Sovereign Health
Medical Group

Doctors of The Foot & Ankle
Henry Slomowitz, D.P.M.
Daniel Waltuch, D.P.M.

Full Name: _____
Last *First* *M.I.*
Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____ DOB: _____

SSN: _____ Gender: □ F □ M Marital Status: □ S □ M □ D □ W

Emergency Contact Name: _____ Relation: _____ Phone #: _____

Referring Provider (First & Last Name): _____

If you were not referred by another provider, how did you hear about our office? _____
Insurance Information: IF WE COLLECTED YOUR CARD(S), ONLY FILL IN THE SUBSCRIBER DOB IF IT IS NOT SELF.

Primary Insurance: _____

Subscriber (if not self): _____ Subscriber DOB: _____

Relation to Subscriber: _____

Subscriber ID: _____ Group #: _____

Secondary Insurance: _____

Subscriber (if not self): _____ Subscriber DOB: _____

Relation to Subscriber: _____

Subscriber ID: _____ Group #: _____

E-RX Consent: Sovereign Medical Group implements the process of ePrescribing in the office. ePrescribing is a federally mandated initiative that requires all physicians prescribe in this manner. ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information. ePrescribing software also lets your doctor see important information, like drug interactions and prescription history. The benefits to you are reduced possibility of medical errors, less chance of adverse drug reactions, fewer trips to drop off at the pharmacy and a safer, faster, easier way to get your prescription filled. **I agree that Sovereign Medical Group may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.**

_____ _____

Patient Signature Date

Notice of Privacy Practices: *The Notice of Privacy Practices describes how Protected Health Information about you may be used and disclosed and how you can get access to this information. Please review it carefully.* Sovereign Medical Group is required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice, which describes the health information privacy practices of our practice, its medical staff, and affiliated health care providers that jointly perform payment activities and business operations with our Practice. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. **PLEASE FEEL FREE TO REQUEST A COPY.**

_____ _____

Signature of Patient/Health Care Agent/Guardian/Relative Date
(This signature indicates you were offered /received a copy of the Notice of Privacy Practices.)

□ Patient is unable to sign due to medical reason □ Patient refuses to sign.

Please circle your ethnicity, language, and race:

Ethnicity: Hispanic Non-Hispanic *Language:* English Spanish Italian Other: _____

Race: American Indian/Alaskan Native Asian Hawaiian Black/African American White Hispanic

Additional Information:

Email Address: _____

Pharmacy: _____ City/State: _____

Please list anyone you authorize us to speak with regarding your medical information (results, refills, appts, etc.):

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Financial Policy- General Consent & Release:

FINANCIAL RESPONSIBILITY: You are responsible to supply our staff with your insurance ID cards. It will automatically file the claim for you; however, you are responsible for any deductible or co-pay due at the time of service as described by your insurance policy. If any of the procedures performed here are not covered under your plan, you will be financially responsible for full payment. You hereby guarantee payment in full to Highland Park Medical Associates, P.A. for all charges for serves rendered and/or charges exceeding third party payments (except when prohibited by law or under contract). You also authorize Highland Park Medical Associates, P.A. to release to government agencies insurance carriers and others who may be financially liable for the services, all information necessary to pre-authorize services, determine medical necessity and/or the extent or amount of liability and challenge denials of medical necessity. You hereby assign all amounts payable for services rendered to Highland Park Medical Associates, P.A.. You understand that this constitutes a waiver of confidentiality under 42 C > F.R. part 2 (drug and alcohol records) and N.J.S.A. 26: 5c-1 et seq. (FTW and AIDS records) and that this authorization is revocable, except to the extent that action has been taken in reliance thereon and will otherwise remain in force indefinitely in order to effectuate the purpose for which it is given. It is your responsibility to understand which insurance plans SMG participates with. The bill is your responsibility. Your insurance policy is a contract between you and your insurance company. Our office is not a part of the contract. We are happy to file your claim for you directly with you insurance company; however, the ultimate responsibility for payment is yours. You certify that the information given to you in applying for payment under the Title XVIII of the Social Security Act is correct. You authorize any holder of medical or other information to release to the Social Security Administration or its intermediaries or carries the information necessary for this or related to the Medicare claim. You request that payment of authorize benefits be made on your behalf. You hereby request and consent to, examination and treatment (including lab procedures, diagnostic and medical/surgical) rendered by Highland Park Medical Associates, P.A. and their associates. You also consent to the removal of specimens taken by lab or pathology examination. It is your responsibility to understand which lab your insurance company affiliates with. Our office will not be held liable for services rendered to you by a non-participating lab. We accept cash, check, money order, and credit cards. There is a $25.00 fee for any returned check. Please be aware in the event your bill remains unpaid, we are forced to use a collection agency and you will be responsible for all costs associated with the process. Do not hesitate to call our office with any billing questions or concerns. Phone: (201) 703-5500. PLEASE NOTE: IF YOU DO NOT SHOW FOR YOUR SCHEDULED APPOINTMENT(S) WITHOUT CALLING THE OFFICE TO CANCEL/RESCHEDULE, YOU WILL BE CHARGED $25. **I certify that I have read this form and understand its contents. I also acknowledge no guarantees have been made to me as to the results of exams or treatment.**

_____ _____

Patient Signature Date

Medical History:

Reason for today's visit: _____

Location of pain: _____ Duration of problem (pain): _____ Quality of pain: □ Sharp □ Burning □ Dull □ Aching

Please rate the severity of your pain: □ Mild □ Moderate □ Severe

Associated signs/symptoms: _____

Please list current medications, dose, and frequency (include vitamins, natural medicines, etc.):

Medication	**Dose**	**Frequency**

Shoe Size: _____

Please list any prior/current illnesses: _____

Do you have any allergies to medications/food: □ No □ Yes

If yes, please list: _____

Please list past surgeries/hospitalization(s): _____

_____

Family History:

Mother: □ Alive □ Deceased □ Diabetes □ Hypertension □ Heart Disease □ Stroke □ Mental Illness □ Cancer

Father: □ Alive □ Deceased □ Diabetes □ Hypertension □ Heart Disease □ Stroke □ Mental Illness □ Cancer

Siblings: □ Alive □ Deceased □ N/A **Children**: □ Alive □ Deceased □ N/A

Do you smoke cigarettes, cigars, and/or chew tobacco? □ No □ Yes Quantity per day: _____

Did you used to smoke? □ No □ Yes If yes, how long ago did you quit: _____

Have you had an alcoholic beverage in the past year? □ No □ Yes

If yes, how often did you have an alcoholic beverage within the past year?

□ Never □ Monthly or Less □ 2-4x a month □ 2-3x a wk. □ 4 + times a week

If yes, how many drinks did you have on a typical day when you were drinking in the past year?

□ 1-2 □ 3-4 □ 5-6 □7-9 □ 10 or more

If yes, how often did you have 6 or more drinks on one occasion in the past year?

□ Never □ Less than monthly □ Monthly □ Weekly □ Daily or almost daily

Please circle any of the following issues you've had or currently have:

Have you ever received a pneumonia vaccine? □ No □ Yes **Approximately when?** _____

Have you recently received an influenza vaccine? □ No □ Yes **Approximately when?** _____

PATIENTS AGED 65+: Have you had any falls in the past year?

□ No □ one fall with injury □two or more falls with injury □ one fall without injury □ two or more falls without injury

(A)Notifier(s):

(B)Patient's Name: **(C) Identification Number:**

Advance Beneficiary Notice of Non-Coverage (ABN)

NOTE: If Medicare doesn't pay for ***(D) the item/items*** below you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the ***(D) item/items*** below.

(D) Non Covered Items	(E) Reason Medicare May Not Pay	(F) Estimated Cost
□ EKG □ PFT □ Hemoccult □ UA □ Cultures □ Supplies and Materials □ Lab work: _____ □ Vaccine: _____ □ Other: _____	□ Medicare does not pay for this test for your condition □ Medicare does not pay for this test as often as this □ Medicare does not pay for experimental or research tests □ May not cover services	□ up to $50 □ $50 to $100 □ $100 to $200 □ $200 to $300 □ More than $300

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading
- Choose an option below about whether to receive the **(D) *item/items*** listed above.

○ **Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

(G) OPTIONS: Check only one box. We cannot choose a box for you.

□ **OPTION 1.** I want the **(D) *item/items*** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

□ **OPTION 2.** I want the **(D) *item/items*** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

□ **OPTION 3.** I don't want the **(D) *item/items*** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

(H) Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

(I) Signature:	(J) Date: