



**PATIENT INFORMATION SHEET**

PLEASE PRINT THE FOLLOWING INFORMATION CLEARLY

FULL NAME \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE (\_\_\_\_\_) \_\_\_\_\_ CELL (\_\_\_\_\_) \_\_\_\_\_

FULL DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ SEX (M) (F)

MARITAL STATUS ( S, M, D, W, SEP.) SOCIAL SECURITY # \_\_\_\_\_

OCCUPATION (POSITION) \_\_\_\_\_ EMAIL: \_\_\_\_\_

**TREATMENT AUTHORIZATION**

I hereby give permission to Dr. Mark A. Majeski and/or associates to administer appropriate care necessary in the diagnosis and/or treatment of my foot condition.

INITIAL \_\_\_\_\_

**INSURANCE AUTHORIZATION**

I hereby give permission to Dr. Mark A. Majeski and/or associates to submit a claim to my insurance carrier or its intermediaries for all services rendered and to release medical information to my insurance carrier for the purpose of claims payment.

INITIAL \_\_\_\_\_

I also understand that if my insurance company denies treatment as non-covered under the terms of my insurance contract I will be responsible for all charges.

I understand I am financially responsible to Dr. Mark A. Majeski and/or associates for insurance deductible and any balance not covered by my insurance carrier.

**A COPY OF THIS SIGNATURE IS VALID AS THE ORIGINAL**

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**PLEASE PRINT THE FOLLOWING INFORMATION CLEARLY**

FULL NAME \_\_\_\_\_ DATE \_\_\_\_\_

AGE \_\_\_\_\_ WEIGHT \_\_\_\_\_ SHOE SIZE \_\_\_\_\_

WHO REFERRED YOU TO OUR OFFICE \_\_\_\_\_

PLEASE LIST YOUR MEDICAL/FAMILY DOCTOR \_\_\_\_\_

WHAT PROBLEMS ARE YOU HAVING WITH YOUR FEET? \_\_\_\_\_

**GENERAL HEALTH**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> ARTHRITIS      | <input type="checkbox"/> GOUT                       | <input type="checkbox"/> HEART ATTACK                |
| <input type="checkbox"/> DIABETES       | <input type="checkbox"/> TUBERCULOSIS               | <input type="checkbox"/> PERIPHERAL VASCULAR DISEASE |
| INSULIN/ NON-INSULIN                    | <input type="checkbox"/> ASTHMA                     | <input type="checkbox"/> LUNG DISEASE                |
| <input type="checkbox"/> HEART DISEASE  | <input type="checkbox"/> SCARLET OR RHEUMATIC FEVER | <input type="checkbox"/> STOMACH PROBLEMS            |
| <input type="checkbox"/> EPILEPSY       | <input type="checkbox"/> HIGH BLOOD PRESSURE        | <input type="checkbox"/> EYE PROBLEMS                |
| <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> VENEREAL DISEASE           | <input type="checkbox"/> OTHER _____                 |
| <input type="checkbox"/> EMPHYSEMA      | <input type="checkbox"/> STROKE                     | _____  |
| <input type="checkbox"/> GLAUCOMA       |   | _____  |

**MEDICATIONS-** Are you presently taking any medications- please list

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES-** If you are allergic to any of the following - please check

- |                                     |  |                                      |
|-------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> PENICILLIN | <input type="checkbox"/> IODINE        | <input type="checkbox"/> POLLEN      |
| <input type="checkbox"/> NOVOCAINE  | <input type="checkbox"/> ADHESIVE TAPE | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> CODEINE    | <input type="checkbox"/> SHELLFISH     | _____                                |
|                                     |  | _____                                |

Have you had any serious illness or operations?  NO  YES (please explain) \_\_\_\_\_

knee/hip/any replacements? RT?LT  Heart stents?

**FAMILY HISTORY-** If any member of your immediate family has any of the following-please check

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> ARTHRITIS     | <input type="checkbox"/> ASTHMA              | <input type="checkbox"/> PERIPHERAL VASCULAR DISEASE |
| <input type="checkbox"/> DIABETES      | <input type="checkbox"/> GOUT                | <input type="checkbox"/> OTHER _____                 |
| <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> HIGH BLOOD PRESSURE | _____  |

**DO YOU SMOKE?**  YES  NO

TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS CORRECT.

X \_\_\_\_\_



**PURPOSE:** To state the overall rights of our facility.

**POLICY:** Each patient shall have the following rights:

- To be offered a written copy of these rights.
- To be given a written or verbal explanation of these rights in terms he/she can understand.
- To be informed of services available in our facility.
- To be informed of the names and professional status of the personnel providing and/or Responsible for patient's care.
- To be informed of fees and related charges; including policies for payment, fee, deposit, and refunds and any charges for services not covered by insurance.
- To be informed if our facility has authorized other health care and/or educational institutions to participate in the patients treatment. The patient also has the right to know the identity and function of the institutions and to refuse to all their participation in the patient's treatment.
- To receive from the patient's physician or clinical practitioner, in terms that he/she understand, and explanation of his/her complete medical health condition or diagnosis, recommended treatment, treatment options, including the option of no treatment, risks of treatment and expected results. If this information would be detrimental to the patients health, or if the patient in not capable of understanding the information, the explanation shall be given to the patient's next of kin or gaurdian.
- To participate in the planning of the patient's care and treatment, and refuse medication and treatment.
- To voice grievances or recommend changes in policies and services to facility personnel, the governing authority and/or outside representative of the patient's choice either individually or as a group, and free from restraint, interference, coercion, discrimination, or reprisal.
- To confidential treatment of information about the patient. Information in the patient's medical record shall not be released to anyone outside our facility without the patient's approval, unless another health care facility to which the patient was transferred requires third-party payment contract, or peer review, or unless the information is needed by the New Jersey State Department of Health for statutorily authorization purpose.
- To be treated with courtesy, consideration, respect and recognition of the patient's dignity, individuality, and right to privacy, including but no limited to, auditory and visual privacy. The patient's privacy shall also be respected when facility personnel are discussing the patient.
- To not be discriminated against because of age, race, religion, sex, nationality, or ability to pay, or deprived of any constitutional, civil, and/or legal rights solely because of receiving services from our facility.

Signature of Patient \_\_\_\_\_ Date: \_\_\_\_\_



## FINANCIAL POLICY

This policy applies to all patients. Payment is due at the time service is received. For your convenience, we accept cash, check and credit cards. Co-payments must be paid on the date of service. Patients are responsible for deductibles, coinsurance amounts and charges not paid by insurance due to failure to present proper paperwork. All charges are subject to a chart and coding review prior to being finalized. Bills on demand are estimates only and should not be used for claims nor are considered final bills.

As a courtesy, our office will automatically file primary and secondary claims. Patient balances due are billed monthly. Accurate and complete insurance information, including changes must be provided to the front desk at the time of service. We will directly bill patients who fail to provide correct, timely information. We understand that unusual circumstances may arise and that payment in full at time of service or post insurance may not always be possible. Patients may discuss special payment needs with the billing department.

Accounts not paid in accordance to terms of credit or incomplete financial arrangements will nullify any prior agreements. Physician services are provided to patients, not insurance companies, thus patients are responsible for charges for care received. If your insurance company has delayed payment on claims past 180 days, balances will revert back to direct patient responsibility. Patients can then independently deal with their insurance. Patient balances due are payable within 90 days after the first invoice. A late fee of \$3.00 will be charged each month to delinquent accounts. After 90 days, we will return delinquent accounts over to collections. Balances in collections are payable to our agent, APEX Collections.

Other fees: Returned check fee is \$25.00 per occurrence. A \$15.00 per form fee, plus any postage applies to forms over and above normal billing and/or medical records handling. Examples of such forms are rental assistance forms of disability forms.

In cases of divorce, the parent who brings in the child/children for treatment is responsible for payment and for collecting from the other parent or attorneys.

Main Street Foot & Ankle, LLC is a participating Medicare provider. This office conducts business in accordance with an internal voluntary compliance plan. We will not comply with requests by patients that are considered fraud by the Government, US and/or NJ. If you have any questions on your bill or believe it to be in error, please notify our billing department immediately. Representatives receive ongoing training and are available to answer your questions. Our Compliance Officer is also available should you require additional assistance. Medicare and commercial insurance policies are complex and contain many details. We will gladly assist you with any questions you have, however, if you are dissatisfied with our billing department, you may have your insurance company contact us directly and we will gladly work with them directly to resolve any issues. Please call our office if you have further questions. Thank You.

*I hereby certify that I have read Main Street Foot & Ankle's financial policy and understand my financial responsibility and agree to the terms stated in this Financial Policy.*

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_



Mark A. Majeski, DPM, FACFAS  
Susan L. Belanger DPM, FACFAS

618 Main Street, Toms River, N.J. 08753  
Tel: (732) 349-0114

## E-PRESCRIBING INITIATIVE: 2009

According to Federal Law, all physicians are required to adopt electronic prescribing by 2011. Thus, unless otherwise required by state law, all prescriptions for Medicare recipients will be issued electronically to your designated pharmacy. This Federal initiative has been enacted to prevent medication duplication errors and to inform all treating physicians of a patient's medication list.

*To help facilitate this process please list the following:*

1) Name: (please print) \_\_\_\_\_

2) Local Pharmacy Name, Address & Telephone: \_\_\_\_\_

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