West Morris Foot and Ankle

Erato Giokas, DPM, MS, DABPM, AACFAS

Board Certified, American Board of Podiatric Medicine
Associate, American College of Foot and Ankle Surgeons

DATE: _____

NAME: _____
LAST *FIRST* *MIDDLE*

DATE OF BIRTH: _____ **SOCIAL SECURITY NUMBER:** _____

STREET ADDRESS: _____

CITY: _____ **STATE:** ___ **ZIP CODE:** _____

GENDER: _____ **MARITAL STATUS:** _____

PRIMARY LANGUAGE SPOKEN: _____

ETHNICITY: Hispanic or Latino? _____

RACE: _____

PHONE NUMBERS: HOME

CELL

EMAIL ADDRESS: _____

EMERGENCY CONTACT NAME: _____ **Phone: (___) - ____ - ____**

WORK STATUS:

EMPLOYER: _____

PRIMARY CARE PHYSICIAN: _____

WHO REFERRED YOU TO OUR OFFICE: _____

NAME OF PRIMARY INSURANCE: _____

NAME OF SECONDARY INSURANCE: _____

POLICY HOLDER NAME: _____ **POLICY HOLDER DOB:** ____/____/_____

RELATIONSHIP TO POLICYHOLDER: _____

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Patient Name: _____ **Today's date:** _____

Reason for today's visit: _____

Date last seen at Primary Care Physician's Office: _____

Allergies: _____

Current Medications:

_____

_____

Past Medical History: _____

_____

Past Surgical History:

_____

Family Medical History:

Father: _____

Mother: _____

Brother(s): _____

Sister(s): _____

Social History:

Do you smoke cigarettes: **Previous smoker?** _____

How many packs per day? **For how many years?** _____

Do you drink alcohol?

How many alcoholic drinks per week?

Shoe Size: _____ **Height:** _____ **Weight:** _____

Pharmacy Name: _____

Pharmacy Address: _____

Patient Signature: _____ **Date:** _____

151 NJ-10, Suite 102, Succasunna, NJ 07876 P: (973)-370-3759 F: (973)-695-1490

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ACKNOWLEDGEMENT OF RECEIPT NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided an opportunity to read (if I chose to) a copy of the notice of Privacy Practices and understood the notice.

_____ **Date:** _____

Patient Name (print)

_____

Parent of Authorized Representative (if applicable)

_____

Signature

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INSURANCE

Although I have health insurance, I am aware that there is no guarantee of payment. If my insurance company denies payment, I understand that I am ultimately responsible for this bill.

If my insurance requires a referral, it is solely my responsibility to obtain the referral before my office visit. If I do not obtain the referral prior to the visit, payment for the visit is my responsibility.

I am responsible to notify the office of any and all changes in my health insurance and present updated cards in coordination. If I do not provide accurate information, I am responsible for the payment of the office visit.

I hereby authorize and guarantee payment for all services rendered.

Although fees for services are due and payment expected at the time services are rendered, if I have been granted a grace period for payment of fees, I acknowledge that payment is due and expected at the time the billing statement is received.

In the event that my account balance becomes delinquent for more than 30 days, I also agree to pay a finance charge of 1.5% per month on any balance due, as well as all reasonable collection costs not to exceed 50%, court costs, attorney fees and interest fees accrued with the collection of this account.

_____

Patient name (Print)

_____ _____

Patient Signature or Responsible Party **Date**

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HIPAA Consent Form

I, _____, understand that under the Health Portability and Accountability Act 1996 (HIPAA) I have certain rights to my privacy regarding my health information. I also understand that West Morris Foot & Ankle originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, test results, diagnosis, treatments and any plans for future care and treatment at West Morris Foot & Ankle.

I understand that this information can be used as:

- **A basis for planning my care and treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly or indirectly**
- **A means of communicating among the many health professionals who contribute to my care**
- **A means by which a third-party payor can verify that the services billed were actually provided and obtain payment from third party payers**
- **A tool for routine healthcare operations such as assessing quality and receiving the competence of healthcare professionals**

I prefer to have notification of my healthcare information by the following methods. Please check all applicable:

_____ Home telephone
_____ Cell phone
_____ If I am not available you may leave a message with family member
_____ Detailed message on answering machine
_____ Work phone with direct contact only

My health information may also be discussed with the following people upon their request:

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Patient Signature: _____ Date: _____