Ambulatory Foot & Ankle Associates

Dr. Howard Abramsohn

(PLEASE COMPLETE ALL PAGES)

Date_____ Social Security. # _____ DOB _____ Age_____

Name_____

First Middle Last

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

May we leave a message at the phone numbers you provided above? YES/NO

Occupation_____ Retired : Yes / No

Gender M F Marital Status S M D W E-Mail _____

Employer _____ City _____ State _____ Zip_____

Emergency Contact

_____ Phone_____

If you are under 18 years old please list a Parent or Guardian_____

Best contact # _____ DOB _____

Physician / Pharmacy Information

REFERRING Physician_____ Phone # _____

Address_____ City_____ State_____ Zip_____

PRIMARY Physician _____ Phone #_____

Address_____ City_____ State_____ Zip_____

Referred By (If other than Physician): Internet Friend Yellow Pages Insurance

PHARMACY (NAME)_____ (CITY)_____ (PHONE #)_____

Primary Insurance

Insurance Name_____ Policy #_____

Group#_____ Subscriber's Name_____ DOB_____

Secondary Insurance

Insurance Name _____ Policy #_____

Group#_____ Subscriber's Name_____ DOB_____

I authorize the release of any Medical Information necessary to process this claim and request payment of Medical Benefits to the undersigned physician for services rendered. I authorize all payments be made directly to Ambulatory Foot & Ankle Assoc., LLC I understand that I am financially responsible for any non-covered services and unpaid balances as well as DEDUCTIBLE and COINSURANCES as determined by MEDICARE/MEDIGAP or other insurance carriers. I am also responsible for any and all collection fees if the account becomes delinquent.

Signature_____ Date_____

PATIENT NAME: _____

DATE OF BIRTH: ___/___/____

YOUR MEDICAL HISTORY

ALLERGIES: ☐ NONE KNOWN ☐ MEDICATIONS _____

☐ ANESTHESIA _____ ☐ FOODS _____

☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N

OTHER CONDITIONS:

HEIGHT _____

WEIGHT _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME	DOSE	HOW OFTEN DO YOU TAKE?

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE

☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ___ PACKS/DAY FOR ___ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____

☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

EMPLOYER: _____ OCCUPATION: _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐10% ☐25% ☐50% ☐75% ☐100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ☐CHILDREN–AGE(S) _____ ☐PET(S)–WHAT KIND? _____

☐ELDERLY OR DISABLED FAMILY MEMBER ☐OTHER _____

EXERCISE: ☐ NEVER ☐RARE ☐ OCCASIONAL ☐WEEKLY ☐ SEVERAL TIMES A WEEK ☐DAILY

TYPES OF EXERCISE: _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES ☐CANCER ☐HEART DISEASE ☐HIGH BLOOD PRESSURE

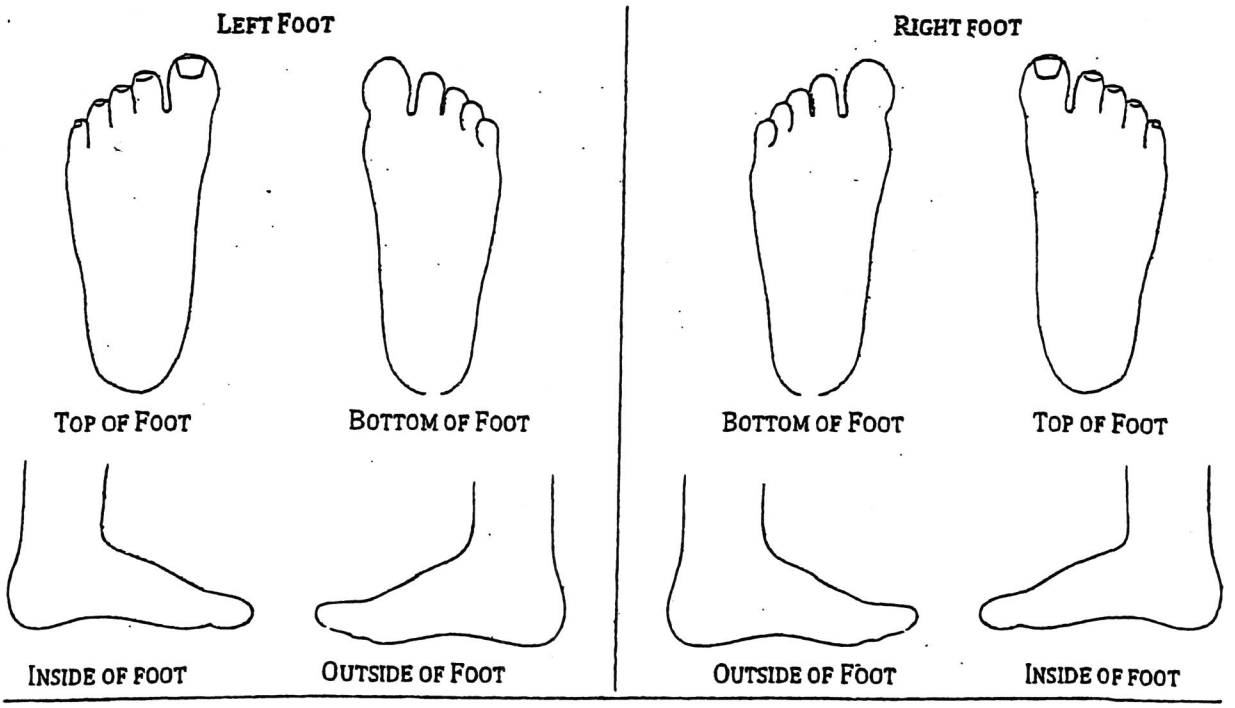
☐STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS

☐OTHER _____

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.



HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING
☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES
☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE
☐ RUNNING ☐ OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) _____ ☐ NO

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____ PRINT NAME OF PATIENT, PARENT OR GUARDIAN

_____ SIGNATURE OF DOCTOR

_____ IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

_____ DATE

_____ SIGNATURE

_____ DATE

AMBULATORY FOOT AND ANKLE ASSOCIATES, LLC

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(Fax) 856-234-3230

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the government rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect. Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation properly.

Thank you for being one of our highly valued patients.

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The Privacy Rule was also created to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients) and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but that must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PIH). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print name: _____ Signature _____ Date _____

FINANCIAL POLICY

Thank you for choosing Ambulatory Foot & Ankle Associates, LLC, as your foot care provider. We are committed to providing you with quality and affordable health care. Please read the following office payment policy and feel free to ask us any questions that you may have. Once you accept this policy, kingly sign in the space provided. A copy will be provided to you upon request.

1.Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payment and Deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit

3. Non-covered Services. Please be aware that some- and perhaps all- of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of Insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. If required, obtaining the proper referral from your Primary Care Physician is your responsibility. Patients presenting to our office without a valid referral will be asked to pay in full. This payment will be held for 48 hours and will become non refundable if the proper referral is not obtained by then.

5. Claims Submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

6. Coverage Changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

7. Nonpayment. Invoices are sent out every 30 days. Your prompt payment will assist us in keeping the cost of healthcare down. If your account is over 90 days past due (4 statements), your account will be referred to our collection agency.

8. Fees. Our fees are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

9. You agree, in order for us to service your account or collect monies you may owe, Ambulatory Foot & Ankle Assoc., 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 us. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing devices, as applicable.

I have read and understand the payment policy and agree to abide by its guidelines:

X_____ _____

Signature of patient or responsible party Date

AMBULATORY FOOT AND ANKLE ASSOCIATES, LLC

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E-PRESCRIBING CONSENT FORM

E-Prescribing is defined by a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA - 2003) listed standards that have to be included in an e-prescribe program.

These include:
- Formulary and benefit transactions - gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions - provides the physician with information about medications the patient is already taking to minimize the number of adverse reactions.

I authorize Ambulatory Foot and Ankle Associates to view my external prescription history via electronic prescribing services. I understand that my prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies, and pharmacy benefit managers may be viewable by my provider and staff at Ambulatory Foot and Ankle Associates. This may include prescriptions that date back in time for several years as well as prescriptions to treat HIV, substance abuse, and psychiatric conditions, if applicable. I understand that my prescription history will become part of my Ambulatory Foot and Ankle Associates medical record.

Understanding all of the above, I hereby provide informed consent to Ambulatory Foot and Ankle Associates to enroll me in the e-Prescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

This consent will remain enforce until revoked or changed.

_____
Patient Name (PLEASE PRINT)

_____ _____
Signature Date