

WELCOME TO OUR OFFICE

PLEASE FILL OUT COMPLETELY

PATIENT INFORMATION

PATIENT NAME: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: () _____ WORK PHONE: () _____

CELL PHONE () _____

DATE OF BIRTH: _____ AGE: _____ MARITAL STATUS: _____

SEX: M F Height: _____ Weight: _____ SSN: _____

PREFERRED LANGUAGE _____ RACE: _____ ETHNICITY: _____

EMPLOYER: _____ ADDRESS: _____

EMERGENCY CONTACT: _____

RELATION: _____ PHONE#: () _____

MEDICAL HISTORY

MEDICATION ALLERGIES: _____

CURRENT MEDICATION: _____

PRIOR SURGERIES (INCLUDE DATES): _____

PLEASE CIRCLE MEDICAL CONDITIONS THAT YOU HAVE, OR HAVE HAD IN THE PAST

HIGH BLOOD PRESSURE KIDNEY DISEASE BLEEDING PROBLEMS

DIABETES LIVER DISEASE SKIN DISORDER

HEART DISEASE THYROID DISEASE RHEUMATOID ARTHRITIS

LUNG DISEASE STOMACH ULCERS OSTEOARTHRITIS

REFERRAL SOURCE

HOW DID YOU HEAR ABOUT US? _____

PRIMARY CARE PHYSICIAN: _____

ADDRESS: _____ PHONE: _____

AUTHORIZATION TO TREAT

Date: _____

Patient's name: _____

Claims Authorization

I hereby authorize any physician, healthcare practitioner, hospital, clinic, or other medical facility to furnish any and all records, medical history, services rendered or treatment given to me or any dependant for purposes of review, investigation or evaluation of any claim submitted to my health insurance carrier(s). I also authorize my insurance carrier(s) to disclose to a hospital or healthcare service plan, self-insurer, or other insurer any medical information obtained if such disclosure is necessary to allow the processing of any claim. If my coverage is under a group contract held by my employer, and association, trust fund, union or similar entity, this authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with my insurer(s) including a reasonable time thereafter, until it's final consummation. This authorization shall be binding upon me, my dependants, and our heirs, executors and administrators.

Assignment of Benefits – Private and Federal (Medicare)

I authorize payments of medical and surgical benefits, including Medicare benefits, to be made on my behalf to this office for any services furnished by my physician(s) to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits payable for related services.

Litigation Disclaimer

It is understood and agreed that I am requesting examination and treatment for medical purposes only, and not in connection with pending or proposed litigation. Should such litigation arise, it is further understood and agreed that the treating physician will not participate in any way in litigation except to provide a true and accurate copy of any medical record and X-ray in the possession and control of this office, pursuant to receipt of property notarized consent for medical information, requested by the patient or his/her legal guardian, and upon payment of the usual fee.

(Signature of patient or guardian)

(Print name)

Photocopy or fax of this form shall be considered as effective and valid as the original.

NEW JERSEY FOOT & ANKLE CENTER

RALPH C. NAPOLI, D.P.M.
Board Certified Foot & Ankle Surgery
Fellow American College of Foot & Ankle Surgeons

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Westwood, NJ 07675
(201) 497-6666
F: (201) 497-6664

67 Broadway (Route 4 West)
Elmwood Park, NJ 07407
(201) 794-3223
F: (201) 794-8411

OFFICE POLICY ON PATIENT CARE

In order to accommodate the needs and request of our patients, we have enrolled in numerous managed care insurance programs.

While we are pleased to be able to provide this service to you, it is extremely difficult for us to keep up to date with all of the specific and various requirements of each and every plan, **WITHOUT YOUR FULL COOPERATION**. Please understand that each plan has different stipulations such as referrals, authorizations, lab work, etc. **IT IS VERY IMPORTANT THAT YOU, THE PATIENT COME INTO OUR OFFICE WITH ALL OF THE REQUIRED DOCUMENTATION AND BE FULLY AWARE OF HOW YOUR PLAN WORKS PRIOR TO THE TIME OF YOUR SCHEDULED APPOINTMENT. YOU, THE PATIENT ARE THE POLICYHOLDER AND IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE PLAN.**

With your cooperation, we, your health care provider, can provide you with all the medical benefits to which you are entitled which is our primary concern.

*****I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATE ABOVE AND AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED ABOVE.**

Signature

Date

NEW JERSEY FOOT & ANKLE CENTER

HIPAA Notice of Privacy Practices

Name _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by-name in the waiting-room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature _____ Date _____

If minor, signature of parent or guardian: _____

Thank you for being one of our highly valued patients.

For office only

A "good faith effort" was made to get a signature from patient/guardian/caretaker. Signature was not obtained due to the following: _____