1211 Hamburg Turnpike ●Wayne NJ 07470
Tel: (973) 692-1111
1060 Clifton Avenue 1st Floor ● Clifton NJ 07013
Tel: (973) 692-1111

Patient Information Form
(PLEASE PRINT)

Date: ___/____/____

Patient Name: _____ _____ Date Of Birth: ____/____/____ Age: ____ Sex: M F
LAST FIRST

Home Address: _____ City/State: _____ Zip: _____

MAY WE LEAVE A MESSAGE?

Home Phone #: (____) ____ - _____ YES NO

Alternate Phone #: (____) ____ - _____ YES NO

E-Mail:_____ YES NO

Primary Language: _____

Do you have a legal guardian or HealthCare Power Of Attorney? YES NO

If yes, Name: _____ Relationship: _____ Phone #: (____) _____ - _____

Emergency Contact: _____ Relationship: _____ Phone#: (____) _____- _____

Primary Care Doctor: _____ Who Referred You to Us? _____

Pharmacy: _____ Location: _____ Phone #: (____) ____ -_____

Is There A Family Member Or Other Person You Would Like For Us To Share Your Medical Information?

____ Yes Name(s) _____

____ No

Who Is Responsible For Payment? _____ Relationship to Patient? _____

Address: _____ City/State: _____ Zip: _____ Phone # :(____) _____ - _____

Insurance Information

Primary Insurance Company Name: _____

Address: _____ City/State: _____ Zip: _____ Phone #: (____) ____-____

Insured Name: _____ Date Of Birth: _____ Employer_____

Contract#:_____ Group#:_____

Secondary Insurance Company Name: _____

Address: _____ City/State: _____ Zip: _____ Phone #: (____) _____-_____

Insured Name: _____ Date Of Birth: _____ Employer_____

Contract#:_____ Group#:_____

Patient Name: _____ Date of Birth: _____

Please List All Medications You Are Currently Taking (Include Prescriptions, Over-The-Counter Meds and Herbal Supplements):

Name **Dose** **How Often Do You Take It**

_____
_____
_____
_____
_____
_____

Please List All Prior Surgeries:

Type of Surgery **Date** **Type of Surgery** **Date**

_____ _____
_____ _____
_____ _____

Please List All Prior Hospitalizations (Other Than For Surgery):

Reason for Hospitalization **Date** **Reason for Hospitalization** **Date**

_____ _____
_____ _____
_____ _____

Social History

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Use of Alcohol: ☐ Never ☐ No Longer Use ☐ History of Alcohol Abuse

Use of Tobacco: ☐ Never ☐ Quit- How Long Ago? _____ ☐ Smoke____Packs/Day for _____ Years

Use of Recreational Drugs: ☐ Never ☐ Quit- How Long Ago? _____ Type_____

Employer: _____ Occupation: _____

How Much Are You On Your Feet At Work? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

Do Others Depend Upon You For Their Care? ☐ Children- Age(s) _____ ▫ Pet(s) - _____

Exercise: ☐ Never ☐ Rare ☐ Occasional ☐ Weekly ☐ Several Times a Week ☐ Daily

Type of Exercise: _____

Family History

Do You Have a Family History Of: ☐ Diabetes ☐ Cancer ☐ Heart Disease ☐High Blood Pressure ☐Stroke

☐Coronary Artery Disease ☐ Thyroid Disease ☐Rheumatoid Arthritis ☐ Other_____

Patient Name: _____ Date of Birth: _____

Your Medical History

Allergies: □ None Known □ Medications _____

□ Anesthesia _____ □ Foods _____

□ Tape □ Latex □ Shellfish □ Iodine □ Other _____

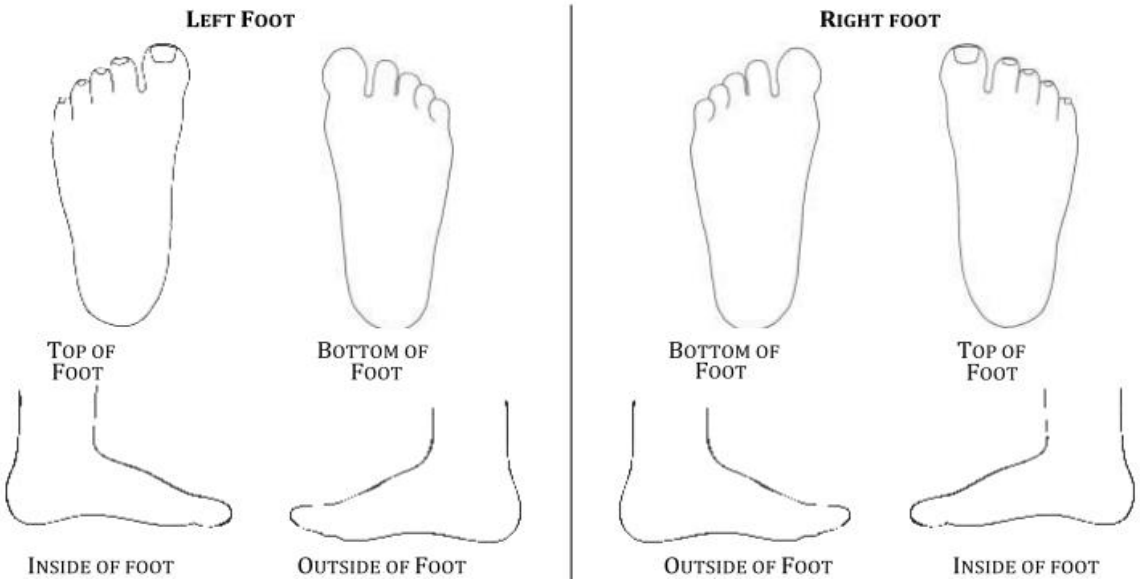
Have You Ever Had Any Of The Following?

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	MIGRANE HEADACHE	Y	N	THRYOID DISEASE	Y	N
DIABETES	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N

Current Problem

What Specific Problem Brings You To Our Office Today? _____

Where Is The Pain/Problem Located? Please Mark On The Pictures Below.



How Long Ago Did This Problem 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? □ No Pain □ Sharp □ Dull □ Aching □ Burning □ Radiating

□ Itching □ Stabbing □ Other: _____

How Would You Rate Your Pain On A Scale From 0 To 10? (Please Circle)

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Possible)

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?_____

How Has This Problem Affected Your LifeStyle Or Ability To Work?_____

Was This Problem Caused By An Injury? □ Yes (Describe) _____ □ No

If Yes, Was It A Work- Related Injury? □ Yes □ No

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.

_____ _____

Print Name Of Patient, Parent Or Guardian **Signature Of Doctor**

_____ _____

If Other Than Patient, Relationship To Patient **Date**

_____

Signature

_____

Date

Patient Name:_____ **Date Of Birth:_____/_____/_____**

REDS
ANKLE & FOOT
ASSOCIATES
DR. HUMAIRA SYED

We at Reds Ankle & Foot Associates are committed to providing you with the best possible care. If you have Medical Insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding on our payment policy.

1. MEDICARE PATIENTS: We would like you to understand that accepting assignment means that YOU are responsible for the YEARLY DEDUCTIBLE and for the 20% (co-insurance) of what Medicare allows. You are also responsible for service that you're supplemental/ secondary insurance does not cover.

2. All co-payments are due at the time of visit. The returned check fee is $45.00.

3. Co-insurance and unmet deductibles are due prior to scheduled surgeries and procedures. Once benefits are verified and your financial responsibility calculated, you will be notified of the payment amount and due date.

4. If your plan requires a referral, it is your responsibility to obtain this prior to being seen by our provider. It is also your responsibility to ensure that our physician is in your insurance network.

5. Cancellations for appointments and procedures must be received at least 24 hours prior to the scheduled appointment. Cancellations for appointments will be charged $25.00 cancellation fee. Cancellations for scheduled surgery must be received at least 5 days prior to the scheduled surgery date and time. Patient who fail to cancel a scheduled surgery will be charged a $100.00 cancellation fee.

6. Medical records requests must be received in writing at least 72 hours prior to the date needed. Fees for medical records are set in accordance with allowable amounts as defined by the state of New Jersey. Fees must be received prior to record delivery, the fee for these records are $25.00.

7. Administrative Services: There is a $25.00 charge for each Administrative Service payable prior to service completion. This Administrative Service Fee covers specific administrative services such as forms completion for family medical leave and disability and letters for insurance authorization.

8. PATIENT REFUNDS: Please allow 60 days from the time your insurance company responds to a claim for your deposit refund to be processed. Refunds will be issued in the form of a paper check that will be mailed to your home address.

I, _____, have received, read, and understand the financial policy at Reds Ankle & Foot Associates

_____ _____

Signature of Patient Date

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To be valid, this form must be filled out COMPLETELY, including what information you are giving us permission to share.

Patient's Legal Name: _____ **DOB:** _____

I HEREBY AUTHORIZE REDS ANKLE AND FOOT ASSOCIATES :

- ✓ $\frac{1}{60}$Any of my medical information, including information about:
- ✓ Mental health diagnoses and treatment* $\frac{2}{10}$
- ✓ My lab results
- ✓ My appointment times, dates, and reasons for the visit
- ✓ The medications I am taking

WITH THE FOLLOWING PEOPLE:

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

I understand that I may cancel this consent at any time (by writing to CHC Medical Records), but that cancelling it will not affect any information that has already been released.

I understand that I do not have to sign this form, and that I should only sign it if I want my medical provider or my clinic to share my information with someone.

Signature: _____
This authorization will only expire if I cancel it in writing.

Witness: _____ Date: _____

A minor patient's signature is required for us to share information about care for conditions

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PAYMENT POLICY

The filing of insurance claims is a courtesy we extend to our patients. We are happy to assist you in billing most insurance companies. However, we must emphasize that your insurance is contract between you and your insurance company. We are not party to that contract.

Many of the services provided in this office are covered and paid by your insurance company. In cases where the service has not been paid, you will be personally responsible for the balance. If the patient is a minor, the person brings the minor to the office for treatment is responsible for payment of the bill.

Payments for services are due at the time service is rendered.

We accept cash, checks and all Visa or MasterCard. To assist you in making payments if special circumstances arise, we would be happy to arrange an automatic debt payment schedule to facilitate regular agreed upon payments.

Account balances:

0-30 days --- no interest

31-60 days – interest accrues

90 days and over will be turned over to CFS, LLC

Signature: _____ Date: _____

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding the attached Notice of Privacy Practices

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information.

USES AND DISCLOSURES BASED ON YOUR AUTHORIZATION

We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation, and training of students.

USES AND DISCLOSURES and disclosures Not Requiring Your Authorization

In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care.
- For certain limited research purposes.
- For purposes of public health and safety.
- To Government agencies for purposes of their audits, investigations and other oversight activities.
- To government authorities to prevent child abuse or domestic violence.
- To the FDA to report product defects or incidents.
- To Law enforcement authorities to protect public safety or to assist in apprehending criminal offenders.
- When required by court orders, search warrants, subpoenas and as otherwise required by the Law.

Patient Rights

- To have access to and/ or a copy of your health information,
- To receive an accounting of certain disclosures we have made of your health information.
- To request restrictions as to how your health information is used or disclosed.
- To request that we communicate with you in confidence.
- To request that we amend your health information.
- To receive notice of our privacy practices.

ACKNOWLEDGEMENT OF RECIEPT 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 understood the notice.

_____ _____

Patient Name (Please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature