Morteza Khaladj, DPM
240 Williamson St. Ste 200 Elizabeth, NJ 07202 (908) 353-1777

Patient Information Form

Date:_____________ Name: ___________________________ Age:______

Home #:________________ Work #:______________ Cell #:____________

Address:_____________________ City: __________ State:_____ Zip ____

Social Security #: _________________________ Date of Birth: _________

Single ______ Married _______ Legally Separated _______ Divorced ______ Widowed ______

Primary Physician's Name:_________________________ Phone: ___________

Emergency contact:______________________________ Phone: __________

Primary Insurance:__________________________ ID#: ________________

Primary Holder's Name: __________________________ Phone: __________

Secondary Insurance: _______________________ ID#: ________________

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

________________________ ________________

Signature *Date*

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Assignment of Benefits Form

Date:____________ Patient Name: ______________________________

SS# / ID#: ____

I hereby instruct and direct all payments by check made out and mailed to:

Elizabeth Foot and Ankle Associates
240 Williamson St. Ste 200 Elizabeth, NJ 07202

for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above the insurance payment.
A photocopy of this Assignment shall be considered as effective and valid as original.
I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.
I authorize Dr. Khaladj to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

___________ ______________________ ______________________
Date Patient Signature Witness

Acknowledgement of Receipt of Privacy Practices

I have received a copy of Elizabeth Foot & Ankle Associates Privacy Practice with an effective date of March 16, 2010.

Name: ________________________________

Signature: ______________________________ Date: _______________