



Dr. Daniel waltuch Dr. Bianca Karmaker

FOOT AND ANKLE

-ull Name:		DOB				
Last Address:	First	M.I.				
City:		State:	Zip	Code:		
Primary Contact #:	Secondary	y Contact#:				
SSN:	Gender: \Box 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 provide	r, how did you hear about our office?					
Insurance Information: IF WE COLLECT	ED YOUR CARD(S), ONLY FILL IN THE	SUBSCRIBER DOB <u>IF IT IS</u>	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 Grouphysicians prescribe in this manner. eP technology used by credit card companie information, like drug interactions and pretrips to drop off at the pharmacy and a prescription medication history from other transports.	rescribing software sends prescriptions s. This helps protect the privacy of your scription history. The benefits to you are r safer, faster, easier way to get your pre-	over the internet to your phe personal information. ePresonated possibility of medical scription filled. I agree that S	armacy in a safe, sec ribing software also le errors, less chance of a overeign Medical Group	cure way, through the same ts your doctor see important diverse drug reactions, fewel to may request and use my		
Patient Signature		Date				
Notice of Privacy Practices: The Notice get access to this information. Please revand to provide you with a copy of this notice, perform payment activities and business opera and that relates to your past, present or future plant.	iew it carefully. Sovereign Medical Group which describes the health information privactions with our Practice. "Protected Health Info	o is required by law to protect the y practices of our practice, its mo prmation" is information about you	privacy of health informatedical staff, and affiliated in including demographic i	ion that may reveal your identity health care providers that jointl information, that may identify you		
Signature of Patient/Health Care Agent/Gu	ardian/Relative	-	Date			

Please circle your ethnicity, Ethnicity: Hispanic Language: English Spanis Race: American Indian/Alas	Non-Hispanic Other: sh Italian Other:		Black/African American	White	Hispanic	
Other:						
Additional Information:						
Email Address:						
Pharmacy:		City/State	·			
Please list anyone you authorize	e us to speak with regar	ding your medic	cal information (results, ref	ills, appts, etc.):	:	
Name:			Relation:			
Name:			Relation:			
Name:			Relation:			
denials of medical necessity. You he confidentiality under 42 C > F.R. part action has been taken in reliance the insurance plans SMG participates wi We are happy to file your claim for yapplying for payment under the Title its intermediaries or carries the infor request and consent to, examination You also consent to the removal of swill not be held liable for services re be aware in the event your bill rema office with any billing questions or confice to CANCEL/RESCHEDULE been made to me as to the results of	2 (drug and alcohol records) ereon and will otherwise remath. The bill is your responsibility ou directly with you insurance XVIII of the Social Security Armation necessary for this or and treatment (including lab specimens taken by lab or pandered to you by a non-participins unpaid, we are forced to oncerns. Phone: (201) 703-556, YOU WILL BE CHARGED	and N.J.S.A. 26: 5 in in force indefinite ty. Your insurance the company; howe ct is correct. You a related to the Mediprocedures, diagnathology examination pating lab. We accuse a collection at 00. PLEASE NOTE	c-1 et seq. (FTW and AIDS reco- ely in order to effectuate the purp policy is a contract between you ever, the ultimate responsibility fu uthorize any holder of medical or dicare claim. You request that p ostic and medical/surgical) rende on. It is your responsibility to und ept cash, check, money order, ar gency and you will be responsible E: IF YOU DO NOT SHOW FOR	rds) and that this and sose for which it is and your insurance or payment is your other information ayment of authorizered by Highland Pederstand which labind credit cards. The for all costs associated as a cost associated which costs associated and credit cards. The for all costs associated which costs associated and credit cards.	uthorization is revorgiven. It is your respectompany. Our offirs. You certify that to release to the Soze benefits be madark Medical Association your insurance concere is a \$25.00 feeroisted with the procent and the procen	cable, except to the extent that ponsibility to understand which ice is not a part of the contract. the information given to you in ocial Security Administration or de on your behalf. You hereby ates, P.A. and their associates. mpany affiliates with. Our office for any returned check. Please cess. Do not hesitate to call our T(S) WITHOUT CALLING THE
Patient Signature			-	Date		
Medical History: Reason for today's visit:						
Location of pain:	Duration of problem	(pain):	Quality of pain:	□ Sharp □ Bu	ırning 🗆 Dull 🛭	□ Aching
Please rate the severity of your pa	ain: Mild Moderate	□ Severe				
Associated signs/symptoms:						
Please list current medications, dose, Medication	and frequency (include vitam	ins, natural medicii Dose	nes, etc.):	Frequency		
						

 $\hfill\Box$ Patient refuses to sign.

□ Patient is unable to sign due to medical reason

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 Benefic	ciary Notice of Non-Coverage (ABN)
NOTE: If Medicare doesn't pay for (D) the item	u/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	□ up to \$50
□ Hemoccult	□ UA	test for your condition	
□ Cultures		Madiana dana naturu fanthia	□ \$50 to \$100
=		□ Medicare does not pay for this test as often as this	│ │ □ \$100 to \$200
 Supplies and Materials 		lest as often as this	\(\pi \) \(\
□ Lab work:		□ Medicare does not pay for	□ \$200 to \$300
□ Vaccine:		experimental or research tests	_ , ,
Other:		·	□ More than \$300
		 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.
- 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)** <u>item/items</u> 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)** <u>item/items</u> 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