Ocean County Foot & Ankle Surgical Associates, P.C.

Robert C. Floros,*
D.P.M., F.A.C.F.A.S.

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Michael Plishchuk,
D.P.M.

Valarie Beck,
D.P.M

Michael J. Felicetta,
D.P.M.

Robin Lenz,
D.P.M.

Kerianne Spiess,
D.P.M.

Amanda Crowell,
D.P.M.

Mary Ellen McCoy,
D.P.M.

Toms River
54 Bey Lea Road
Toms River, NJ 08753
732-505-4500
fax: 732-505-9787

1178 Route 37 W
Toms River, NJ 08755
732-240-5677
fax: 732-240-0926

Forked River
638 Lacey Road
Forked River, NJ 08731
609-693-3202
fax: 609-693-7865

Whiting
61 Lacey Road
Whiting, NJ 08759
732-350-2424
fax: 732-350-2444

A Note to our Patients about Insurance

While we make every effort to assist you with your insurance questions and submissions, you must understand that it is YOUR responsibility to verify your insurance coverage and to understand the extent of that coverage.

Insurance companies are obligated to YOU, THE INSURED, and not to our office. It is often difficult or impossible for us to get information regarding your insurance. Together, we can make sure you receive the best care possible under your insurance company guidelines.

Thank you.

Beth Swanton

Beth Swanton, B.A., B.A.
Billing Manager

OCEAN COUNTY FOOT & ANKLE SURGICAL ASSOCIATES, P.C.

Name:_____ SS#: _____

Date of Birth: _____ Age: _____ Home Phone #: _____

Cell #: _____ E-Mail _____

Address:_____

City: _____ State: _____ Zip: _____

PLEASE CIRCLE: Female / Male Married / Single / Other

Race: White / American Indian / Asian / African American / Other: _____

Ethnicity: Hispanic or Latino - Not Hispanic or Latino

Primary Language: _____

Employed By: _____ Occupation:_____

Business Phone:_____Address:_____

City: _____ State:_____ Zip:_____

PHARMACY: _____/Phone: _____/Address:_____

Primary Care Physician:_____ Phone: _____

Please list any specialists currently treating you:

Specialist: _____Phone #: _____ Specialty: _____

Specialist: _____Phone #: _____ Specialty: _____

In Case of an Emergency, whom may we contact? _____

Relationship: _____Phone Number: _____

Whom May We Thank for Referring You? _____

I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND THAT I HAVE READ (OR HAD THE OPPORTUNITY TO READ IF I SO CHOSE) AND UNDERSTOOD THE NOTICE. TO ASSIST IN THE COORDINATION OF MY CARE, I HEREBY GIVE WRITTEN CONSENT TO THE DOCTORS OF OCEAN COUNTY FOOT & ANKLE SURGICAL ASSOCIATES, PC TO VIEW MY PRESCRIPTION HISTORY PROVIDED THROUGH ELECTRONIC HEALTH RECORD EXCHANGE.

_____ _____

SIGNATURE DATE

OCEAN COUNTY FOOT & ANKLE SURGICAL ASSOCIATES, P.C.

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Patient Name:_____

Date of Birth: _____

I request that all communications to me (by telephone, mail or otherwise) by Ocean County Foot & Ankle Surgical Associates, P.C., and/or its staff be handled in the following manner:

- For **Written** Communication: Address to:

  _____

  _____

  _____

- For Oral Communication: Call Telephone #: _____

- I give my permission for Ocean County Foot & Ankle Surgical Associates, P.C. to leave a message on my voicemail.

  We may discuss your medical history with (Name & Relationship to You):

  _____

  We may discuss your bill with (Name & Relationship to You):

  _____

Patient Signature: _____

Date: _____

****

For Practice Use Only

Practice: Accepts Denies

Entered (Initial): _____

Date: _____

OCEAN COUNTY FOOT & ANKLE SURGICAL ASSOCIATES, P.C.

Assignment of Benefits, Release Form & Financial Policy

Patient Name: _____

Primary Insurance: _____

Policy Number:_____ Group Number: _____

Subscriber Name: _____ Date of Birth: _____

Subscriber Employer: _____

Secondary Insurance: _____

Policy Number: _____ Group Number: _____

Subscriber Name: _____ Date of Birth: _____

Subscriber Employer: _____

Do you have prescription drug coverage? YES NO

Is today's visit related to an auto accident or workmen's comp. claim? YES NO

***** If the above question applies to you,**
please fill out the reverse side of this form ***

I hereby instruct and direct the mentioned insurance companies to pay by check, made out and mailed to:

Ocean County Foot & Ankle Surgical Associates, P.C.
54 Bey Lea Road
Toms River, NJ 08753

for the professional or medial expense benefit allowable, otherwise payable to me.

This is a direct assignment of my rights and benefits under this policy.

- I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered
- I also authorize the release of any information pertinent to my case to any insurance company, adjustor or attorney involved in this case.
- I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signature: _____ Date: _____

Relationship (if not self): _____

****

For Office Use Only:

□ Insurance Card & ID Scanned _____ by _____
Date Initials

OCEAN COUNTY FOOT & ANKLE SURGICAL ASSOCIATES, P. C.

AUTO ACCIDENT / WORKERS COMPENSATION

Patient Name: _____

AUTO/COMP Insurance Carrier: _____

Claims Address: _____

_____

Claim Number: _____

Date Of Accident/Loss: _____

Adjusters Name & Telephone Number: _____

_____

Adjusters Fax Number: _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.

I authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

I authorize the doctor to initiate a complaint to the insurance commissioner for any reason on my behalf.

Signature: _____

Relationship (If not self):_____

Date Signed: _____

Ocean County Foot & Ankle Surgical Associates, P.C.
Patient Questionnaire

Name: _____ Date: _____

Chief Complaint: _____

Statistics: Height: _____ Weight: _____ Shoe Size: _____

Past Medical History: Please check all that apply.

- ❑ Diabetes (Problems with blood sugar) Type I or Type II
- ❑ Thyroid Disorders Hyperthyroid or Hypothyroid
- ❑ Congestive heart failure
- ❑ Angina (chest pain) Onset _____
- ❑ Previous heart attack Onset _____
- ❑ Heart murmur Onset _____
- ❑ Valve Problem Please Specify _____
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Stroke/TIA Onset _____
- ❑ Cancer: When diagnosed? What type? _____
- ❑ Seizures: What type? When was last one? _____
- ❑ Bleeding disorders: Please specify:_____
- ❑ Sleep apnea
- ❑ Asthma
- ❑ Emphysema
- ❑ COPD
- ❑ Sarcoidosis
- ❑ Tuberculosis: When diagnosed_____/Treatment Date_____
- ❑ HIV / AIDS
- ❑ Autism: Please specify _____
- ❑ Gastrointestinal Disorders: Please specify ___ _____
- ❑ Kidney Disorders: Please specify _____ _____
- ❑ Hepatitis: What type _____
- ❑ Cirrhosis
- ❑ Liver Disease
- ❑ Rheumatoid Arthritis
- ❑ Osteoarthritis
- ❑ Osteopenia
- ❑ Osteoporosis
- ❑ Bone Density Date: _____
- ❑ Lupus
- ❑ Migraines
- ❑ Back or neck problems
- ❑ Glaucoma
- ❑ Cataracts: Right Eye, Left Eye, Both Eyes
- ❑ Rheumatic fever
- ❑ Depression
- ❑ Prostate problems: Please specify _____
- ❑ Difficulty with anesthesia: What happens?_____ _____
- ❑ Gout
- ❑ No Past Medical History

❑ Please list any other medical conditions not listed above: _____

_____

Allergies:	**Yes**	**No**	**Reaction**
Do you have allergies to medications:	[ ]	[ ]	
Please Specify: _____			
Latex	[ ]	[ ]	_____
Shellfish	[ ]	[ ]	_____
X-ray contrast /Iodine	[ ]	[ ]	_____

Have you ever had radiation treatment? If yes, when? _____

Do you have a living will or advanced directive? (for patients 18 yrs & above) _ _____

If yes, can you provide our office a copy?

Do you or your caregiver have any of the following barriers that may affect your medical care? Please describe.

Cultural/Religious Barrier _____Language Barrier_____

Visual Barrier_____ Auditory Barrier_____

History Reviewed by Doctor: _____
See Attached List.

Medications:

Please list all medications that you currently take both prescription and over the counter:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Do you currently take any of the following? If yes please explain.

Blood Thinners _____
Vitamin E _____
Aspirin _____
Ginkgo Biloba _____
Motrin/Ibuprofen/Advil or any other anti-inflammatory agent _____
Weight Loss Supplements or Herbal Preparations _____

Past Surgical History:

Please list any surgery that you have had and the date they were performed:

_____
_____
_____

Family History:

Does anyone in your family suffer from any of the following medical conditions? If yes, please state the person and describe the medical problem.

Bleeding problems/Clotting Disorders _____
Cancer _____ _____
Diabetes _____ _____
Heart Disease _____ _____
Hypertension _____ _____
Thyroid Problems _____ _____
Any other medical condition not listed ___ _____
_____

Social History:

Do you drink alcohol? _____ If yes, what type? Beer, Wine, Liquor

How much do you drink? _____ How often do you drink? _____
Do you smoke? _____ Have you ever smoked: _____
If yes, how many years? _____ If yes, how much do you smoke per day? _____
If you no longer smoke, when did you quit? _____

Do you drink Coffee? _____ If yes, how much per day? _____

Do you drink Soda with caffeine? _____ If yes, how much per day? _____

Do you drink Tea? _____ If yes, how much per day? _____

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Roshni Gandhi,
D.P.M

ATTN: State of New Jersey Medicaid Participants
Effective 12-1-2011

The Department of Human Services, as part of the 2012 budget initiatives, has moved some of the Medicaid client population to Medicaid managed care health plans. There are four health plans available: Amerigroup of New Jersey, Healthfirst Health Plan of New Jersey, United Healthcare Community Plan and Horizon NJ Health.

We here at Ocean County Foot & Ankle Surgical Associates are ONLY participating with Horizon NJ Health. Please note that a referral is required for Horizon NJ Health and you will not been seen without it and/or responsible for your bill.

If you have Amerigroup of New Jersey, Healthfirst Health Plan of New Jersey or United Healthcare Community Plan, we are non-participating and you will be responsible for any charges incurred with our office.

By signing below, you understand the aforementioned.

Patient Signature: _____

Patient Printed Name: _____

Patient Date of Birth: _____

Date: _____

Toms River
54 Bey Lea Road
Toms River, NJ 08753
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MEDICATION TREATMENT CONTRACT

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Roshni Gandhi,
D.P.M

The treatment of chronic pain may involve the use of many different modalities such as nerve blocks, exercise, surgery, psychology techniques and pain medications. Some of the medications prescribed by your doctor may include substances such as Ibuprofen (Motrin and Advil), Ultram or Amitriptyline (Elavil) an anti-depressant drug that may decrease pain. Your doctor may also decide to do a trial with an opioid analgesic, such as Percocet, Oxycodone or a derivative, to assess its efficacy in treating your pain.

Some patients have an excellent response to Percocet and Percocet-like drugs (opioids). These patients experience a notable decrease in their pain without interfering side effects, such as sedation and nausea. This favorable response allows these patients to increase their function. Unfortunately, not all patients have a favorable response to these medications and may experience significant side effects that prevent further use of this type of pain medication. Additionally, these drugs do not decrease all pain syndromes. Your doctor has no way of knowing what side effects you may experience or how much pain relief you may experience. Furthermore, these medicines may cause unintended psychological effects such as a false sense of well-being and improved ability to cope with problems. Sometimes patients who experience these psychological effects may use these medicines in a way other than prescribed.

There exists significant misunderstandings regarding the use of certain analgesics. The following definitions are important for you to understand.

1. **Physical Dependence:** A pharmacological property of certain drugs, such as caffeine and opioids that cause biochemical changes in the body, such that abruptly stopping these drugs will result in withdrawal response.

2. **Addiction:** A psychological and behavioral syndrome in which there is a drug craving and drug-seeking behavior for purposes other than those intended by your physician. For example, addictive behavior would include increasing your usual dosage or opioid (without prior discussion with your doctor) for psychological benefit to self-medicate during a stressful situation.

3. **Tolerance:** A pharmacologic property of certain drugs defined by the need for increasing dosages to maintain effect.

The risk of addiction in patients who do not have a prior addiction history can happen. The risk of addictive behavior is much higher in patients who have a prior history of addiction. Your doctor may decide that certain medicines are no longer appropriate, while others you should continue but only with very careful treatment guidelines.

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INFORMED CONSENT

I understand that the use of certain opioid analgesics can be safe and effective treatment for my acute and/or chronic pain. I also understand that there exists a risk of developing an addiction disorder; however, I also understand that this is unusual in patients who have no prior addiction history.

I **will not** increase my dosage unless I discuss this with my physician first, and he or she advises me to do so.

I **will not** give, lend, share, sell or transfer my medication to anyone else. Likewise, I will not receive, borrow or purchase additional opioid analgesics from anyone who is not a healthcare provider.

I **will** fill my prescriptions with only one pharmacy. If, for some reason, I need to change pharmacies or use more than one, I will notify my physician and both pharmacies about the change.

I **will** obtain opioid analgesics from only one physician. If I receive these medications from another physician, I will not request or obtain these medications from Ocean County Foot & Ankle Surgical Associates.

If I obtain these medications from Ocean County Foot & Ankle Surgical Associates, then I **will not** get additional opioid analgesics from any other healthcare provider unless I notify him/her about this agreement. Even if I get treatment in an emergency department, I will inform the provider about this agreement. If I get additional medications, I will notify the physician's office on the next business day.

If any of my medication is lost or stolen, I will report this to the local police department and obtain a stolen/missing item report.

I **will not** alter my prescription in any way.

I have no history of substance (drug or alcohol) abuse. If I previously or concurrently use drugs or alcohol, I have brought it to my physician's attention.

I **will** agree to random urine/serum (blood) drug testing if and when requested.

IF I VIOLATE THIS AGREEMENT, MY DRUG THERAPY WILL BE TERMINATED.

PATIENT NAME: _____

PATIENT SIGNATURE: _____ DATE: _____

WITNESS: _____

PHARMACY NAME AND ADDRESS: _____

PHYSICIAN OBTAINING CONSENT: _____