Amit Shah, D.P.M., FACFAS
Simran Bains, D.P.M., AACFAS

Sports Medicine and Foot & Ankle Specialist
Board Certified in Foot & Ankle Surgery

619 AMBOY AVENUE
EDISON, NJ 0883
PHONE: 732-903-2500
Fax: 732-297-8421

3176 ROUTE 27 SUITE 1C
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109 S. MAIN STREET
CRANBURY, NJ 08512
PHONE: 732-297-9535
Fax: 732-297-8421

Date: _____

Patient Name: _____ **Date of Birth:** _____

Age: _____ **Sex:** M F **Primary Language:** _____ **Race:** _____ **Ethnicity:** _____

Address: _____ **City/State:** _____ **Zip:** _____

Home Phone: (_____) _____-_____ **Cell Phone:** (_____) _____-_____

Email Address: _____ **(will not be shared)**

Employer: _____ **Work Phone:** (_____) _____-_____

Emergency Contact: _____ **Relationship:** _____ **Phone:** (_____) _____-_____

Primary Care Doctor: _____ **Date last seen:** _____

Phone: (_____) _____-_____ **Address:** _____ **City/State:** _____

Pharmacy: _____ **Location:** _____ **Phone:** (_____) _____-_____

Who is responsible for payment? _____ **Relationship:** _____

Phone: (_____) _____-_____ **Who referred you to us?** _____

Insurance Information

Primary Insurance Company Name: _____

Address: _____ **City/State:** _____ **Zip:** _____ **Phone:** (_____) _____-_____

Insured Name: _____ **Date of Birth** _____ **Employer** _____

ID # _____ **Group #** _____

Secondary Insurance Company Name: _____

Address: _____ **City/State:** _____ **Zip:** _____ **Phone:** (_____) _____-_____

Insured Name: _____ **Date of Birth** _____ **Employer** _____

ID # _____ **Group #** _____

MEDICATIONS

Please list all medications you are currently taking (Include prescriptions, over-the-counter meds and herbal supplements):

Medication Name	Dose	How often do you take it?

Please list all prior surgeries:

Type of Surgery	Date	Type of Surgery	Date

Social History

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

Use of Alcohol: ☐ Never ☐ No longer use ☐ History of alcohol abuse
☐ Current USE - Type _____ ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

Use of Tobacco: ☐ Never ☐ Quit – how long ago? _____ ☐ Smoke _____ packs/day for ____ years

Use of Recreational Drugs: ☐ Never ☐ Quit – How long ago? _____ Type _____

☐ Current USE - Type _____ ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

Family History

Do you have a family history of: ☐ Diabetes: Type 1 or Type 2 ☐ Cancer ☐ Heart Disease

☐ High Blood Pressure ☐ Stroke ☐ Coronary Artery Disease ☐ Bleeding Disorder

☐ Rheumatoid Arthritis ☐ Other _____

Your Medical History

Allergies: ☐ Medications _____

☐ Anesthesia _____ ☐ Foods _____

☐ Tape ☐ Latex ☐ Shellfish ☐ Iodine ☐ Other _____

☐ None Known

REACTION: _____

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	Migraine Headaches	Y	N	Thyroid Disease	Y	N
Diabetes: Type 1 or Type 2 (circle)	Y	N	Mitral Valve Prolapse	Y	N	Tuberculosis	Y	N
Other Conditions:											

Current Problem

What specific problem brings you to our office today?

_____

How long ago did this problem first 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 or symptoms?

☐ No pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning

☐ Radiating ☐ Itching ☐ Stabbing ☐ Other _____

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 treatments have you had for this problem? _____

Was this problem caused by an injury? ☐ Yes ☐ no (Describe)_____

If yes, was it a work-related injury? ☐ Yes ☐ No

E-Prescribing Consent

E-Prescribing is defined by a physician's ability to electronically send an accurate, error free, and understandable prescription directly to your pharmacy. The government has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The medicare modernization act 2003, listed standards that have to be included in an e-prescribing program. These include: (1) Formulary and benefit transactions, which gives the prescriber information about which drugs are covered by a drug benefit plan; (2) medication history transactions, which provides the physician with information about medications the patient is already taking to minimize adverse drug events.

I authorize Amit Shah, DPM, LLC, to view my external prescription history via electronic e-prescribing services. I understand that prescription history from multiple, other unaffiliated, providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by the providers and staff of Amit Shah, DPM, LLC 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 record at this practice. Understanding all of the above, I hereby provide informed consent to Amit Shah, DPM, LLC, to enroll me in the e-prescribe program. This consent will remain enforced until revoked or changed.

_____ _____

patient signature parent/legal guardian signature

I certify, 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.

I give permission to the doctors at Amit Shah, DPM, LLC, a division of New Jersey podiatric physicians and surgeons group, llc, to administer and perform any diagnostic, therapeutic and/or operative procedures as may be deemed medically necessary in diagnosis and/or treatment of my condition.

Patients/minors under the age of 18, will not be treated without a parent or legal guardian present. If another family member, caretaker or friend, over the age of 18 will be present; written consent from the parent/legal guardian stating as such must be presented at the time of the appointment. Thank you.

_____ _____

print name of patient print parent/legal guardian

_____ _____

patient signature signature parent/legal guardian

_____

date

PATIENT BILLING: 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 may be forwarded to collections with interest accruing on balance. It is also your responsibility to pay for the interest accrued if sent to collections. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payment methods: cash, all major credit cards and personal checks. An additional $35.00 will be added to your statement if the check is returned for insufficient funds. In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance. I have read the above policy regarding my *financial responsibility* to Amit Shah, DPM, LLC for medical services provided. I agree to pay Amit Shah, DPM, LLC any balance unpaid by my insurance carrier for myself or the below named person.

Assignment of Benefits
I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Amit Shah, DPM, LLC, a division of New Jersey Podiatric Physicians & Surgeons Group**,** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested a physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

PRINT Patient Name: _____Signature: _____

FINANCIALLY RESPONSIBLE PARTY:

PRINT Name: _____Signature: _____

Relationship to Patient: _____ Date: _____

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PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Practice's *Notice of Privacy Practices*:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

_____ _____ _____
Name of Patient **Date of Birth** **Signature of Patient/Parent/Guardian**

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such a person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name:_____**Last four digits SSN (required):**_____
Print Name:_____**Last four digits SSN (required):**_____
Print Name:_____**Last four digits SSN (required):**_____

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home Telephone Number: **Written Communication Address:**

_____ _____ _____ _____ _____

___ OK to leave message with detailed information
____ Leave message with call back numbers only

____ OK to mail to address listed above
____ Email me at:_____

Work Telephone Number: **Fax Number:**

_____ _____

___ OK to leave message with detailed information
____ Leave message with call back numbers only

____ OK to Fax at the number listed above
____ Email me at:_____

Other:_____

_____ _____
Name of Patient (Printed) Signature of Patient/Parent/Guardian

_____ _____
Witness signature Date

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Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

Appointment: A Scheduled appointment means that time is reserved only for you. If an appointment is missed or cancelled with less than twenty-four hours notice, you will be billed **$50.00**. Your health plan does not cover payment for missed appointments; therefore, you are responsible for payment in full.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE: We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However; that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any coinsurance, which is usually 20% of the allowed amount for an item or service.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

COPAYMENTS AND DEDUCTIBLES: All copayments and deductible must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

SELF PAY: Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment of these services.

REFERRALS/AUTHORIZATIONS: We are <u>required</u> to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you <u>must</u> have a referral from your primary care physician prior to seeking specialty care. Obtaining referrals from your primary physician and keeping track of your visits is your responsibility. If you do not have a valid referral at the time of your visit, your appointment will be rescheduled.

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility. Your insurance benefit is a contract between you and your insurance company.