FOOT & ANKLE ASSOCIATES OF WYCKOFF

Dr. Edward R. Nieuwenhuis Jr./Dr. Edward R. Nieuwenhuis Sr./Dr. Edward F. Younghans
350 Franklin Ave., Ste. 2, Wyckoff, NJ 07481
201.891.4930/Fax: 201-891-4715
Website: www.wyckoffpodiatrist.com

Welcome to our office.
We appreciate your expression of confidence in choosing our office for your foot care.

Name_____Gender____
FIRST M.I. LAST SUFFIX

Social Security #:_____/_____/_____ DOB:_____/_____/_____

E-Mail address:_____@_____

Address_____City_____State___Zip_____

Phone: Home_____Work_____Mobile_____

Who is your Primary Care Physician? First Name_____Last_____

City & State_____

Primary language:_____Race:_____Hispanic/Latino Origin? Yes No (circle one)

Marital status: □ Married □ Single □ Widow(er) □ Divorced □ Other

Occupation:_____Employer: _____

Employer Address:_____

Whom may we thank for referring you to our office?_____

PRIMARY INSURANCE	*ADDITIONAL INSURANCE*
Name: _____	Name: _____
Address:_____	Address:_____
_____	_____
Policyholder:_____	Policyholder:_____
Policyholder Date of Birth:_____	Policyholder Date of Birth:_____
Relationship to Patient:_____	Relationship to Patient:_____
ID#_____	ID#_____
Group#_____	Group#_____
Co-pay Amount: $_____	Co-pay Amount: $_____
Effective Date_____	Effective Date_____

Pharmacy name:_____Location:_____

*Signature*_____ *Date*___/___/_____

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Podiatric Medicine and Surgery

Edward R. Nieuwenhuis, Jr., DPM *#
Edward R. Nieuwenhuis, DPM
Edward F. Younghans, DPM*#
*Board Certified, American Board of Podiatric Surgery
#Fellow, American College of Foot & Ankle Surgeons

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MEDICAL HISTORY

What is the reason for your visit?_____

How long have you had this condition?_____

Have you previously been treated for this condition? If so, when? _____

Please list any medications you are currently taking:

_____

Are you allergic to any medication? □ NO □ YES Which one(s)?_____

Have you ever, or are you presently, being treated for any of the following:

□ ARTHRITIS
□ BACK PAIN
□ BLOOD CLOTS
□ BREATHING PROBLEMS
□ CANCER
□ DIABETES
□ FROSTBITE
□ GOUT
□ HIGH BLOOD PRESSURE
□ HEPATITIS
□ HEART DISEASE
□ KIDNEY DISEASE
□ LEG CRAMPS
□ NUMBNESS
□ PHLEBITIS
□ POOR CIRCULATION
□ SHORTNESS OF BREATH
□ SWOLLEN FEET
□ STOMACH ULCERS
□ OTHER (PLEASE LIST)_____

_____

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Patient Financial Responsibilities
PLEASE READ CAREFULLY

1. It is the patient's responsibility to know and understand their particular insurance policy and their benefits. We will not be responsible for misunderstandings in coverage. If you have any questions about your insurance coverage, it would be to your advantage to contact your insurance carrier prior to any care.

2. Managed Care (HMO) patients are responsible for acquiring completed referral forms per visit from their Primary Care Physician. If you have a referral for multiple visits, it is your responsibility to know when it runs out and when you will need a new one. Failure to comply may result in denial of insurance claim and will be the responsibility of the patient or guarantor for all charges incurred.

3. If the patient does not have insurance, he/she will be required to pay at the time of the visit unless previous arrangements have been made.

4. This office does NOT participate with the following insurances: Aetna, AmeriHealth, Emblem Health, First Health/Coventry, GHI, IDA, MagnaCare, Medicaid, Meritain Health, 1199SEIU, Horizon BCBS Advance. We will submit these to the insurance company as a courtesy, but the patient or guarantor will be responsible for the full amount.

5. I hereby authorize and guarantee payment for all services rendered. Although fees for services are due and payment may be expected at the time services are rendered, if I have been granted a grace period for payment of fees, I acknowledge that payment is due and expected at the time the first billing statement is received. In the event that my account becomes delinquent for more than 30 days, I also agree to pay a finance charge, if applicable, of 1.5% per month on any balance due, as well as all reasonable collection costs not to exceed 50%, court costs, attorney fees, interest fees and any other fees accrued with the collection of this account.

6. There will be a $25 charge for appointments not cancelled or rescheduled within 24 hours of appointment time.

By signing below, you acknowledge that you have read, understand, and agree to all of the above.

_____ _____

Signature of patient or guarantor Date

_____

Print name

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HIPAA PRIVACY PRACTICES

A copy of the HIPAA Notice of Privacy Practices is available upon request.

By signing, I acknowledge that I have read, or been given the opportunity to read if I so choose, and understand the Notice.

_____ _____

Signature Date

_____ _____

Patient Name (please print) Signature of parent or Authorized Representative (if applicable)

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Dear Patient,

For those services received in our office for which we will be billing the insurance company, a signed release is necessary allowing us to collect directly from the insurance company for your care.
PLEASE READ CAREFULLY:

I request that payment of my insurance benefits be made directly to Foot & Ankle Associates of Wyckoff for any services rendered to me by this office. I authorize release to the insurance company and its agents any information needed to determine these benefits payable for related services.

I have read and understand the above statements and information. By my signature, I am agreeing to these.

_____ _____

Print Name Signature

_____

Today's Date

→PERSON TO NOTIFY IN CASE OF EMERGENCY:

_____ _____

Name Relation to Patient

_____ _____

Phone-home Mobile