PATIENT INFORMATION SHEET

FULL NAME ____ DATE ___________

ADDRESS___________________________________ CITY __________________ STATE _______ ZIP _________

HOME PHONE (_____)____________________ CELL (_____)________________________

FULL DATE OF BIRTH _________________________________ AGE ____________ SEX (M) (F)

MARITAL STATUS (S, M, D, W, SEP.) SOCIAL SECURITY # ______________________________________

OCCUPATION ____ EMAIL _______________________________

TREATMENT AUTHORIZATION

I hereby give permission to Dr. Mark A. Majeski and/or associates to administer appropriate care necessary in the diagnosis and/or treatment of my foot condition.

INITIAL _____________

INSURANCE AUTHORIZATION

I hereby give permission to Dr. Mark A. Majeski and/or associates to submit a claim to my insurance carrier or its intermediaries for all services rendered and to release medical information to my insurance carrier for the purpose of claims payment.

INITIAL _____________

I also understand that if my insurance company denies treatment as non-covered services under the terms of my insurance contract, I will be responsible for all charges.

I understand that I am financially responsible to Dr. Mark A. Majeski and/or associates for insurance deductibles and any balance not covered by my insurance carrier.

A COPY OF THIS SIGNATURE IS VALID AS THE ORIGINAL

PATIENT SIGNATURE ____ **DATE** ___________

PLEASE PRINT THE FOLLOWING INFORMATION CLEARLY

FULL NAME ____ DATE _____________

AGE _______________ HEIGHT ______________ WEIGHT _____________ SHOE SIZE __________

WHOM MAY WE THANK FOR REFERRING YOU____

PLEASE LIST YOUR MEDICAL/FAMILY DOCTOR ____

WHAT IS THE REASON FOR YOUR VISIT? ____

____

Is this a workman's comp case/auto accident? ____

Name/Phone number of Local Pharmacy ____

GENERAL HEALTH

- □ ARTHRITIS
- □ ASTHMA
- □ DIABETES (INSULIN/ NON-INSULIN)
- □ EMPHYSEMA
- □ EPILEPSY
- □ EYE PROBLEMS
- □ GLAUCOMA
- □ GOUT
- □ HEART ATTACK
- □ HEART DISEASE
- □ HIGH BLOOD PRESSURE
- □ HIGH CHOLESTEROL
- □ KIDNEY DISEASE
- □ LUNG DISEASE
- □ PVD / PAD
- □ RHEUMATIC FEVER
- □ SCARLET FEVER
- □ STOMACH PROBLEMS
- □ STROKE
- □ TUBERCULOSIS
- □ VENEREAL DISEASE
- □ OTHER ____

____

MEDICATIONS/ DOSAGES (please list all medications you are currently taking)

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

ALLERGIES (please check allergies)

- □ ADHESIVE TAPE
- □ CODEINE
- □ IODINE
- □ LATEX
- □ NOVOCAINE
- □ PENICILLIN
- □ SHELLFISH
- □ SULFA DRUGS
- □ OTHER ______________________________

____

Have you had any serious illnesses or operations? □ **NO** □ **YES** (please explain) ___________________________

____

□Knee replacement? RT / LT □Hip replacement? RT / LT □Heart stent? □Pacemaker?

FAMILY HISTORY- if any member of your immediate family has any of the following, please check

- □ ARTHRITIS
- □ ASTHMA
- □ DIABETES
- □ GOUT
- □ HIGH BLOOD PRESSURE
- □ HIGH CHOLESTEROL
- □ HEART DISEASE
- □ PVD
- □ OTHER ______________________________

Do you smoke? □ Current Smoker □ Former Smoker □ Non-smoker

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS CORRECT

PATIENT SIGNATURE ____ **DATE** ___________

PURPOSE: To state the overall rights of our facility.

POLICY: Each patient shall have the following rights:

- To be offered a written copy of these rights.
- To be given a written or verbal explanation of these rights in terms he/she can understand.
- To be informed of the services available in our facility.
- To be informed of the names and professional status of the personnel providing and/or responsible for the patient's care.
- To be informed of fees and related charges, including policies for payment, deposits, and refunds and any charges for services not covered by insurance.
- To be informed if our facility has authorized other healthcare and/or educational institutions to participate in the patient's treatment. The patient also has the right to know the identity and function of the institutions and to refuse their participation in the patient's treatment.
- To receive from the patient's physician or clinical practitioner, in terms that he/she can understand, an explanation of his/her complete medical health condition or diagnosis, recommended treatment, treatment options (including the option of no treatment,) risks of treatment and expected results. If this information would be detrimental to the patient's health or if the patient is not capable of understanding the information, the explanation shall be given to the patient's next of kin or guardian.
- To participate in the planning of patient's care and treatment. To refuse medication and treatment.
- To voice grievances or recommend changes in policies and services to facility personnel, the governing authority and/or outside representative of the patient's choice either individually or as a group, and free from restraint, interference, coercion, discrimination or reprisal.
- To keep treatment information about the patient confidential. Information in the patient's medical record shall not be released to anyone outside our facility without the patient's approval, unless another health care facility in which the patient was transferred requires third-party payment contract, or peer review, or unless the information is needed by the New Jersey Department of Health for authorization purpose.
- To be treated with courtesy, consideration, respect and recognition of the patient's dignity, individuality and right to privacy, included by not limited to auditory and visual privacy. The patient's privacy shall also be respected when facility personnel are discussing the patient.
- To not be discriminated against because of age, race, religion, sex, nationality, or ability to pay. To not be deprived of any constitutional, civil, and/or legal rights solely because of receiving services from our facility.

May we leave a voicemail on your answering machine? YES / NO
Please list the people you permit us to share your medical information with ____________________________
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PATIENT SIGNATURE ____ **DATE** ___________

FINANCIAL POLICY

This policy applies to all patients. Payment is due at the time service is received. For your convenience, we accept cash, checks and credit cards. Co-payments must be paid on the date of service. Patients are responsible for deductibles, coinsurance amounts and charges not paid by insurance due to failure to present proper paperwork. All charges are subject to a chart and coding review prior to being finalized. Bills on demand are estimates only and should not be used for claims nor are considered final bills.

As a courtesy, our office will automatically file primary and secondary claims. Patient responsible balances are billed monthly. Accurate and complete insurance information, including changes, must be provided to the front desk at the time of service. We will directly bill patients who fail to provide correct, timely information. We understand that unusual circumstances may occur and that payment in full at the time of service or post insurance payment may not always be possible. Patients may discuss special payment needs with billing department.

Accounts not paid in accordance to terms of credit or incomplete financial arrangements will nullify any prior agreements. Physician services are provided to patients, not to insurance companies, thus patients are responsible for charges for care received. If your insurance company has delayed payment on claims past 180 days, balances will revert directly back to patient responsibility. Patients can then independently deal with their insurance company. Patient balances due are payable within 90 days after the first invoice. A late fee of $3.00 will be charged each month to delinquent accounts. After 90 days, we will send delinquent accounts over to a collections agency. Balances in collections are payable to our agent, APEX Collections.

I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary.

I agree, in order for us to service your account or to collect monies you may owe, Main Street Foot and Ankle, LLC and /or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

Other fees: Returned check fee is $25.00 per occurrence. A $15.00 per form fee, plus any postage, applies to forms over and above normal billing and/or medical records handling. Examples of such forms are rental assistance forms, disability forms, and motor vehicle forms.

In cases of divorce, the parent who brings the child/children into the office for treatment is responsible for payment and for collecting from the other parent or attorneys.

Main Street Foot & Ankle, LLC is a participating Medicare provider. This office conducts business in accordance with an internal voluntary compliance plan. We will not comply with requests from patients that are considered fraud by the Government, United States and/or New Jersey. If you have any questions about your bill or believe it to be an error, please notify our billing department immediately. Representatives receive ongoing training and are available to answer your questions. Our Compliance Officer is also available should you require additional assistance. Medicare and commercial insurance policies are complex and contain many details. We will gladly assist you with any questions you have, however, if you are dissatisfied with our billing department, you may have your insurance company contact us directly and we will gladly work with them directly to resolve any issues. Please contact our office if you have any further questions. Thank you.

I hereby certify that I have read Main Street Foot & Ankle's financial policy and understand my financial responsibility and agree to the terms stated in this financial policy.

PATIENT SIGNATURE ____ **DATE** ___________