Progressive Podiatry of North Jersey

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725 River Rd. 201A
Edgewater, NJ 07020

WELCOME TO PROGRESSIVE PODIATRY OF NJ. PLEASE FILL OUT ALL PERTINENT SECTIONS AND SIGN WHERE INDICATED.

Last Name:	Home Phone#:
First Name: M. I.	Work Phone#: ☐
Street Address: Apt#	Cell Phone#:
Street Address2:	Date of Birth:
Zip Code:	Social Security #:
City: State: Sex (M/F):	Marital Status: ☐ Single ☐ Married ☐ Other
Employed: ☐ Employed ☐ Full-time student ☐ Part-time student	E-Mail Address:

EMERGENCY CONTACT

Last Name:	First Name:
Address:	City: State: Zip::
Do you give our office permission to discuss your medical information with the person listed above? ☐ YES ☐ NO	Phone#:

PRIMARY CARE PHYSICIAN ALSO REFERRING DOCTOR	PREFERRED PHARMACY
Last Name: First Name:	Pharmacy Name:
Address: Phone#:	Address: Phone#:
City: State: Zip:	City: State: Zip:

PRIMARY INSURANCE INFORMATION

Insurance Plan Name:	Group Name or Number:
Insurance ID#:	Copay: Deductible Amount:

Your relationship to the insured person: **___Self __ Husband____Wife __Child Other**

PRIMARY INSURED PARTY: If the insured party is different from the patient, please complete information below.

First Name:	Last Name:		M. I.	Sex: (M)ale (F)emale
Address:	City:	State:	Zip:	Phone#::
Date-of-Birth:		Insured' s Social Security Number:		

SECONDARY INSURANCE INFORMATION

Insurance Plan Name:	Group Name or Number:
Insurance ID#:	Copay: Deductible Amount:

Your relationship to the insured person: **___Self __ Husband____Wife __Child Other**

SECONDARY INSURED PARTY: If the insured party is different from the patient, please complete information below.

First Name:	Last Name:		M. I.	Sex: (M)ale (F)emale
Address:	City:	State:	Zip:	Phone#::
Date-of-Birth:		Insured' s Social Security Number:		

PATIENT'S NAME (LAST, FIRST): ______________________________

REASON FOR TODAY'S VISIT: ______________________________ **DATE:** ______________

DO YOU HAVE A HISTORY OF:	Yes	No	Family	Explain/ Specify:
Heart disease: High blood pressure, pacemaker, defibrillator, heart murmur, irregular heartbeat, chest pain, fainting				
Vascular Disease: Leg swelling/pain, vein inflammation/ phlebitis, deep vein thrombosis (DVT)				
Pulmonary Disease: Asthma, chronic cough, wheezing, emphysema, sleep disturbances due to breathing				
Gastrointestinal: Reflux, crohns / ulcerative colitis, change in appetite, heartburn, nausea/vomiting, abdominal pain, change inbowel habits				
Endocrine: Diabetes, thyroid disease (hyperthyroidism or hypothyroidism), polycystic ovarian syndrome				
Genitourinary: Kidney disease, frequent urination, genital rash or sores				
Rheumatologic: Lupus, rheumatoid arthritis, dermatomyositis, polymyositis, other autoimmune disease				
Musculoskeletal: Arthritis, joint pain or stiffness, artificial (prosthetic) joint, muscle weakness				
Hematologic: Hemophilia, anemia, other bleeding disorder				
Allergic: Seasonal allergies, hives, eye irritation, changes in vision, frequent colds, nosebleeds, bleeding gums				
Psychiatric: Mood disorder, depression, memory changes, thoughts of suicide or violence, PTSD, ADHD				
Neurologic: Convulsions/seizures, headaches, tremors, weakness/numbness, paralysis				
Infectious: HIV/AIDS, hepatitis *(type)*______, blood transfusion, cold sores/herpes				

Other Medical Problems: ______________________________

Medication: Any/All currently taking. ______________________________

Allergies: All - Food/Medication/Other. ______________________________

Height: ______________ **Weight:** ______________ **Shoe Size:** ______________

Social History: Occupation: ______________________________

☐ Smoking ☐ Alcohol ☐ Recreational/Illicit Drugs ☐ Prior or current sexually transmitted disease *(if checked, please specify)*:

____

Past Surgical History:

Please list any prior surgical procedures: ______________________________

Appointment Cancellation/No Show Policy

Patients who fail to show for an appointment will be considered a No Show and charged a $25.00 fee. Please give 24 hours' notice if you need to make changes to an appointment.

Balances/Deductibles/Co-Insurance/Copayments

Insurance companies will provide an Explanation of Benefits (EOB) once a claim has been processed. There are instances whereby a patient will carry a balance. This typically occurs if the fee has been applied to a deductible or co-insurance, or if the insurance plan denies coverage for a particular service or item of durable medical equipment (DME). Late fees will apply to unpaid balances after 30 days. Accounts with unpaid balances will be forwarded to collections after 90 days.

Please read the following statement carefully and sign below

All of the information that I have provided on this form is true and complete. The signature below will also be used as a "signature on file" for insurance purposes including any medical information necessary to process relevant claims. I hereby assign my insurance benefits to be paid directly to Progressive Podiatry of North Jersey, LLC. I am aware it is my responsibility to obtain a referral if one is required by my insurance. I authorize the release of medical information necessary to process claims to insurance companies or their agencies (including Medicare) for the purpose of filing and payment of medical claims. I certify that the insurance information I have provided above is accurate and that the coverage I have listed above is currently active and not expired. I give my permission for photographs to be taken for diagnostic purposes and to enhance medical records and I agree that these photographs may be used for medical, scientific, or educational purposes provided that they do not include any information or content that could reveal my identity. (Please cross out the previous sentence if not desired.) I hereby authorize Corinne Gehegan, DPM. And the staff at Progressive Podiatry of North Jersey, LLC to administer any treatment or to administer such anesthetics and to perform such procedures as may be deemed necessary or advisable for my diagnosis and treatment. I have read the Progressive Podiatry of North Jersey, LLC Financial Policy Statement along with the credit card policy and agree that I am ultimately responsible for all non-covered services. I am aware that I am entitled to a copy of the HIPPA policy.

Printed Name (First, Middle, Last): ______________________________

Signature: ______________________________ Date: _____/____/______

CREDIT CARD AUTHORIZATION REQUIREMENT

Progressive Podiatry asks you to provide your insurance card and credit/debit card information at the time of your visit. After your visit a claim will be submitted to your insurance company. Once the claim is processed any remaining balance left unpaid by insurance will be charged to the card left on file. By using the payment authorization program you will not receive a bill for services. If you would like a copy of your paid statement please call the office and we can email or mail you a copy.

- Credit/Debit information left on file is secure.
- We will not place a hold or charge on your card.
- Your card will only be charged after your insurance claim is processed.
- Your card information will not be used for any other purpose.

NOTE: All co-pays are due at the time of visit

Please initial you preference and sign below.

☐ Option 1: Statement

I would like a statement mailed to the address I provided and understand that a $25 fee will be applied to unpaid balances after 30 days of receiving a statement. An additional $25 will be added every 30 days on unpaid balances. After 90 days accounts will be placed in collections.

Signature:____Date:_____/____/______

☐ Option 2: Credit Card

I would like my remaining balance to be charged to the card below.

Credit Card/Cardholder information

I would like my remaining balance to be charged to the card below.

Is this a HSA (Health Savings Account) or FSA (Flexible Spending Account)?

☐ Yes ☐ No

☐ VISA ☐ MC ☐ DISC ☐ AMEX

Card Number: ______________________________________Exp. Date: ________________

Card Holder's Name: ____

Signature:____Date:_____/____/______