



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

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

Vincent J. Migliori,\*  
D.P.M., F.A.C.F.A.S.

Russell D. Petranto,\*  
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D.P.M., F.A.C.F.A.S.

Nikki Migliori,  
D.P.M.

Matthew Modugno,  
D.P.M.

## 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.

Billing Manager

### **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

### **Browns Mills**

Medical Office Bldg.  
6 Earlin Ave., Suite 240  
Browns Mills, NJ 08015  
609-836-6608  
fax: 732-350-2444

### **Brick**

194 Jack Martin Blvd.  
Unit 1A  
Brick, NJ 08724  
732-458-4911

**ocfasa.com**

**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



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:

I authorize my healthcare provider to disclose to third parties, who may intercept these messages, notification of a pending or missed appointment.

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.

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

Please list any other medical conditions not listed above: \_\_\_\_\_

<b><u>Allergies:</u></b>	<b>Yes</b>	<b>No</b>	<b>Reaction</b>
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? \_\_\_\_\_





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

**Browns Mills**

Medical Office Bldg.  
6 Earlin Ave., Suite 240  
Browns Mills, NJ 08015  
609-836-6608  
fax: 732-350-2444

**Brick**

1451 Rt. 88, Suite 8A  
Brick, NJ 08724  
732-458-4911  
fax: 732-458-4922

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 be 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: \_\_\_\_\_

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RECONSTRUCTIVE FOOT & ANKLE SURGERY | DIABETIC FOOT CARE & LIMB SALVAGE | TRAUMA OF THE FOOT, ANKLE & LEG

*\*Diplomate American Board of Podiatric Surgery \*Fellow American College of Foot and Ankle Surgeons*





*Ocean County Foot & Ankle  
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**MEDICATION TREATMENT CONTRACT**

Robert C. Floros,\*  
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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 affects 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.

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**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, 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: \_\_\_\_\_