Complete Foot and Ankle, LLC

400 Route 17 South
Ridgewood, NJ 07450
Tel: (201) 445-2288
Fax: (888) 591-9039

210 Passaic Street
Garfield, NJ 07026
Tel: (201) 445-2288
Fax: (888) 591--9039

Last Name: ______________________ First Name: ______________________

Street: ______________________ Apt/Box: ______________________

City: ______________________ St: ____________ Zip: ____________

Phone :( )______________________ SSN: ________-__________-__________

Cell :( )______________________ Work: ( ) ______________________

Gender M/ F DOB: ____/____/____ Age: _______ Height: ______ Weight: ______ Shoe Size_______

Patient's Marital Status ______________________ Email Address: ______________________

Race: ______________________ Ethnicity: ______________________

Patient Employer: ______________________ Patient Occupation: ______________________

Sports, Activities or Hobbies: ______________________

**** How were you referred to this office? ______________________

Primary Physician: ______________________ Phone :( )______________________

Town/State: ______________________ Date of Last Visit: ______________________

Pharmacy: ______________________ Town: ______________ Phone :( )______________________

In case of an Emergency please notify: ______________________ **Tel: ( )** ______________________

Have you or any of your family members been treated for diabetes? ____________ If yes, who? ______________

List any medical conditions you have: ______________________

____

Have you had any injuries or operations on your feet or legs? ______________________

What is the main reason for your visit today? ______________________

How long have you had these symptoms? ______________________

Please Rate the Pain Level None or 1 to 10 ______________

What have you done to address the problem? ______________________

Tobacco Use *(Please circle):* Yes No Former Smoker

How many packs per day? ______________

Alcohol Use *(Please circle):* Yes No

If yes, Describe: Rarely Moderately Daily

If Daily, how much a day? ______________

Patient Name______________________________ Date______________

PAST SURGICAL HISTORY:

Previous Hospitalizations/ Surgeries/ Serious Illnesses	When	Hospital, City, State

REVIEW OF SYSTEMS

Allergic / Immunologic:

	YES	NO
Aspirin or Other Pain Remedies		
Iodine, Merthiolate or Other Antiseptic		
Latex		
Morphine, Demerol or other Narcotics		
Novocain or other Anesthetics		
Penicillin or Other Antibiotics		
Tetanus Antitoxin or Other Serums		

Other Drugs/Medication Allergies: ______________________________

Known Food Allergies: ______________________________

Environmental Allergies: ______________________________

MEDICATIONS

Name	Dosage	Frequency

PAST MEDICAL HISTORY

	Age	Disease(s)	If deceased, cause of death
Father			
Mother			
Sibling(s)			
Children			

I HEREBY GIVE PERMISSION TO JACOB REINKRAUT, DPM AND OR ASSOCIATES FOR THE EXAMINATION AND RENDERING CARE FOR MY FOOT/ANKLE PROBLEM AND/OR RELATED CONDITION. TO THE BEST OF MY KNOWLEDGE, THE QUESTIONS ON THIS FORM HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR'S OFFICE OF ANY CHANGES IN MY MEDICAL STATUS.

SIGNATURE:______________________________ DATE:______________________

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PATIENT INFORMATION:
SEX: MALE [ ] FEMALE [ ]

BIRTH DATE: ____/____/________

SOCIAL SECURITY# ________-________-________

LAST NAME: ______________________________

FIRST NAME: ______________________ M.I. ____

ADDRESS: ______________________________

CITY: ______________ STATE: ______ ZIP: ______

HOME PHONE: ( ) ______________________

WORK PHONE: ( ) ______________________

CELL PHONE: ( ) ______________________

INSURED'S INFORMATION
EMPLOYER OF INSURED: ______________________
YOUR RELATIONSHIP TO INSURED:
SELF [ ] SPOUSE [ ] CHILD [ ] OTHER [ ]
INSURED PERSON: [ ] MALE FEMALE [ ]
INSURED'S NAME (if other than self):

LAST NAME: ______________________________

FIRST NAME: ______________________ M.I. ____

ADDRESS: ______________________________

CITY: ______________ STATE: ______ ZIP: ______

HOME PHONE: ( ) ______________________

WORK PHONE: ( ) ______________________

DATE OF BIRTH: ______________________

SOCIAL SECURITY #: ________/________/________

INSURANCE INFORMATION- INSURANCE CARD IS REQUIRED

PRIMARY INSURANCE NAME: ______________________________________
IDENTIFICATION # ______________________________ Group # ____________

SECONDARY INSURANCE NAME: ______________________________________
IDENTIFICATION # ______________________________ Group # ____________

AUTHORIZATION / RESPONSIBILITY AGREEMENT:

I HEREBY AUTHORIZE MY INSURANCE COMPANY TO PAY THE PROCEEDS OF ANY BENEFITS TO DR. JACOB REINKRAUT DPM, AND / OR ASSOCIATES AND WILL BE RESPONSIBLE FOR THE REMAINING BALANCE. A COPY OF THIS FORM CAN BE CONSIDERED AS AN ORIGINAL FOR INSURANCE PURPOSES.

I HEREBY AGREE TO PAY MY ACCOUNT AS SERVICES ARE PROVIDED. HOWEVER, IF I AM NOW OR IN THE FUTURE BECOME A MEMBER OF AN HMO OR MANAGED CARE PLAN, I WILL PROVIDE PROPER AUTHORIZATION OR REFERRALS FOR THIS AND UPCOMING VISITS. SHOULD MEDICAL CARE BE GIVEN AND PROPER AUTHORIZATION OR REFERRAL NOT OBTAINED, I AGREE TO PAY ANY OUTSTANDING BALANCE DIRECTLY TO COMPLETE FOOT AND ANKLE, LLC.

UNDER CERTAIN CIRCUMSTANCES, I MAY HAVE ARRANGED FOR THE DOCTOR TO BILL MY INSURANCE COMPANY ON MY BEHALF; I CLEARLY UNDERSTAND THAT THE BILL IS STILL MY RESPONSIBILITY AND I WILL MAKE SURE THE BILL IS PAID IN A REASONABLE TIME FRAME (45 DAYS). IF FOR ANY REASON ANY PORTION OF MY BILL IS NOT PAID BY MY INSURANCE, I AGREE TO PAY PROMPTLY. ANY OUTSTANDING BILLS MAY BE SENT TO A BILLING AGENCY AND A 15% SERVICE FEE WILL BE ADDED.

SIGNED: ______________________________________ DATE: ____________________

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**ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES**

I acknowledge that I may request 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.

______________________________ ______________________________
Patient Name (please print) Date

____
Patient or Authorized Representative (if applicable)

____
Signature

SIGNATURE ON FILE

______________________________ ______________________________
Patient's Name (print) Insured/Medicare Number

I request that payment of authorized insurance and Medicare benefits be made either for me or on my behalf to Jacob Reinkraut, D.P.M and/or Associates for any services furnished to me by him and or associates. I authorize any holder of medical information concerning me to release to my Insurance carrier or the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits to related services.

______________________________ ______________________________
Signature of Patient Date

Yearly renewal of signature on file as described above

______________________________ ______________________________
Signature of Patient Date

______________________________ ______________________________
Signature of Patient Date

Complete Foot and Ankle, LLC

Cancellation Policy/No Show Policy for Doctor Appointments and Surgery

1.Cancellation/ No Show Policy for Doctor Appointment: We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel, and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a forty-dollar ($40) fee; this will not be covered by your insurance company.

2. Scheduled Appointments: We understand that delays can happen however we must try to keep the other patients and doctors on time.

If a patient is 30 minutes past their scheduled time, we will have to reschedule the appointment and a cancellation fee of forty-dollar ($40) will apply; this will not be covered by your insurance company.

3. Cancellation/ No Show Policy for Surgery: Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office.

If surgery is not cancelled at least 5 days in advance you will be charged a seventy-five-dollar ($75) fee; this is will not be covered by your insurance company.

______________________	______________________________	____/____/____
Print Name	**Patient Signature Patient/Guardian**	**Date**

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Complete Foot and Ankle

ASSIGNMENT OF BENEFITS

&

LIMITED POWER OF ATTORNEY

I, ______________________________________ irrevocably assign to you, my medical provider, all of my rights and benefits under my insurance contract and/or any employee welfare benefit plan for payment for services rendered to me, including but not limited to all of my rights and benefits under the Employee Retirement Income Security Act ("ERISA") applicable to the medical services at issue. I irrevocably authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP carrier/health care carrier/employee welfare benefit plan for any and all rights and benefits under ERISA or applicable statute/law, including but not limited to the claim for penalties and fees under ERISA for failure to provide Plan documents and other equitable relief. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills and/or to file insurance claims on my behalf for services rendered to me. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize and consent to your acting on my behalf in this regard and in regard to my general health insurance coverage and I specifically authorize you to pursue any administrative appeals conducted pursuant to ERISA.

In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is challenged or deemed invalid, I execute this **limited/special power of attorney** and appoint and authorize your collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case, in my name, including filing an arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney-in-fact. I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me. **I authorize you and or your attorney to receive from my insurer, immediately upon verbal request, all information regarding last payment made by said insurer on my claim, including date of payment and balance of benefits remaining.**

I authorize you and or your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider(s) to release all such information to you about me, including medical reports, X-ray reports, narrative reports, and any other report or information regarding my physical condition.

If you, my medical provider, initiates a collection proceeding against me, whether through litigation, arbitration or otherwise, in connection with any and all claims unreimbursed and/or under-reimbursed by my insurance carrier, I agree to pay any and all of my medical provider's attorneys' fees and court fees in connection with that proceeding.

Dated: ______________

____

Patient Signature