Brucato Foot & Ankle Surgery

1011 Clifton Avenue
CLIFTON NJ 07013

PATIENT REGISTRATION FORM

Today's Date:			
PATIENT INFORMATION			
Patient's last name: First:		Middle:	Marital status:
Birth date: (mm/dd/yyyy)		Social Security Number	Sex: M F
Address:			
Cell Phone Number:	Home Phone Number:		Email:
Occupation:	Employer:		Employer phone no.:
How did you hear about us? (Please be specific): **IF REFERRED BY FRIEND, THEN PLEASE WRITE THEIR NAME**			

Primary Care Physician Name:_____ Address:_____

City:_____ State: _____ Zip Code: _____

Pharmacy: _____ Pharmacy Phone Number : _____

INSURANCE INFORMATION

(Please give your insurance card and photo ID to the receptionist.)

Please indicate primary insurance:

Subscriber's name (if not self):	Subscriber's S.S. no.:	Birth date:	Address:
Patient's relationship to subscriber:			
Name of secondary insurance (if applicable):		Subscriber's name:	
Patient's relationship to subscriber:			

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Brucato Foot & Ankle Surgery or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

Patient Communication Form

Describe your reasons for visiting the office in as much detail as possible:

How long has the problem(s) been present?

What specific incident started this problem?

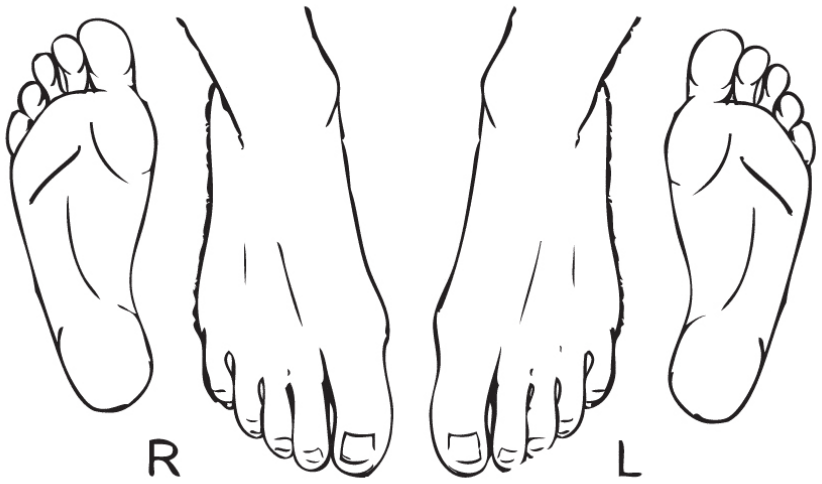
If the problem is painful, then how do you rate the pain on a scale of 1-10? (10 being most severe)

If there is pain, then describe the nature of pain: (e.g. dull, aching, throbbing, burning, N/A)

What makes the problem worse? (e.g. walking, standing, sitting, laying, exercise, etc)

What treatments have you tried? Did they Help? Yes or No

Please indicate the area involved on the figure below:



List all medical problems:

Are you diabetic? (please circle) **YES** **NO**

List all prescription medications with dosage:

List all allergies:

List all past surgeries:

Do you smoke? **Yes** **or** **No**

Do you drink? **Yes** **or** **No**

If yes, then how often?

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION AND DISCLOSURE FORM

I. ACKNOWLEDGEMENT OF PRACTICE'S *NOTICE OF PRIVACY* PRACTICES

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

II. DESIGNATION OF RELATIVES, CLOSE FRIENDS & OTHER CAREGIVERS AS MY PERSONAL REPRESENTATIVE

I agree that the practice may disclose certain pieces of my health information to a Personal Representative of my choosing, since such person Is involved with my healthcare or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my healthcare

Print Name_____DOB_____

Print Name_____DOB_____

III. REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATIONS BY ALTERNATIVE MEANS:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me as I have listed below:

Is cell phone number [___] OK to leave a detailed message

Is home phone number [___] OK to leave a detailed message

IV. THE FOLLOWING PERSON(S) ARE AUTHORIZED TO RECEIVE MY PATIENT HEALTH INFORMATION (PHI)

Print Name_____ Print Name_____

V. The HIPAA Privacy rule requires healthcare providers to make reasonable steps to limit the use or disclosure of and requests for PHI. I understand that this accounting will not reflect disclosures that are made in the course of the Practice's ordinary healthcare activities related to providing patient treatment, obtaining payment for its services, or for its internal operations. Also, the Practice does not have to account disclosures for which I have executed an Authorization permitting disclosures of my PHI.

a. The above authorizations are voluntary and I may refuse to their terms without affecting any of my rights to receive healthcare at the Practice.
b. These authorizations may be revoked at any time by notifying the Practice in writing at the Practice's mailing address marked to the attention of "HIPAA Compliance Officer."
c. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.
d. If you request it, a copy of information described in this form can be obtained at the front desk.
e. This form was completely filled in before I signed it and I acknowledge thatall of my questions were answered to my satisfaction and that I fully understand this authorization form.
f. This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked.

_____ _____ _____

Name of Patient (Printed) Signature Date

PAYMENT POLICY

Insurance

Knowing your insurance benefits is your responsibility.

Co-Payments and Deductibles

It is our policy to collect a co-payment at every visit. If you do not pay your co-payment at the time of the visit, you will be billed for the co-payment. It is impossible for us to know which company exempts which type of visit; often we must wait up to three months for the insurers' explanation of benefits statement to find this out. If we should find out about an exemption when we receive the statement, we will adjust your previously paid co-payment as a credit balance.

Claims Submission

We will submit your claims and assist you in any way we reasonably can to help get your claims. If your insurance company does not pay your claim within 90 days, the balance will automatically be billed to you. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Financial Agreements

We will expect you to honor the financial agreements you have made with our office. Our office will submit claims to insurance carriers. In case of insurance partial payment, the balance is due by YOU and we will send you a billing statement. Should you require a payment plan, our billing department will be glad to discuss your options with you.

_____	_____	_____
Name of Patient (Printed)	Signature of Patient	Date