NEW STEP FOOT & ANKLE ASSOCIATES, LLC
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2124 Oak Tree Rd. 2nd fl.
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TEL. 201-613-3327
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NEW PATIENT INTAKE FORM

NAME:_____ DATE OF BIRTH_____/_____/_____

RESPONSIBLE PARTY:_____ SS#_____

HOME ADDRESS:_____ MARITAL STATUS_____

CITY_____ STATE_____ ZIP CODE_____ SEX: ☐M ☐F

HOME PHONE: (_____)_____ CELL PHONE (_____)_____

EMAIL ADDRESS:_____

OCCUPATION:_____ EMPLOYER:_____

WORK PHONE: (_____)_____

WORK ADDRESS_____

REFFERED BY:_____ PRIMARY PHYSICIAN:_____

PREVIOUS PODIATRIST:_____

Primary Insurance:_____ Are you the insured? ☐Y ☐N

Insured Information

Subscriber Name: _____

Relationship to insured: ☐Spouse ☐Child ☐Self ☐Other

Phone #: _____ Sex: ☐Male ☐Female DOB: ___/___/___

Address *(Skip Address if same as above):*

_____

Policy ID: _____ Group ID: _____ Employer: _____

Secondary Insurance:_____ Are you the insured? ☐Y ☐N

Insured Information

Subscriber Name: _____

Relationship to insured: ☐Spouse ☐Child ☐Self ☐Other

Phone #: _____ Sex: ☐Male ☐Female DOB: ___/___/___

Address *(Skip Address if same as above):*

_____

Policy ID: _____ Group ID: _____ Employer: _____

PLEASE NOTE:
I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION OR OTHER INFORMATION NEEDED FOR THE PROCESSING OF THE ATTACHED MEDICAL CLAIM AND REQUEST THAT PAYMENT BE MADE DIRECTLY TO THE TREATING DOCTOR. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. IT IS UNDERSTOOD THAT THE PATIENT IS RESPOSIBLE FOR THE MEDICAL SERVICES THEY RECEIVE. I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND I HAVE READ (OR HAD THE OPPORTUNITY TO READ IF I SO CHOOSE) AND UNDERSTOOD THE NOTICE.

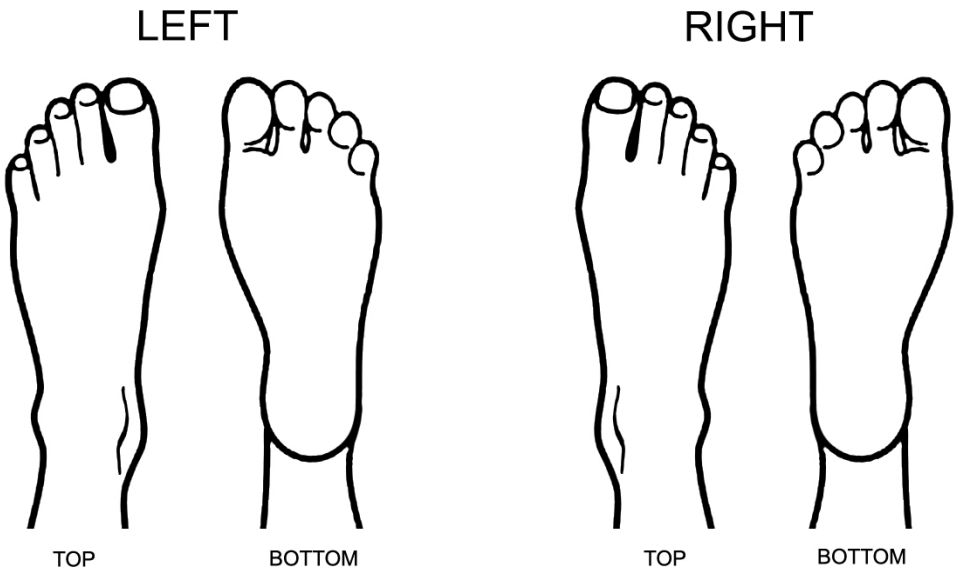
SIGNATURE:_____ DATE:_____
(Parent signature if patient is a minor)

NEW STEP FOOT & ANKLE ASSOCIATES, LLC
MEDICAL INFORMATION

PATIENT NAME: _____ DATE OF BIRTH_____/_____/_____

Height:_____ Weight:_____ Shoe Size:_____

Please circle area of concern on below diagram



Allergies:_____

Current Medication:_____

Pharmacy Name and Address:_____

PERSONAL MEDICAL HISTORY

Please indicate whether you have had any of the following medical problems

- ☐ Asthma
- ☐ Bleeding or Clotting Disorder
- ☐ Cancer
- ☐ Chest Pain
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Shortness of Breath
- ☐ Stroke
- ☐ Weakness / Numbness in Extremities
- ☐ Other (Please specify):

PAST SURGERY HISTORY: If yes, please list all prior operations with dates.

_____

_____

_____

SOCIAL HISTORY:

Tobacco Use: ☐ Yes ☐ No If yes, how long have you used tobacco: _____

Alcohol Use: ☐ Yes ☐ No If yes, how often do you use alcohol: _____

Recreational Drug Use: ☐ Yes ☐ No

FAMILY HISTORY: Any illness that runs in the family?

If yes, please

_____

_____

PATIENT CONTACT PREFERENCE:

Phone Number:_____

☐ OK to leave detailed message. ☐ Leave message with call back number only.

In general, the HIPAA privacy rule gives individual the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication PHI be made by alternative means, such as sending correspondences to the individual's office instead of the individual's home.
The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and request for PHI to be minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made to pursuant to an authorization requested by the individual.

PATIENT SIGNATURE: _____ DATE:_____

NEW STEP FOOT & ANKLE ASSOCAITES, LLC
PATIENT FINANCIAL RESPONSIBILITY POLICY

Welcome to New Step Foot & Ankle Associates. The following is a description of our policies relative to payment based on your insurance.

All copays, deductibles, and estimated insurance balances are due at the time of services.

To ensure that we have accurate information to process your claim, we will make a copy of your insurance identification card at the time of your appointment. NEW STEP FOOT & ANKLE ASSOCIATES will make every effort to assist you in understanding the scope of your insurance benefits. It is not the responsibility of NEW STEP FOOT & ANKLE ASSOCIATES to verify your insurance coverage or determine which services are or are not covered.

If your insurance denies payment for any reason, the amount owed is your responsibility and must be paid promptly. As courtesy to our patients, we will bill insurance carriers for services provided by our office, whether or not we are provider for that carrier. Payment of benefit will be subject to all terms, conditions, limitations, and exclusion of your contract at time of service.

Any medical supplies purchased in the office must be paid at the date of service. These are not billable and all sales are final.

You are required to inform us immediately of any changes in demographic information or insurance information. Patients without insurance are required to pay in full at the time of service.

A $35 fee will be charged for any returned checks or credit cards. Interest of 12% annually will be charged to all balance's unpaid past 90 days.

We would be happy to answer any questions you might have regarding our office policy.

I have read and understand the above information and accept full responsibility if any insurance does not pay for services rendered. I authorize payments to be made directly to the NEW STEP FOOT & ANKLE ASSOCIATES and fully understand that I am the responsible party for all charges incurred by me or my dependents at this facility. I also authorize the release of any and all information required to collect and process my medical insurance claims. I have read the "PATIENT FINANCIAL RESPONSIBILITY POLICY", which I understand and agree with it. By my signature below, I hereby authorize the assignment of financial benefits directly to NEW STEP FOOT & ANKE ASSOCIATES or services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.

PATIENT SIGNATURE:_____ DATE:_____