



Sovereign
Health
System

JERSEY FAMILY

Dr. Daniel Waltuch

Dr. Bianca Karmaker

FOOT AND ANKLE

Full Name: _____ DOB: _____
Last First M.I.

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Contact #: _____ Secondary Contact#: _____

SSN: _____ Gender: ☐ F ☐ M ☐ Non Binary 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
(This signature indicates you were offered /received a copy of the Notice of Privacy Practices.)

Date

- Patient refuses to sign.

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	☐ Medicare does not pay for this test for your condition	☐ up to \$50
☐ Hemocult ☐ UA		☐ \$50 to \$100
☐ Cultures	☐ Medicare does not pay for this test as often as this	☐ \$100 to \$200
☐ Supplies and Materials		☐ \$200 to \$300
☐ Lab work: _____	☐ Medicare does not pay for experimental or research tests	☐ More than \$300
☐ Vaccine: _____		
☐ Other: _____	☐ May not cover services	

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.
- o **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:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CM, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850. Form CMS-R-131 (03/08) Form Approved OMB No. 0938-0566