS & SURGEONS GROUP, LLC

E-PRESCRIBING CONSENT

E-PRESCRIBING IS DEFINED BY A PHYSICIANS 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 **LAWRENCEVILLE FOOT CARE, LLC,** DIVISION OF NJPPSG, 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 **LAWRENCEVILLE FOOT CARE, LLC,** DIVISION OF NJPPSG, 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 **LAWRENCEVILLE FOOT CARE, LLC,** DIVISION OF NJPPSG, TO ENROLL ME IN THE E-PRESCRIBE PROGRAM. THIS CONSENT WILL REMAIN ENFORCED UNTIL REVOKED OR CHANGED.

X_____ _____

PATIENT SIGNATURE PARENT/LEGAL GUARDIAN SIGNATURE

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 **LAWRENCEVILLE FOOT CARE, LLC**, A DIVISION OF NEW JERSEY PODIATRIC PHYSICIANS AND SURGEONS GROUP, LLC, 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, CARE TAKER 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

X_____ _____

PATIENT SIGNATURE SIGNATURE PARENT/LEGAL GUARDIAN

_____

DATE

LAWRENCEVILLE FOOT CARE, LLC

DIVISION OF NEW JERSEY PODIATRIC PHYSICIANS & SURGEONS GROUP, LLC

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.

_____ _____ X _____

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:_____**Date of Birth(required):**_____
Print Name:_____**Date of Birth(required):**_____
Print Name:_____**Date of Birth(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 Fax at the number listed above
_____ Leave message with call back numbers only ____ E-mail me at:_____

Other:_____

_____ X_____

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

_____ _____

Witness signature Date

LAWRENCEVILLE FOOT CARE, LLC

DIVISION OF NEW JERSEY PODIATRIC PHYSICIANS & SURGEONS GROUP, LLC

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 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.

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. Obtaining referrals from your primary physician and keeping track of your visits is your responsibility. If you do not have a valid referral at the time of your visit, your appointment will be rescheduled.

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. 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. We accept the following payment methods**: Credit Cards, Debit Cards, Cash, Checks.** 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 **LAWRENCEVILLE FOOT CARE, LLC** for medical services provided. I agree to pay **LAWRENCEVILLE FOOT CARE, LLC** 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 **LAWRENCEVILLE FOOT CARE, LLC, division of New Jersey Podiatric Physicians & Surgeons Group,** 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: X_____

FINANCIALLY RESPONSIBLE PARTY:

PRINT Name: _____ Signature: X_____
Relationship to Patient: _____ Date: _____