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.

Dr. Russell D. Petranto
Dr. Vincent J. Migliori
Dr. Robert Floros
Dr. Matthew Regulski
Dr. Darelle Pfeiffer
Dr. Girish Nair
Dr. Megan Lubin
Dr. Michael Plishchuk
Dr. Valarie Beck
Dr. Michael J. Felicetta
Dr. Robin Lenz
Dr. Kerianne Spiess
Dr. Amanda Crowell
Dr. Krystle Troyer
Dr. Mary Ellen McCoy
Staff
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
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: ________________________________
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
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:  ____________________________________________________________
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

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 ___________________________
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? _________________________
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, P.C. 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: __________
MEDICATION TREATMENT CONTRACT

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.

There is a risk of addiction and overdose associated with opioid drugs, EVEN when taken as prescribed. Alternative treatments are available. Opioids are highly addictive, with the risk of developing dependency, risk of taking more than prescribed and/or mixing sedatives, benzodiazepines or alcohol, which can result in fatal respiratory depression. 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.
INFORMED CONSENT

I understand that the use of certain opioid analgesics can be safe and effective treatment for my acute pain. I also understand that there exists a risk of developing an addiction disorder, even if taken as directed.

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, P.C., 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: _______________________________________________
SAFE and SECURE
MEDICINE DISPOSAL

WHAT DO I DO WITH MY UNUSED MEDICATIONS?

Drop it off!

Unused medications that remain in your medicine cabinet are susceptible to theft and misuse. To prevent medications from getting into the wrong hands, New Jersey's Office of the Attorney General and Division of Consumer Affairs urge you to properly dispose of your expired and unwanted prescription medicine at a nearby Project Medicine Drop location.

DROP OFF IS SIMPLE, ANONYMOUS AND AVAILABLE 24 HOURS A DAY – 365 DAYS A YEAR, NO QUESTIONS ASKED. Simply bring in your prescription and over-the-counter medications and discard them in an environmentally safe manner. Always scratch out the identifying information on any medicine container you are discarding.

For a list of Project Medicine Drop locations, please visit NJConsumerAffairs.gov/meddrop

NJConsumerAffairs.gov/meddrop