PATIENT BACKGROUND

S.S. # DATE

PATIENT'S NAME

ADDRESS PHONE # Home

AGE DATE OF BIRTH SEX MARITAL STATUS S M W D

HEIGHT WEIGHT SHOE SIZE

Guardian's name if patient is a minor

Guardian's address if different from above Phone #

Occupation Business Address Phone #

Occ. of Spouse/Parent Business Address Phone #

By whom were you referred? Name Address

INSURANCE: ( ) Medicare ( ) Blue Shield ( ) Union ( ) Major Medical ( ) Private Insurance

Name of Insurance Co.

Please tell us as well as you can, the main problem as well as other problems, that bring you to our office.

Please answer the following questions related to your general health so we may better know you and your medical background.

The feet often reflect systemic problems, and conversely, often the feet affect bodily functions.

( ) I am not allergic to anything I am aware of

( ) I am allergic to (please check):	( ) Novocaine	( ) Aspirin	( ) Codeine
	( ) Demerol	( ) Penicillin	( ) Sulfur
	( ) Mercurials	( ) Iodine	( ) Tape
	( ) Mercurochrone, Merthiolate		( ) Other:

Are you in ( ) good health ( ) fair health ( ) poor health

Are you under the care of a doctor? ( ) Yes ( ) No

Physician's name and address

If yes, please state for what reason or problem

What medications are you now taking?

Are you pregnant?

Please check appropriate places:

I HAVE / HAVE HAD	I HAVE / HAVE HAD	I HAVE / HAVE HAD	I HAVE / HAVE HAD
( ) / ( ) Diabetes	( ) / ( ) Asthma	( ) / ( ) Anemia	( ) / ( ) Bleeding Tendencies
( ) / ( ) Cancer	( ) / ( ) Tumors	( ) / ( ) Epilepsy	( ) / ( ) Glaucoma
( ) / ( ) Gout	( ) / ( ) Heart Trouble	( ) / ( ) Kidney/Bladder Trouble	( ) / ( ) High Blood Pressure
( ) / ( ) Nervousness	( ) / ( ) Rheumatism/Arthritis	( ) / ( ) Stomach Ulcers	( ) / ( ) Stroke
( ) / ( ) Tuberculosis			

What sports do you participate in? 1. 2. 3.

Do you ( ) run ( ) jog Amount/times per week:

Thank you. This little extra effort on your part helps us help you.

AUTHORIZATION FOR TREATMENT:

I hereby authorize Dr. to treat me for correction and alleviation of the above mentioned complaints and conditions.

Signed: Date:

PHYSICAL HISTORY:

PAST OPERATIONS

INJURIES

PRESENT AILMENT:

OTHER COMPLAINTS:

PERIPHERAL VASCULAR:	R	L	NEUROLOGIC:	R	L
Pulses - Dorsalis Pedis			Deep Tendon Responses		
Posterior Tibial			Plenter Response		
Temperature Gradient			Pellesthesia		
Color of Skin			Epicritic sherp/dull		
Hair Distribution					
Pedal Temperature					
Venous Filling Time					
Oscillometry					
Blood Pressure					
Misc.					

Foot and Ankle Center of Fort Lee
Patient Information Form

Name:	*Hm Phone:*	*Wk Phone:*
Home Address:	*City:*	*Zip Code:*
Spouse's Name:	*Wk Phone:*	
Nearest Relative not living with you:		*Phone:*
Nearest Friend not living with you:		*Phone:*
Physician:	*Phone:*	

Whom may we contact in the case of an emergency?
_____ *Phone:* _____
Whom may we thank for referring you to us?
_____ *Phone:* _____
Social Security #: _____ *Date of Birth:* _____
Who is responsible for this bill? _____

I will be paying today by: Cash____ Check ____ Credit Card ____

Please tell us the last time you visited a podiatrist_____. If you have never seen a podiatrist please check here_____.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

_____ _____
Signature *Date*

_____ _____
Patient (if minor) *Date*

FOOT & ANKLE CENTER OF FORT LEE, LLC

Greg Khaimov, DPM., Jake Kwon, DPM., Yoon S. Yi, DPM.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this Acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

_____

Print Name

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify): _____

FOOT & ANKLE CENTER OF FORT LEE, LLC

Greg Khaimov, DPM., Jake Kwon, DPM., Yoon S. Yi, DPM.

AUTHORIZATION FOR MEDICARE PAYMENTS

NAME: _____

MEDICARE NUMBER:_____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the Foot & Ankle Center of Fort Lee, LLC for any services furnished to me by these physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related service.
Foot & Ankle Center of Fort Lee, LLC will accept my Medicare assignment. The 20% Co-Insurance and deductible will be my responsibility as required by Medicare.
I understand that Foot & Ankle Center does not participate with Medicaid. The 20% Co-insurance and Deductible will be my responsibility to pay.

**SIGNED:_____

DATE:_____

PLEASE COMPLETE THE FOLLOWING:

Name, Address, and Telephone Number of Internist/Primary Care Physician:

_____

_____

** I have not seen a podiatrist within the last 61 days

Notifier(s): FOOT AND ANKLE CENTER OF FORT LEE, LLC
Patient Name: **Identification Number:**

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for items checked or listed in the box below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the items listed or checked in the box below.

Listed or Checked Items Only:			
Reason Medicare May Not Pay:			
Estimated Cost:			

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the checked items listed in the first box above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

Options: Check only one box. We cannot choose a box for you.

- ❑ **OPTION 1.** I want the _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- ❑ **OPTION 2.** I want the _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.
- ❑ **OPTION 3.** I don't want the _____ listed above. I understand with this choice I am **not responsible for payment,** and I cannot appeal to see if Medicare would pay.

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048).
Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	**Date:**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.