

## PATIENT INFORMATION SHEET

### PLEASE PRINT THE FOLLOWING INFORMATION CLEARLY

Full Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ Email Address \_\_\_\_\_  
Full Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex (M) (F)  
Marital Status ( S, M, D, W, Sep) Social Security Number \_\_\_\_\_  
Occupation (Position) \_\_\_\_\_ Driver's License No. \_\_\_\_\_

This portion of the form is for the insurance department and it is necessary that you complete this fully and accurately. This information is needed so we can process all claims quickly and accurately. **If you have coverage with more than one insurance carrier, please supply the information of both insurance carriers.**

### A. INSURANCE

1. Primary Insurance Company \_\_\_\_\_  
Subscriber/Insured Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Insurance ID No. \_\_\_\_\_ Group No. \_\_\_\_\_ DOB \_\_\_\_\_
  
2. Secondary Insurance Company \_\_\_\_\_  
Subscriber/Insured Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Insurance ID No. \_\_\_\_\_ Group No. \_\_\_\_\_ DOB \_\_\_\_\_

### B. NO INSURANCE/SELF PAY

Person Responsible For Bill \_\_\_\_\_

**Note To Divorced Parents:** Parent or guardian who presents child for treatment will be responsible for all charges incurred.

Responsible Person's Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Social Security No. \_\_\_\_\_  
Nearest Living Relative \_\_\_\_\_  
Telephone Number \_\_\_\_\_

### C. AUTO ACCIDENT/WORKERS COMPENSATION

Insurance Company \_\_\_\_\_ Date of Injury \_\_\_\_\_  
Insurance ID No. \_\_\_\_\_ Group No. \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Person to Contact \_\_\_\_\_  
Telephone No. \_\_\_\_\_

**Please Print The Following Information Clearly**

Full Name \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe Size \_\_\_\_\_

Who referred you to our office \_\_\_\_\_

Please list your medical/family doctor's name \_\_\_\_\_

Address \_\_\_\_\_

What is your foot problem \_\_\_\_\_

**General Health** (Please check all that apply)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Arthritis      | <input type="checkbox"/> Gout                       | <input type="checkbox"/> Heart Attack                |
| <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Tuberculosis               | <input type="checkbox"/> Peripheral Vascular Disease |
| <input type="checkbox"/> Heart Disease  | <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Lung Disease                |
| <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> Scarlet or Rheumatic Fever | <input type="checkbox"/> Stomach Problems            |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> High Blood Pressure        | <input type="checkbox"/> Eye Problems                |
| <input type="checkbox"/> Emphysema      | <input type="checkbox"/> Venereal Disease           | Other _____  |
| <input type="checkbox"/> Glaucoma       | <input type="checkbox"/> Stroke                     | _____  |

**Medications** - Are you presently taking any medicines – please list

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies** – If you are allergic to any of the following – please check

- |                                     |  |                                 |
|-------------------------------------|--|---------------------------------|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Iodine        | <input type="checkbox"/> Pollen |
| <input type="checkbox"/> Novocaine  | <input type="checkbox"/> Adhesive tape | Other _____                     |
| <input type="checkbox"/> Codeine    | <input type="checkbox"/> Shellfish     | _____                           |

**Family History**

If any member of your immediate family has any of the following – please check

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Peripheral Vascular Disease |
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Gout                | Other _____  |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure | _____  |

Do you smoke? Yes No

To the best of my knowledge, the above information is correct.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**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 authorize 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 \_\_\_\_\_

**MANAGED CARE/HMO AGREEMENT**

I understand it is my responsibility to obtain the proper referral form complete with valid certification number from my Primary Care Physician prior to treatment by Dr. Mark A. Majeski and/or associates. If valid referral form is not presented at time of treatment, I understand I will be responsible for all charges at time of treatment.

I also understand that if my insurance company denies treatment as non-covered 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 AS VALID AS THE ORIGINAL.

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**MAIN STREET FOOT & ANKLE CARE**  
618 Main Street, Toms River, NJ 08753  
732-349-0114

**Financial Policy**

This policy applies to all patients. Payment is due at the time service is received. For your convenience, we accept cash, check 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 balances due are billed monthly. Accurate and complete insurance information, including changes must be provided to the front desk at time of service. We will directly bill patients who fail to provide correct, timely information. We understand that unusual circumstances may arise and that payment in full at time of service or post insurance may not always be possible. Patients must discuss special payment needs with the billing department. Payment plans are available, subject to approval by Management.

Accounts not paid in accordance to terms of credit or incomplete financial arrangements will nullify any prior arrangements. Physician services are provided to patients, not 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 back to direct patient responsibility. Patients can then independently deal with their insurance. 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 return delinquent accounts over for collection. Balances in collection are payable to our agent, Medical Dental Hospital Bureau.

Other fees: Returned check fee is \$25.00 per occurrence. A \$15 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 or disability forms.

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

Main Street Foot & Ankle is a participating Medicare provider. This office conducts business in accordance with an internal voluntary compliance plan. We will not comply with requests by patients that are considered fraud by the Government, US and/or NJ. If you have any questions on your bill or believe it is to be in 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 be glad to work with them directly to resolve any issues. Please call 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.*

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Patient Signature

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Date

## MAIN STREET FOOT & ANKLE CARE

**PURPOSE:** To state the overall rights at 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 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, fee, deposit and refunds and any charges for services not covered by insurance.
- To be informed if our facility has authorized other health care and/or education institutions to participate in the patient's treatment. The patient also has the right to know the identity and function of these institutions, and to refuse to allow their participation in the patient's treatment.
- To receive from the patient's physician or clinical practitioner, in terms that he/she understands, an explanation of his/her complete medical/health condition or 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 the patient's care and treatment, and to refuse medication and treatment.
- To voice grievances or recommend changes in policies and services to facility personnel, the governing authority and/or outside representatives of the patient's choice either individually or as a group, and free from restraint, interference, coercion, discrimination, or reprisal.
- To confidential treatment of information about the patient. 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 to which the patient was transferred requires third party payment contract, or a peer review, or unless the information is needed by the New Jersey State Department of Health for statutorily authorize purpose
- To be treated with courtesy, consideration, respect and recognition of the patient's dignity, individuality, and right to privacy, including but 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, or deprived of any constitutional, civil and/or legal rights solely because of receiving services from our facility.

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Signature of Patient

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Date