Elizabeth Foot & Ankle Associates

240 Williamson St, Suite 200   Elizabeth, NJ 07202   908-353-1777

Today's Date:	Primary Doctor:	Doctor's Phone Number:

PATIENT INFORMATION

Last name:	First:	Middle:	Marital status: (circle one) Single Married Divorced Separated Widowed

Email:	Birth date:	Age:	Sex: ◯ M ◯ F

Address:	Town:	State:	Zip code:

LAST FOUR of Social Security number:	Home phone no.:	Cell phone no.:
Occupation:	Employer	Employer phone no.:

Chose clinic because/referred to clinic by:

Pharmacy Name:	Address:

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Primary Insurance Name:	Policy number:	Group number:
Secondary insurance Name (if applicable):	Policy number:	Group number:

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Elizabeth Foot & Ankle Associates or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

Elizabeth Foot & Ankle Associates

240 Williamson St Suite 200   Elizabeth, NJ 07202   908-353-1777

Date: ________________________________

Last Name:_______________________________ First Name_____________________ DOB:_____________

Physical

Age:_________   Weight:______________

Height: _____________   Shoe Size:________________

Social History

Marital Status (circle): Single   Married   Divorced   Widowed

Drink (No) (Yes) <how many drinks per week> __________________________

Smoke (No) (Yes) <how many packs per week> __________________________

Past Medical History

- AIDs/HIV
- Alzheimer
- Anemia
- Arrhythmia
- Asthma
- Cancer
- Diabetes
- Epilepsy
- Fibromyalgia
- GERD
- Glaucoma
- Gout
- Hearing disorder
- Heart Attack
- Hepatitis
- High Blood Pressure
- High Cholesterol
- Hyperthyroid
- Hypothyroid
- Kidney Disease
- Liver Disease
- Lung Disease
- Nerve disorder
- Osteoporosis
- Poor Circulation
- Psychiatric Disorder
- Rheumatoid Arthritis
- RSD
- Sciatica
- Stomach Ulcer
- Stroke
- Valve Heart Disease
- Other:_______________

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____

Past Surgical History: ____

____

Allergies: ____

Medications: ____

____

____

Family History: (Heart Disease) (Diabetes) (Poor Circulation) (Other): __________________________

Foot problems that run in family? (NO)   (Yes):   _________________________________

Elizabeth Foot & Ankle Associates
240 Williamson Street Suite 200
Elizabeth, NJ 07202
Tel: (908) 353-1777

Patient Rights and Responsibilities

You are responsible for:

- Giving your Doctor's your correct and complete health history information, e.g. allergies, past and present illnesses, medications and hospitalizations.
- Providing staff with correct and complete name, address, telephone and emergency contact information each time you see your Doctor so we can reach you in the event of a schedule change or to give medical instructions.
- Providing staff with current and complete insurance information, including any secondary insurance, each time you see your Doctor.
- Telling your Doctor about all prescription medication(s), alternative, i.e. herbal or other, therapies, or over-the-counter medications you take.
- Telling your Doctor about any changes in your condition or reactions to medications or treatment.
- Asking your Doctor questions when you do not understand your illness, treatment plan or medication instructions.
- Following your Doctor's advice. If you refuse treatment or refuse to follow instructions given by your health care provider, you are responsible for any medical consequences.
- Keeping your appointments. If you must cancel your appointment, please call the office at least 24 hours in advance.
- Paying copayments at the time of the visit or other bills upon receipt.
- Following the office's rules about patient conduct; for example, there is no smoking, food, drinks, playing music, or use of cell phones in the office.
- Respecting the rights and property of our staff and other persons in the office.

Patient Signature:___________________________ **Date: _______________**

Elizabeth Foot & Ankle Associates
240 Williamson St Suite 200 Elizabeth, NJ 07202 908-353-1777

Assignment of Benefits Form

Date: ________________________

Patient Name: ____

LAST FOUR of Social Security #: ____

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

Elizabeth Foot & Ankle Associates
240 Williamson St Suite 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.
I have agreed to pay and financially responsible for all charges, in a current manner, of the above insurance:

- **Copays upon EACH visit**
- **Co-insurance**
- **Deductible**
- **Collection agency fees, attorney fees, and all fees pertaining to this collection.**
- **Past due bills are subject to interest charges at the rate of 1.5% per month.**

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 **Elizabeth Foot & Ankle Associates, PA** to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

______________________ ______________________ ______________________
Date Patient Signature Witness

Acknowledgment of Receipt of Privacy Practices

I have received a copy of Elizabeth Foot & Ankle Associates, PA privacy practice.

______________________ ______________________ ______________________
Date Patient Signature Witness

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describe your rights to access and control your protected health information. “Protected health information” is information mental health or condition and related health care services.

1. **Uses and Disclosures of Protected Health Information**

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminical Activity: Military Activity and National Security: Workers’ Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 126.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. Upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal

You have the right to change the terms of this notice and will inform your by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:____

Signature/Guardian;______________________________________ Date:____________________

For Office Use Only

A “good faith effort” was made to get a signature from the patient, guardian or caretaker. It was not obtained because:

- The patient, guardian or caretaker refused to sign or
- Other (Specify):____
- Physician Name:__________________________________ Signature: ______________________________________