SOLE FOCUS FOOT AND ANKLE

601 Route 73 North, Suite 104
Marlton, NJ 08053
Office: (856) 831-7700 Fax: (856) 831-7770

Patient Name _____ Todays Date _____/_____/_____
First Name Last Name Middle Initial MM DD YYYY

Birth Date _____/_____/_____ Age _____ Gender: Male Female Other Prefer Not to Respond
MM DD YYYY

Marital Status _____ Best Number to Reach You? Home Cell

Home Address _____ Home Phone No. (_____) _____

_____ Cell Phone No. (_____) _____
City State Zip

Email (required for portal acct) _____ Consent to Text you at the mobile number provided?
YES / NO

Check here if you DO NOT want a Portal Account _____

How Were You Referred To Us? Google - Insurance Website - Social Media - Referring Physician

Primary Pharmacy _____

Your Primary Care Physician (MD, DO, PA, NP)? _____

Emergency Contact Name, Phone #, Relationship _____

Insurance Information
Primary Insurance

Name of Insurance Carrier_____

Identification Number _____

Group Number _____

Relation to Patient _____

Policy Holder's Name & Date of Birth _____

Secondary Insurance

Name of Insurance _____

Identification Number _____

Group Number _____

Relation to Patient _____

Policy Holder's Name & Date of Birth _____

Release: I hereby authorize the release of any information acquired during my examination which said insurance company may request. **Responsibility & Assignment:** I also assign and request payment of medical benefits to the above stated physician for medical services. I also understand that I am financially responsible for payment of my bill. As a courtesy, we will bill your insurance company.

Signature: _____ Date:_____

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Patient Medical History

Please describe in detail the reason for your visit _____

_____

When did your problem begin? ____/____/_____ What activities aggravate your problem? _____

Any prior treatments/self or other? (please describe) _____

Please describe your pain? (please circle) Aching Throbbing Sharp Pins & Needles Electrical Numbness Dull

Please rate your pain on a scale of 1 - 10 (worst pain) _____

Please list all past surgical history _____

Date Last Seen by Podiatrist (or MD/DO if not seen by Podiatrist): _____

Diabetic Patients: Most recent blood sugar reading (fasting/A.M.): _____ HbA1C (if known) _____

Please list your current past medical history and all medications: _____

_____

Allergies / Drug Allergies: _____

_____

Do you currently smoke? YES NO If YES, how much do you currently smoke? _____

Have you ever smoked? YES NO If YES, how many years did you smoke for? _____

Alcoholic beverages? NONE OCCASIONAL MODERATELY HEAVY QUIT? If QUIT, when? _____

Any non-prescribed or illicit Drugs (current or prior history)? YES NO _____

Have you ever had a serious illness or Test Positive for MRSA? YES NO _____

What type of Diet do you follow? _____ Your Exercise Level? _____

Please list your family's medical history (i.e. diabetes, stroke, heart disease, high blood pressure, migraines, etc.)

_____

Do you have any problems with, or have you noticed any change in the following areas? If yes, please check that apply to you.

___Chest Pain	___Asthma	___Breast Masses	___Enlarged Lymph Nodes	___Sprain
___Palpitations	___Diabetes	___Balance Problems	___Weight Loss	___Arthritis
___Irregular Heart Beats	___Excessive Thirst	___Seizures	___Malaise	___Stiffness
___High Blood Pressure	___Excessive Hunger	___Hallucinations	___Fever	___Weakness
___Anemia	___Incontinence	___Depression	___Atrophy	___Numbness
___Bleeding Tendency	___Urinary Hesitancy	___Incoordination	___Skin Ulcers	___Diarrhea
___Cough	___Burning Urination	___Double Vision	___Dermatitis	___Abdominal Pain
___Bloody Sputum	___Menstrual Problems	___Blurred Vision	___Skin Rashes	___Constipation
___Shortness of Breath	___Pregnancies	___Sleep Disturbances	___Fracture	

If YES to any of the above, please explain: _____
If there is anything pertinent in your health that was not mentioned above, please explain:

_____

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Office Policies Regarding Insurance Assignment

(Please read the following information carefully)

Co-Payments: All co-payments are collected at the time of check-in. Your insurance company required that you pay your copay at the time of your visit. If you are unable to pay your copay, we will be happy to reschedule your appointment

Referrals: I understand that I am solely responsible for acquiring referrals from my prior care physician PRIOR to my appointment and knowing how many visits have been issued. If a referral was not issued, your office visit and treatment are considered NOT COVERED by your insurance; therefore, you will be responsible for the cost of your visit. Sole Focus Foot and Ankle is NOT obligated to call your primary care physician to obtain a referral on your behalf.

For Medicare patients: We are a participating practice with Medicare, which means, we will accept the amount that Medicare approves for our services. Medicare pays 80% of their established rate for services. You as the patient are responsible for the remaining 20% of the fees, either through secondary insurance of self-payments. Medicare also has a deductible each year that must be met before payment for services is rendered . Acceptable forms of payment are cash, check, credit card, and debt / HAS / FSA cards.

Insurance and Co-Insurance: Sole Focus Foot and Ankle is required to process your insurance claims with your primary insurance carrier. We will bill any secondary insurance as a courtesy to you, the patient. Please let us help you receive the maximum benefit from your insurance companies. Have a current copy of your insurance card/cards so we may copy them for your record. If you change your health insurance during your treatment, please provide us with the updated information promptly. If you have questions about our insurance policy, feel free to ask them at the time of your visit, or call during normal business hours. It is our policy to bill your insurance companies for reimbursement, however, we shall allow no more than sixty (60) days for payment. After this period, the patient will be directly billed for any outstanding balances on account. The office will not enter a dispute with your insurance company over any claim. It is your responsibility to contact your insurance company and review your claim

Assignment of Insurance Benefits – Appointment as Legal Authorized Representative: I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to Sole Focus Foot and Ankle and is providers and their authorized representatives (collectively hereinafter, "My Authorized Representatives"), and I appoint them as my authorized representative with the power to:

- ✓ File medical claims, appeals and grievances with the health plan
- ✓ File appeals and grievances with the health plan
- ✓ Discuss or divulge any of my personal health information or that of my dependents with any third party including the health plan

I certify that the health insurance information that I provided to the Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

Authorization to Release Information: I hereby authorize My Authorized Representatives to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

I have fully read and understand the Office Policies regarding Insurance Assignment:

Name: _____ Signature: _____ Date:_____

Sole Focus Foot and Ankle
Vrunda Dalal, D.P.M.

Four Greentree Center
601 Route 73 North, Suite 104
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856-831-7700

FINANCIAL PAYMENT OPTIONS

Patient Name: _____ Date of Birth: _____
If patient is a child, PARENT/GUARDIAN bringing child today: _____

Many insurance companies assign a portion of fees for allergy and asthma testing and/or office visits to the patient. This is referred to as "co-insurance," "co-pay," or "deductible," for which the patient is ultimately responsible. This is the amount left to the patient's responsibility after insurance has completed processing claims dependant on your policy details. Please check your insurance policy and your EOB (explanation of benefits) for a detailed look at what your policy covers.

In the effort of going paperless with statements, bills, etc. there are two payment options available.

PLEASE CHOOSE ONE OF THE OPTIONS BELOW AS YOUR PREFERRED METHOD OF PAYMENT IN THE EVENT OF A BALANCE AFTER INSURANCE PROCESSES THE CLAIM.

ONE OF THE TWO OPTIONS MUST BE SELECTED:

[ ] OPTION 1: LEAVE A CREDIT CARD ON FILE

Credit card information will be stored by secure, password-protected online software called Ingenico Merchant. All billing and data entry is done in-house. The card on file will only be charged for a balance due after insurance processes the claim. We will notify you by email or text 5-7 days prior to charging the card on file.

NOTE: YOU WILL RECEIVE COPIES OF YOUR STATEMENT AND PAYMENT RECEIPT BY EMAIL OR BY TEXT.
PREFERRED EMAIL/CELL PHONE (PRINT CLEARLY): _____
NAME ON CARD: _____
BILLING ADDRESS: _____
BILLING ZIP CODE: _____
To use a FSA or HSA card, please be sure it has adequate funding prior to being charged.

[ ] OPTION 2: DEPOSIT MADE EACH OFFICE VISIT

A deposit of $175 for new patients and $75 for established patients will be collected at the time of each appointment with the provider. It will be applied toward any balance due after insurance has completely processed your claim. If no balance is owed, it can either be refunded to you or applied toward a future visit. Please allow at least 30 business days for completion. If the balance due is larger than the deposit amount, then a statement will be sent to you for the remaining balance plus a $5 processing fee.

PATIENT/LEGAL GUARDIAN SIGNATURE:_____DATE:_____

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Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read and/or had the opportunity to read and understand the Notice. I authorize Sole Focus Foot and Ankle to obtain any protected health information from healthcare professionals who are involved in my care. I understand that this information is strictly confidential and solely used for the purpose of my medical care.

Authorization to Release Medical Records

I hereby authorize my primary care physician to disclose (if necessary) to Sole Focus Foot and Ankle any information which they have obtained by examination. By signing this, I release them of any consequence.

HIPPA

I understand that I have certain rights to privacy regarding my protected health information (PHI). These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent, I authorize Sole Focus Foot and Ankle to use and disclose my PHI to carry out Treatment, Obtaining Payment, and Day-to-day healthcare operations of the office. The Patient agrees and provides consent to the Practice to discuss and disclose his/her personal health and medical information with any of its staff, its representatives and third parties for purposes of treatment, payment of services or operations. Specifically, the Practice may release Patient PHI to its billing company and other Authorized Representatives for the purpose of obtaining reimbursement of services provided to the Patient by the Practice. In addition, I specifically authorize Practice and its Authorized Representatives to discuss or disclose any Patient PHI relating to Patient's Medical Claims with my Health Insurer, Health Care Plan and any assigned administrator of the Plan, or any regulatory authority. I have also been informed of and given the right to review and secure a copy of the Notices of Privacy Practices, which contains a more complete description of the uses and disclosures of your PHI and your rights under HIPPA. Additional information can also be obtained at the office upon request. I understand that Sole Focus Foot and Ankle reserves the right to change the terms of this notice from time to time, consistent with the states' latest policies and laws. You may contact Sole Focus Foot and Ankle at anytime to obtain the current copy of this notice I understand that I have the right to request restrictions on how my PHI is used and disclosed to carry out treatment, payment/s and health care operations, but that Sole Focus Foot and Ankle is not required to agree to these/those requested restrictions. However, if in agreement, both are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date revoked will not affect this consent.

Name: _____ Signature: _____Date:_____

If patient is a minor, please enter parent or guardian's information below.

Name: _____ Relationship: _____

Parent/Guardian Signature: _____