RIDGE
FOOT AND ANKLE ASSOCIATES

PATIENT REGISTRATION FORM

LAST NAME: _____ FIRST NAME: _____ MI: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

ADDRESS:_____City/State/ ZIP_____

PHONE: HOME: ( ) _____ CELL: ( ) _____ E-MAIL: _____

ETHNICITY: _____ PREFERRED LANGUAGE: _____

PRIMARY INSURANCE: _____ ID#_____

SECONDARY INSURANCE: _____ ID#_____

PRIMARY CARE PHYSICIAN:_____ PHONE NUMBER:( ) _____

PHARMACY:_____ ADDRESS:_____

City/State/ ZIP _____ PHONE :( ) _____

TODAY'S VISIT

REASON FOR YOUR VISIT TODAY: _____

Who referred you? Physician / Insurance / Self _____

ACCIDENT RELATED: Y / N MOTOR VEHICLE / WORK RELATED: Y / N

Have you seen another physician for condition? If so, who/when? _____

RESPONSIBLE PARTY
(Complete Only if Patient is Not the Responsible Party)

LAST NAME: _____ FIRST NAME: _____ MI: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

ADDRESS:_____City/State/ ZIP_____

PHONE: HOME: ( ) _____ CELL: ( ) _____ E-MAIL: _____

COMMUNICATION PREFERENCES

Consent to send email / Internet based reminders about appointments? Y / N

Who can we leave voice messages with? _____

MEDICAL HISTORY

Please indicate if you have experienced or have been diagnosed with any of the following (check all that apply):

- ☐ Alcoholism
- ☐ Allergies
- ☐ Arthritis
- ☐ Blood clot / disorders
- ☐ Cancer
- ☐ Circulation problems
- ☐ Diabetes (type 1, type 2)
- ☐ Gout
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Liver conditions
- ☐ Mental Illness
- ☐ Musculoskeletal
- ☐ Neuropathy
- ☐ Skin disorders
- ☐ Stomach / bowel issues
- ☐ Stroke
- ☐ Thyroid disease *(specify)* _____
- ☐ Other *(specify)* _____

ARE YOU PREGNANT? Yes / No **ARE YOU NURSING?** Yes / No

DO YOU SMOKE? (Please Circle): CURRENT SMOKER / FORMER SMOKER / NEVER **If so how much?** _____

DO YOU DRINK ALCOHOL? Yes / No **If so how much?** _____

PAST SURGICAL HISTORY: _____

_____

_____

FAMILY MEDICAL HISTORY: _____

_____

PLEASE LIST ALL MEDICATIONS (AND DOSAGE) YOU ARE PRESENTLY TAKING: _____
_____
_____

ARE YOU ALLERGIC TO OR HAVE YOU EVER REACTED TO ANY FOOD OR MEDICATION (AND DOSAGE): _____
_____
_____

REVIEW OF SYSTEMS (Please circle all that apply):

Cardiovascular:
Leg pain when walking / Fever / Chest pain / Pressure / Leg swelling / Cold hands-feet / Fainting / Palpitations / Vascular disease/ Valve problems

Genitourinary:
Increased urgency / Excessive urination / Kidney disease / Kidney stones

Gastrointestinal:
Abdominal pain / Heartburn / Blood in stool / Vomiting / Ulcers / Constipation / Diarrhea / Trouble swallowing / Decrease appetite / Increase appetite

Integumentary:
Athletes foot / Nail abnormalities / Keloids / Itchiness / Dry, scaly skin

Hematologic:
Lower leg ulcers / Sickle Cell disease / Anemia / Blood thinners / Clotting disorders

Neurological:
Tingling / Weakness / Seizures / Numbness / Headaches / Tremors / Paralysis

Musculoskeletal:
Back pain / Joint swelling / Muscle weakness / Muscle pain / Neck pain / Sciatica / Joint Stiffness / Joint Pain / Joint instability / Arthritis

Respiratory:
Chest pain / Wheezing / COPD (Chronic Pulmonary Disease) / Coughing / Snoring / Shortness of breath / Emphysema

VITALS: **Blood Pressure:** _____/_____ **Height** _____ **Weight**_____

Authorization to Share Medical Information:

Please list any person that you authorize our office to discuss and release your medical information to (DO NOT INCLUDE ANY DOCTORS ON THIS LIST):

NAME: _____ RELATIONSHIP:_____ DOB: _____ PHONE: _____

NAME: _____ RELATIONSHIP:_____ DOB: _____ PHONE: _____

PLEASE READ THE FOLLOWING AND SIGN: The information on my intake forms is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible to notify the physician/medical staff of any changes or updates in my information. I authorize payment of medical benefits to the practice named above. I authorize the release of any medical information necessary to process my claim. I acknowledge that I received my HIPPAA Privacy notice. I authorize the physician's office to retrieve my medication history.

PATIENT NAME:_____

SIGNATURE:_____ **DATE:**_____

WELCOME TO RIDGE FOOT AND ANKLE ASSOCIATES

Please read these policies carefully, as they contain information pertaining to our office policies and procedures. Ridge Foot and Ankle Associates is committed to providing you with the finest quality podiatric care. We look forward to establishing a long-term healthcare relationship with you.

HIPAA ACKNOWLEDGEMENTS AND AUTHORIZATIONS:

We are required by law to maintain the privacy of protected health information and provide individuals with this Notice of our legal duties and privacy practices with respect to protected health information. By signing below, patient acknowledges that he/she has been given the option of receiving a copy or been afforded an opportunity to review this Notice of Ridge Foot and Ankle Associate's HIPAA Notice of Privacy Practices.

Signature: X_____

CANCELLATION POLICY:

Ridge Foot and Ankle Associates has a 24 hour cancellation policy. The purpose of this policy is to ensure that any cancellations are made with adequate time for patients who are waiting to be provided with the opportunity to be offered any available appointment. Appointments that are not cancelled with more than 24 hours notice may be subject to a cancellation fee of $50.00. All cancellation fees in accordance with this policy are assessed at the discretion of Ridge Foot and Ankle Associates. By signing this form, the patient acknowledges that they have been informed of, and consent to, the Ridge Foot and Ankle Associates cancellation policy.

Signature: X_____

PROTECTED HEALTH INFORMATION RELEASE:

I hereby authorize direct payment of surgical/medical benefits to Ridge Foot and Ankle Associates for services rendered by the physician in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance. I certify that the information given by me in applying for payment is correct. I authorize release of all medical records on request. I request that payment of authorized benefits be made on physician's behalf.

Signature: X_____

PATIENT FINANCIAL LIABILITY STATEMENT:

I understand that I am personally and financially responsible for charges incurred for services rendered at Ridge Foot and Ankle Associates if any of the following apply:

1. My health benefit plan requires prior authorization or referral by a primary care physician before receiving services at Ridge Foot and Ankle Associates.

2. My health plan coverage has lapsed or expired at the time I receive services at Ridge Foot and Ankle Associates

3. My health plan is not one that Ridge Foot and Ankle Associates participates in.

I also understand that I am responsible for all co-payments, co-insurance and deductible sums under my health plan.

Any account that has a balance for over 60 days runs the risk of being placed in collections. If an account is placed in collections, any and all collection and legal fees associated with the collections of the account will be the patient's responsibility. Patients who do not have their account paid in full will also be unable to schedule future appointments until the account is cleared.

Signature: X_____

USE OF PHOTOGRAPHY / VIDEO:

I authorize Ridge Foot and Ankle Associates to photograph/film/video the treatment site for record purposes. I agree that any photo identification and photos taken at the time of my appointment will be considered a part of my medical record and will be used solely for the purpose of my treatment and medical care. *I understand that due to HIPAA privacy laws my name and identity will not be disclosed.*

Signature: X_____

WORKER'S COMPENSATION:

We require written approval / authorization from your employer and / or your Worker's Compensation Carrier prior to your initial visit in order to process your treatment as a Worker's Compensation Claim. If your claim is denied, you will be responsible for the full balance of the non-covered services.

Signature: X_____

PATIENT TREATMENT AND OFFICE VISIT AUTHORIZATION:

I, _____, hereby give the providers of Ridge Foot and Ankle Associates permission to administer treatment and perform such procedures as may be deemed necessary in the diagnosis and for the treatment of foot conditions AFTER SUCH TREATMENT AND DIAGNOSES HAVE BEEN EXPLAINED TO ME.

I hereby assign, transfer, and act over to Ridge Foot and Ankle Associates all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine my insurance benefits / coverage. This authorization will remain valid until written notice is given by me revoking said authorization. In understand that I am financially responsible for any and all charges regardless of whether or not they are covered by insurance or if I am paying using another method for services. I also understand that if my account is placed in collections, I am responsible for any and all collection and legal fees associated with the collections of the account. It is also my responsibility to ascertain if my treating physician at Ridge Foot and Ankle Associates participates in my insurance network.

Signature: X_____

Thank You for Choosing Ridge Foot and Ankle Associates for Your Podiatric Care!

Out of Network Consumer Protection, Cost Containment and Accountability Act (New Jersey)

Ridge Foot and Ankle Associates is pleased to be in-network with:

- Aetna
- AARP Medicare Complete PPO
- AmeriHealth NJ
- Cigna
- Clover
- Horizon BCBSNJ
- Horizon NJ Health
- Humana
- Medicare
- Prime Healthcare (provided through Keenan)
- QualCare
- United Healthcare / Oxford

***** Not ALL Physicians participate in ALL Insurance Plans! *****

Please contact your insurance company to confirm the doctor you are scheduled to see is considered in-network with your specific plan. It is ultimately the patient's responsibility to confirm if their specific plan will cover any and all treatments rendered by any provider at Ridge Foot and Ankle Associates.

Out of Network Consumer Protection, Cost Containment and Accountability Act (New Jersey)

Effective as of September 2018, the Out of Network Consumer Protection, Cost Containment, and Accountability Act began in the state of New Jersey.

By Law, Ridge Foot and Ankle Associates is required to inform you:

1. Information on which of our physicians currently participate in-network with your insurance plan and which do not.

2. If your treating physician at Ridge Foot and Ankle Associates is NOT IN-NETWORK with your insurance plan, this will be disclosed when you book your appointment and again when you arrive at the office on the day of your appointment(s). For all services that are to be provided, patients receive a billing estimate with corresponding CPT codes, if requested by the patient.

Payment for all out-of-network services is due at the time of service. Patients who choose to be treated out-of-network are financially responsible for all services renders by an out-of-network provider.

I understand and agree to the statements listed above.

PATIENT NAME:_____

SIGNATURE:_____ DATE:_____

PATIENT FINANCIAL RESPONSIBILITY POLICY

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship.

- **INSURANCE COVERAGE** - Your insurance policy is a contract between YOU and YOUR INSURANCE COMPANY. As a courtesy, we will file your insurance claim. However, the patient is required to provide the office with the most correct and updated information about their insurance. It is the responsibility of the patient for any charges incurred if any provided information is not correct or current.
- **APPOINTMENTS** – Ridge Foot and Ankle Associates has a 24-hour cancellation policy. Appointments that are not cancelled with more than 24 hours notice may be subject to a cancellation fee of $50.00.
- **REFERRALS** - If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If your plan requires a referral and you do not obtain one, YOU will be responsible for all visit charges at the time of service.
- **OUT-OF-NETWORK PLANS** - You will be responsible for any charges incurred from services rendered that are not covered per their explanation of benefits form. In the case of out-of-network insurance policies, most plans will not provide out-of-network benefit coverage and the patient is responsible for all charges incurred for services, without exception. Ridge Foot and Ankle Associates will always send a courtesy bill to any out-of-network carrier on your behalf. However, should they not pay your claim in 45 days, you will be responsible for the full amount due.
- **SELF-PAY PATIENTS** – Full payment is expected at the time of service.
- **MEDICARE** - As a courtesy, we will send claims to Medicare and if you have a secondary insurance we will also submit to them on your behalf. However, should your claims remain unpaid by your insurance company, final responsibility for deductible and 20% coinsurance amounts is that of the patient.
- **DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS** - The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Ridge Foot and Ankle Associates will not be involved with separation or divorce disputes.

You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment, you will be held responsible for whatever charges we incur as a result of this.

_____ _____

Patient Signature Date