RIVERVIEW FOOT & ANKLE ASSOCIATES

130 Maple Avenue, Ste 130
Red Bank, NJ 07730
Ph: 732-747-2111
Fx: 732-530-1348

509 Stillwells Corner Road, Ste. E9
Frrehold, NJ 07728
Ph: 732-866-8400
Fx: 735-530-1348

312 Applegarth Road, Ste 207
Monroe Twp., NJ 08831
Ph: 609-409-8381
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www.riverviewfootandankle.com

Steven Deitch, D.P.M. • Richard A. Leichter, D.P.M. • Joseph Wendolowski, D.P.M • Nazia Shah, D.P.M. • Sharon I. Monter, D.P.M.

General Vital Information

Today's Date: _____

Name: _____ Nickname: _____

Sex: M / F SS #:_____ DOB: _____

E-mail: _____ House #: _____

Address: _____ Work #: _____

City: _____ State: _____Zip:_____ Cell #: _____

Preferred way for confirming appointments: ☐ Text ☐ Email

Preferred Phone Number: _____

Primary Care Physician: _____ PCP Phone: _____

PCP Address: _____ Town: _____

Preferred Pharmacy: (Name) _____ (Phone): _____

(Address) _____ (Town)_____

Emergency Contact Name: _____ Relationship to Patient: _____

Emergency Contact Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Widowed ☐ Divorced

Employer/School: _____ ☐ Full-Time ☐ Part-Time ☐ Retired

Please provide a copy of your insurance card to our staff.

Insurance Policy Holder Name: _____Policy Holder DOB: _____

Relationship of patient to Policy Holder: _____Policy Holder's SS #: _____

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NAME: _____

MEDICAL INFORMATION

Please answer the following questions completely.

MEDICAL HISTORY

Please indicate if you have a problem with any of the following:

AIDS/HIV	Yes	No	Hepatitis or Jaundice	Yes	No
Alcoholism	Yes	No	High / Low Blood Pressure	Yes	No
Allergies	Yes	No	High Cholesterol	Yes	No
Anemia	Yes	No	Kidney Problems	Yes	No
Angina	Yes	No	Liver	Yes	No
Arthritis	Yes	No	Musculoskeletal	Yes	No
Artificial Heart Valves/Joints	Yes	No	Neurological	Yes	No
Asthma	Yes	No	Neuropathy	Yes	No
Back Problems	Yes	No	Phlebitis	Yes	No
Blood Disorders	Yes	No	Psychiatric Care	Yes	No
Blood Clot/DVT/PE	Yes	No	Radiation Treatment	Yes	No
Breathing Problems	Yes	No	Rash	Yes	No
Cancer	Yes	No	Respiratory Disease	Yes	No
Chemical Dependency	Yes	No	Rheumatic Fever	Yes	No
Chest Pain	Yes	No	Shortness of Breath	Yes	No
Chronic Diarrhea	Yes	No	Sinus Problems	Yes	No
Circulation problems	Yes	No	Skin Disorder	Yes	No
Depression/anxiety	Yes	No	Sleep Apnea	Yes	No
Diabetes (type 1, type 2)	Yes	No	Stomach	Yes	No
Ear Problems	Yes	No	Stroke	Yes	No
Epilepsy	Yes	No	Swollen Neck Glands	Yes	No
Eye Problems	Yes	No	Thyroid	Yes	No
Fainting	Yes	No	Tuberculosis	Yes	No
Gout	Yes	No	Ulcers	Yes	No
Headaches	Yes	No	Varicose Veins	Yes	No
Heart Disease	Yes	No	Venereal Disease	Yes	No
Heart Murmur	Yes	No	Weight Loss, unexplained	Yes	No
Hemophilia	Yes	No	Other:_____		

Are you pregnant? ☐ **YES** ☐ **NO** **Are you nursing?** ☐ **YES** ☐ **NO**

MEDICAL INFORMATION

NAME: _____

MEDICATIONS

Please list current prescriptions prescribed by a doctor, including over the counter medications, vitamins and supplements.

_____

_____

_____

_____

Pharmacy Name

_____

Pharmacy Phone #

_____

Pharmacy Town

_____

ALLERGIES

Are you allergic or sensitive to any of the following:

☐ Penicillin ☐ Sulfa ☐ Tape ☐ Latex ☐ Betadine (iodine) ☐ Aspirin ☐ NONE
☐ Tylenol ☐ Ibuprofen ☐ Vicodin ☐ Codeine ☐ Other (specify) _____
☐ Local or general anesthesia

SURGICAL HISTORY

Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? ☐ YES ☐ NO

If yes, please describe surgeries you have had: _____

_____

_____

Do you have any artificial joints? Where? ☐ YES ☐ NO _____

Do you have an artificial heart valve? ☐ YES ☐ NO

FAMILY HISTORY

Is there any family history of any of the following: (Please circle if applicable)

Arthritis	Bleeding Disorder	Blood Clot/DVT/PE	Bunions
Cancer	Circulation Problems	Diabetes	Neurological
Heart Disease	Strokes	Other (specify):_____	

MEDICAL INFORMATION

NAME: _____

PODIATRIC HISTORY

What is the main complaint for which you came to be treated? _____
_____
_____

How long has this bothered you? _____ Days _____ Weeks _____Months _____ Longer

What treatments have you tried? _____
_____
_____
_____

Have you ever been to a podiatrist before: Yes NO Last visit: _____

How did you hear about our office? _____

Please indicate which foot problems you now have or have had in the past:

- ☐ Ankle Pain
- ☐ Ankle instability (easy twisting injuries)
- ☐ Ankle swelling or stiffness
- ☐ Achilles Tendon Pain
- ☐ Leg Pain
- ☐ Bunions
- ☐ Numbness in feet/toes or legs
- ☐ Flat Feet
- ☐ Cramps in feet or legs
- ☐ Heel or Arch Pain
- ☐ Swelling in feet or ankles
- ☐ Ingrown Toenails
- ☐ Athlete's Foot
- ☐ Corns/ Calluses
- ☐ Plantar Warts
- ☐ Tired Feet
- ☐ Pale or blue discoloration of the feet
- ☐ Non/poor healing sore, ulcer or gangrene on the leg or foot
- ☐ Pain or fatigue of feet or legs during activity or exercise
- ☐ "Toe-in" or "Toe-out" gait (walking)

SHOES:

Shoe Size _____ Height _____ Weight _____

What type of shoes do you wear most often? _____

SOCIAL HISTORY

Your occupation: _____

Do you smoke?	Yes	No
Did you smoke in the past?	Yes	No
Do you drink alcohol?	Yes	No
Do you use recreational drugs?	Yes	No

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Assignment of Benefits & Authorization to Release Information

(Patient releases benefits and agrees to pay us for our services)

If I am entitled to benefits under the Medicare or any insurance policy or other health benefit plan (covering me or anyone legally responsible for me), in consideration for services provided to me by Riverview Foot and Ankle Associates, I assign, transfer and convey the benefits payable under such program, policy or plan for services rendered to me. I authorize payment of benefits directly to Riverview Foot and Ankle Associates, with such benefits to be applied to my bill. I understand and acknowledge that this assignment does not relieve me of financial responsibility for charges incurred by me or anyone on my behalf, and I hereby acknowledge responsibility for and agree to pay charges not paid under this assignment, including any coinsurance amounts, deductibles, Durable Medical Equipment, and any charges for services deemed to be non-covered, not pre-certified, or not pre-authorized by my insurance.

_____ (initial) I give my consent for examination and treatment by Riverview Foot and Ankle Associates.

Responsible Party Signature: _____

Relationship: _____ Date: _____

E-PRESCRIBING CONSENT FORM

(The patient allows us to access their pharmacy records and send prescriptions)

ePrescribing id defined by a Physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribe program.

These include:

- Formulary and benefit transactions – gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions – provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

I authorize Riverview Foot and Ankle Associates to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my provider and staff at Riverview Foot and Ankle Associates 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 Riverview Foot and Ankle Associates record.

Understanding all of the above, I hereby provide informed consent to Riverview Foot and Ankle to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction. This consent will remain valid until revoked or changed.

Signature of Patient/Parent/Guardian: _____ Date: _____

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FINANCIAL RESPONSIBILITY

We at Riverview Foot and Ankle 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.

Unless INSURANCE ARRANGEMENTS have been approved in advance by our staff, payment for services is due at the time services are rendered. We accept payment in the form of cash, check, MasterCard, American Express, Discover and Visa. We will be happy to help you process your insurance claim at each visit.

Returned checks and balances older than 30 days are subject to additional collection fees and interest of 1.5% per month. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize, however, that:

1. Insurance is a contract between you and your insurance company.

2. Our fees generally fall within the acceptable range by most insurance companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of U.C.R. “U.C.R.” is defined as Usual, Customary and Reasonable fees for this region. Thus, our fees are considered Usual, Customary, and Reasonable by most companies. This does not apply to companies who reimburse based on arbitrary “schedule” of fees, which bears no relationship to the current standard of fees and cost of care in this area.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily refuse to cover certain services. We have no control over this.

4. MEDICARE PATIENTS: We would like you to understand that accepting assignment means that YOU are responsible for the YEARLY DEDUCTIBLE and the 20% (co-insurance) of what Medicare allows. You are also responsible for services that your supplemental /secondary insurance does not cover. If your supplemental/ secondary insurance does not pay this amount, YOU are responsible for it.

The filing of insurance claims is a courtesy that we have always extended to our patients. However, all charges are your responsibility, not your Insurance Company’s. We will make our best effort to collect from them, but if, despite our best efforts, we are not successful, you are responsible for the unpaid balance.

We realize that temporary financial problems may affect timely payment of your account. We don’t want any financial problems to get in the way of our good relationship with you. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We really are here to help you.

1. All co-payments are due at the time of visit. Postdated checks are not accepted.
2. 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.
3. You are ultimately responsible for payment of charges for services you receive from our office.
    a. In accordance with your insurance member handbook, it is your responsibility to provide accurate insurance information and to present your insurance ID card at the time of your visit. If you do not have insurance or do not present a valid insurance card, you will be responsible for payment at the time of service. We will provide you with a copy of our billing form so that you can obtain reimbursement from your insurance company.
4. It is your responsibility to ensure that our physician is in your insurance network.
5. If you plan requires a referral, it is your responsibility to obtain this prior to being seen by our provider.
6. Cancellations for appointments and procedures must be received at least 24 hours prior to the scheduled appointment. Cancellations for scheduled surgery must be received at least 5 days prior to the scheduled surgery date and time. Patients who fail to cancel a scheduled appointment will be charged a $50.00 cancellation fee.
7. Payment is due for rendered services 30 days from the date of your billing statement. Unpaid previous balances must be paid in full prior to any additional visits, unless arrangements have been made with our financial counselor.
8. The returned check fee is $35.00
9. 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. No more than 5 pages may be faxed.
10. 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, letters for insurance authorization for brand or non-formulary drugs, letters for employers, school, health clubs, and any other administrative item not covered by insurance.
11. All sales are final with any over the counter (OTC) or durable medical equipment (DME) items.
12. PATIENT REFUNDS: Please allow 60 days from the time your insurance company responds to a claim for your refund to be processed. Refunds will be issued in the form of a paper check that will be mailed to your home address.
13. COLLECTIONS FEE: 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 will be forwarded to our collection agency. If your account is sent to a collection agency, a 35% fee will be added to your account. You bear complete financial responsibility for any fee(s) incurred.

I, _____, have received, read, and understand the financial policy of Riverview Foot and Ankle Associates.

_____ _____

Signature of Patient **Date**

_____ _____

Signature of Guardian **Date**