KINETIC
FOOT AND ANKLE

Kinetic Foot and Ankle | 1030 McBride Avenue Unit #103 | Woodland Park, NJ 07424

Office Phone: (973) 638-1555 | Fax: (877) 376-3367 | www.kineticfootandankle.com

Chart#:_____

ROS Completed: _____ INFO IN CHART: _____
INS & LIS UPLOAD: _____ INTAKE UPLOAD: ___

PATIENT REGISTRATION

FIRST NAME _____ LAST NAME _____

DATE OF BIRTH _____ Male | Female AGE _____ SS #_____

MARITAL STATUS ○ Single ○ Married ○ Divorced ○ Separated ○ Widowed ○ Partner ○ Minor

ADDRESS _____

EMPLOYER _____ OCCUPATION _____

HOME # _____ CELL # _____ WORK # _____

EMAIL _____

EMERGENCY CONTACT _____ PHONE # _____

RELATIONSHIP _____ ADDRESS _____

RESPONSIBLE FOR PATIENT ACCOUNT (put n/a if same as above)

FIRST & LAST NAME _____ CELL # _____

HOME # _____ WORK # _____ RELATIONSHIP _____

ADDRESS _____

INSURANCE: PRIMARY INSURANCE CARRIER INFORMATION

INSURED FULL NAME _____ POLICY # _____

INSURANCE CARRIER _____ GROUP # _____ EFFECTIVE DATE_____

PLAN: ○ HMO ○ PPO ○ OTHER DOB _____ RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE CARRIER INFORMATION

INSURED FULL NAME _____ POLICY # _____

INSURANCE CARRIER _____ GROUP # _____

EFFECTIVE DATE _____ DOB _____ RELATIONSHIP TO PATIENT _____

VISIT INFORMATION

Chief Complaint_____

WHOM CAN WE THANK FOR YOUR REFERRAL? ○Physician ○Friend ○Internet ○Social Media ○ Other _____

HOW DID YOU HEAR ABOUT US? _____ PRIMARY CARE PHYSICIAN: _____

DATE OF LAST VISIT TO PRIMARY CARE PHYSICIAN: _____ PHONE # _____

PHARMACY NAME: _____ PHONE # _____

ARE YOU PREGNANT? ○Yes ○ No |If yes, ___ # OF MONTHS |IS THERE A CHANCE YOU ARE PREGNANT? ○Yes ○No

REVIEW OF SYSTEMS

(Check the following symptoms if applicable)

CONSTITUTIONAL	○ Chills ○ Weight Gain	○ Fatigue ○ Weight Loss	○ Fever	○Weakness
CARDIOVASCULAR	○ Chest Pain ○ Heart Murmur ○ Palpitations	○ Cool Extremities ○ Heart Valve ○ Rheumatic Fever	○ Cramps in Legs/Feet ○ High Blood Pressure ○ Varicose Veins	○ Hair Loss on Legs ○ Leg/Foot Ulcers ○ Vascular Grafts
MUSCULOSKELETAL	○ Ankle Sprain ○ Broken Ankle ○ Corns ○ Childhood Foot Problems ○ In-Toeing ○ Knee Pain ○ Neuroma	○ Arch Pain ○ Broken Foot Bone ○ Flat Feet ○ Gait (Walking) Problems ○ Joint Implants ○ Lower Back Pain ○ Orthotic or Shoe Insert Use	○ Arthritis ○ Bunions ○ Gout ○ Hammer or Mallet Toes ○ Joint Pain ○ Muscle Cramps ○ Paralysis	○ Back Problems ○ Calluses ○ Heel Pain ○ High Arch Feet ○ Joint Stiffness ○ Muscle Stiffness ○ Weakness ○ Toe Walking
DERMATOLOGICAL	○ Athlete's Foot ○ Hives ○ Mole Changes	○ Dryness ○ Ingrown Nails ○ Rash	○ Eczema ○ Itching ○ Scars	○ Fungal Nails ○ Lumps ○ Warts
NEUROLOGICAL	○ Blackouts ○ Neuromas ○ Stroke	○ Burning ○ Numbness ○ Tingling	○ Charcot Neuroarthropathy ○Tremors	○ Fainting ○ Speech Problems ○ Unsteady Gait (Walking)
ENDOCRINE	○ Fatigue ○ Weight Loss	○ Goiter ○ Weight Gain	○Thirst	○ Thyroid
HEMATOLOGIC/ LYMPHATIC	○ Anemia ○ Recent Chemotherapy	○ Bleed Easily ○ Slow Healing Clots	○Blood Clots ○Swollen Glands	○ Easy Bruisability ○ Transfusion Reaction
ALLERGIC/ IMMUNOLOGIC	○ Hives ○ Sneezing ○ Wheezing	○ Itchy Nose ○ Stuffy Nose	○Itchy Eyes ○Swelling	○ Runny Nose ○ Watery Eyes

ALLERGIES: (Please also note any reactions if exposed)

MEDICATION HISTORY: (Please include dosages)

_____

_____

_____

Do you consent to request previous prescription history from the pharmacy database? ○ **YES** ○ **NO**

Check if applicable

FAMILY HISTORY	○ Anemia ○ Back Problem ○ COPD ○ Dermatitis ○ Gout ○ Hepatitis ○ Migraines ○ Stroke	○ Anxiety ○ Breast Cancer ○ Dementia ○ Diabetes ○ Glaucoma ○ High Blood Pressure ○ Pneumonia ○ Thyroid Disease	○ Arthritis ○ Cancer ○ Depression ○ Epilepsy ○ Headache ○ HIV ○ Prostate Issues ○ Tuberculosis	○ Asthma ○ Congestive Heart Failure ○ GERD ○ Heart Attack ○ Hypercholesterolemia ○ Kidney Problems ○ Stomach Ulcers
MEDICAL HISTORY	○ Anemia ○ BPH ○ Congestive Heart Failure ○ Dementia ○ Gout ○ HIV ○ Myocardial Infarction ○ Stroke	○ Anxiety ○ Back Problem ○ COPD ○ Depression ○ Epilepsy ○ Headache ○ Migraine ○ Tuberculosis	○ Arthritis ○ Breast Cancer ○ Cancer ○ Dermatitis ○ GERD ○ Hepatitis ○ Pneumonia ○ Thyroid Disease	○ Asthma ○ CAD ○ High Cholesterol ○ Diabetes ○ Glaucoma ○ Hypertension ○ Kidney Stone ○ Ulcer (GI)

List any additional ***family*** history: _____

List any additional ***medical*** history: _____

IMMUNIZATIONS

Check which immunizations you have received: ○ MEASLES ○ MUMPS ○ TETANUS ○ POLIO ○ INFLUENZA

○ TYPHOID ○ CHICKEN POX ○ TUBERCULOSIS ○ PNEUMONIA ○ OTHER _____

SOCIAL HISTORY

CIGARETTES Date Last Used _____ Daily Usage _____ Years Smoking _____ Cessation Attempts _____ Packaging _____	**CIGARS** Date Last Used _____ Daily Usage _____ Years Smoking _____ Cessation Attempts _____ Packaging _____	**PIPES** Date Last Used _____ Daily Usage _____ Years Smoking _____ Cessation Attempts _____ Packaging _____
CHEWING TOBACCO Date Last Used _____ Daily Usage _____ Years Smoking _____ Cessation Attempts _____ Packaging _____	**DIPPING TOBACCO** Date Last Used _____ Daily Usage _____ Years Smoking _____ Cessation Attempts _____ Packaging _____	
BEER ○ Social ○ Occasional ○ Light ○ Heavy	**WINE** ○ Social ○ Occasional ○ Light ○ Heavy	**HARD LIQUOR** ○ Social ○ Occasional ○ Light ○ Heavy

Social Use: < 3 standard drinks during a social, holiday, or special event. **Occasional Use**: ≤ 3 standard drinks per week. **Light Use:** 4-7 standard drinks per week, heavy use is defined as: ≥ 7 standard drinks per week.

List any recreational drug use: _____

SURGICAL HISTORY				
	⭕ AAA Repair ⭕ Breast Reduction ⭕ Cesarean Section ⭕ ESWL ⭕ Gastric Banding ⭕ Hip Surgery ⭕ Knee Surgery ⭕ Oophorectomy Unilateral ⭕ Prior Surgeries ⭕ Shoulder Surgery ⭕ Thyroidectomy	⭕ Aortic Aneurysm ⭕ CABG ⭕ Cholecystectomy ⭕ Ectopic Pregnancy ⭕ Heart Valve ⭕ Hysterectomy ⭕ LS Spine Surgery ⭕ PTCA ⭕ Prostate Biopsy ⭕ Sinusectomy (Nasal) ⭕ Tonsillectomy	⭕ Appendectomy ⭕ Carotid Endarterectomy ⭕ Colectomy ⭕ Fracture Repair ⭕ Hernia Abdominal ⭕ Intestinal By-Pass ⭕ Lasik ⭕ PVD Procedure ⭕ Prostatectomy Retro ⭕ Splenectomy ⭕ Tubal Ligation	⭕ Breast Augmentation ⭕ Cataract Extract ⭕ Duodenal Ulcer Repair ⭕ Gallbladder Surgery ⭕ Hip Fracture ⭕ Knee Arthroscopy ⭕ Mastectomy ⭕ Pacemaker ⭕ Shoulder Arthroscopy ⭕ TURP ⭕ Vasectomy

List any additional surgical history: _____

VITALS

Height: _____ Weight: _____ Shoe size:_____

If you are a diabetic, please complete the following: Blood pressure (most recent/date): _____

HbA1C% (most recent/date): _____ Fasting Blood sugar (most recent/date): _____

WORKMAN'S COMP | AUTO ACCIDENT

Is your visit due to a job related injury or due to an auto accident? ⭕ YES ⭕ NO Date of Injury : _____

Type of Injury: ⭕ WORK ⭕ AUTO ⭕ OTHER Has a claim been filed? ⭕ YES ⭕ NO Claim Number: _____

Where was the claim filed? _____ Cause of Injury: _____

Attorney: _____ Contact Phone Number : _____

FINANCIAL POLICY FOR KINETIC FOOT AND ANKLE LLC

Thank you for choosing Kinetic Foot and Ankle LLC. Our goal is to keep our patients informed about our billing policies.

1. Your insurance policy is a contract that exists between you and your insurance company. Our relationship is with you, the patient, and not the insurance company. It is the patient's responsibility to know the specifics of the policy (referral requirements, in and out of network physicians and facilities, Tier 1/Tiers 2, etc.). *If you have questions about your policy, please call the phone number provided on the back of your insurance card.*
2. We are happy to help you understand your insurance benefits but highly encourage you to call your insurance and understand your benefits. We do call your insurance to verify your benefits, however we are not responsible for incorrect information received which results in unexpected, out of pocket expenses. Cost and/or payment by your insurance company cannot be guaranteed by our staff. Regardless of your insurance plan, you are financially responsible for payment for services rendered by Kinetic Foot and Ankle LLC.
3. If your insurance plan requires a referral, you are responsible for providing Kinetic Foot and Ankle LLC the referral at the time of your appointment. It is the responsibility of the patient to provide Kinetic Foot and Ankle LLC with a new referral if the previous referral expired and keep track of the number of visits allowed. Failure to obtain a referral will shift the payment to you the patient and not the insurance carrier.
4. All copayments and deductibles must be paid at the time of service. If your annual out of pocket expenses have not been met, you will be required to pay a $125 deposit at the time of your visit. This will be applied to your account and a statement will be sent reflecting any additional monies owed following response from your insurance carrier. If it has been stated by your carrier that a deductible deposit cannot be collected at the time of service, a valid credit card will be required and stored securely. Upon claim response, your credit card will be charged and a detailed statement will be provided along with a paid receipt.
5. If you are unable to pay the full amount and a payment plan is agreed upon, a credit card must be kept on file. The card will be charged in the event that you fail to make timely payments as agreed upon in the payment plan.
6. You are responsible to inform us of all insurances in effect and to notify us immediately of any changes**.** Failure to do so will result in the patient being responsible for the cost of services rendered. When multiple policies exist, it is the patient's responsibility to inform us which policy is the primary plan.
7. Co-pays will be collected at the time of the appointment.
8. If you do not have insurance, have a non-participating plan, or are receiving services that are not covered by your plan, payment is required at the time of service.
9. If you miss or cancel an appointment less than 24 hours of the appointment time, the patient may be assessed and will be responsible for a $30 fee.
10. A $30 fee will be assessed on all returned checks.
11. If balances are not received within 30 days from the postmark date of a mailed statement, a$12 rebilling fee will be added to each additional statement sent due to the unpaid balance. Past due accounts of more than ninety days will be turned over to our collection agency. A $35 administrative fee will be added.
12. We reserve the right to require collection of outstanding balances before your next appointment.
13. We reserve the right to charge a $15 fee for completion of disability forms/other requested documentation.

Assignment of Benefits

I, _____, (or my dependent) hereby authorize Kinetic Foot and Ankle LLC to administer such procedures and treatment as deemed necessary in the diagnosis and treatment of my feet, ankles and lower legs. I authorize Kinetic Foot and Ankle LLC to bill my insurance company on my behalf for medical services and or supplies rendered by the practice. I certify that the insurance information and medical information that I have reported is accurate and authorize the release of all necessary medical and insurance information for myself and any and all dependents for any and all claims to my insurance company or Medicare. I request that payment of authorized Medicare/Insurance company benefits be made to Kinetic Foot and Ankle LLC for any services rendered.

NOTICE OF PRIVATE PRACTICES

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.

USES AND DISCLOSURES

Treatment: Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, the results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment to who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations: Your health information may be used as necessary to support the day-to-day activities and management of Kinetic Foot and Ankle. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires specific authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Info: Your health information will be used by our staff to send you appointment reminders.

Information About Treatments: Your health information may be used to send you information that you may find interesting on the treatment or management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights: You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Kinetic Foot and Ankle's Duties: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are required to abide by the private policies and practices that are outlined in this notice.

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information: You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your reports by contacting Rico M. A . Visperas, D.P.M. Your requests will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints: If you would like to submit a comment/complaint about our privacy practices, you can do so by sending a letter outlining your concerns to: Rico Visperas, DPM | Kinetic Foot and Ankle, LLC | 1030 McBride Avenue Unit #103 |Woodland Park, NJ 07424

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint. Contact Person: The name and address of the person you can contact for further information concerning our privacy practices: Rico M. A. Visperas, D.P.M. | Kinetic Foot and Ankle, LLC | 1030 McBride Avenue Unit #103 | Woodland Park, NJ 07424

By signing below, I acknowledge that I have read, understand and agree to comply with Kinetic Foot and Ankle's LLC Financial Policy and all statements above.

_____	_____	_____	_____
Patient's Name	Date of Birth	Patient's Signature	Today's Date

_____	_____
If under 18, Parent's Name	If under 18, Parent's Signature