NJC FOOT & ANKLE SURGICAL SPECIALIST

☐ Nicholas Coretti, D.P.M., Foot & Ankle Surgeon

9600 NE 2nd Ave, Miami Shores, FL 33138

Phone:(954) 404-8279
Fax:(954) 404-8279

The Doctor and his staff would like to welcome you to this office.
Please assist us in answering the following questions to help us become better acquainted with you.

PATIENT INFORMATION: (PLEASE PRINT)

Date _____

Name (First)_____ (MI) _____ (Last) _____ Marital Status_____

Address_____ Apt. No.____ City_____ State_____ Zip_____

Home Phone _____ Cell Phone _____E-Mail_____

Driver's License # _____ Driver's License State _____

DOB _____/_____/_____ Age _____ Sex _____ Social Security No _____ Occupation_____

Employer/School _____ Business Phone _____

Address_____Apt. No. _____ City_____ State_____ Zip _____

Permanent Resident Yes____ No___ If no, please list second address:

Address_____Apt. No. _____City_____State_____ Zip_____

If patient is a minor- please complete

Father's Name _____ Mother's Name _____

Employer_____ Employer_____

Position_____ Phone_____ Position_____ Phone_____

Please list the name of a person to contact in case of an emergency other than a spouse or parent:

Name_____ Relationship_____ Phone_____

Address_____ Apt. No._____ City_____ State_____ Zip_____

PRIMARY INSURANCE: Name of Company _____ Phone _____

Address _____City _____State _____ Zip_____

ID#_____ Group #_____ Is this an Employer's Plan? Yes No

Insured's full name _____ Insured SS#_____ Insured DOB _____

Relationship to Insured (self, spouse, child, other)_____

SECONDARY INSURANCE: Name of Company _____ Phone_____

Address _____City _____State _____ Zip_____

ID#_____ Group #_____ Is this an Employer's Plan? Yes No

Insured's full name _____ Insured SS#_____ Insured DOB _____

Relationship to Insured (self, spouse, child, other)_____

AUTHORIZATION FOR TREATMENT/RELEASE OF INFORMATION/FINANCIAL AGREEMENT. I, the undersigned, knowing the patient, (minor) and/or self, is suffering from a condition requiring health care, diagnosis and/or medical treatment hereby voluntarily agree to such diagnostic procedure and health care and assignees. I authorize the release of medical information to my referring doctor, health agency, government agency, insurance company or Worker's Compensation. I request that payment to insurance benefits made on my behalf be paid directly to the doctor. I assume full financial responsibility for all debts incurred in any treatment and follow-up care received. I understand that any unpaid patient balances will be assessed at an interest rate of 1.5% per month. Any patient assigned to collections will be assessed a 25% surcharge on the balance.
I understand that no guarantee or assurance has been made as to the results of the procedure or treatment and that it may not cure the condition. It is the patient's responsibility to obtain authorization from their Primary Care Physician or insurance company (if required by your insurance company) prior to services being rendered.

*I acknowledge that I was provided a copy of Notice of Privacy Practices and have read (or had the opportunity to read if I so chose) and understand the Notice.
* Our practice has made a strong effort to keep our costs down in an attempt to consider taking all types of health insurance including Medicare and Medicaid. This allows us to provide medical services to our community. With that effort, we are sorry but find it necessary to charge patients **$35** for all appointments that were "NO SHOWS". This means no effort was made to cancel or reschedule the appointment. The charge will be applied to your outstanding balance.

Patient's or Legal Guardian's Signature _____ Date _____

NJC Foot & Ankle

MEDICAL HISTORY

Primary Care Doctor_____ Phone No. _____ Date of Exam: _____

Describe the condition that brought you to this office:_____

_____

If auto accident, date of accident_____ Previous care for this condition? ◻ Yes ◻ No
Dr._____ Date_____

Whom may we thank for referring you to us?_____

◻ Bell South ◻ City Limits ◻ Our City Weston ◻ Salud al Dia ◻ Parklander
◻ Weston Lifestyle ◻ Estate Lifestyle ◻ Weston Express ◻ Hospital ◻ Insurance Company
◻ Sport and Activities ◻ Pines/Miramar Advisor ◻ Davie and the Ranches ◻ Parkland Lifestyle ◻ Expressions
◻ Doctor's Name_____ ◻ Patient Name_____ ◻ Other_____

MEDICAL: (Please check any of the following if it pertains to you).

◻Diabetes ◻ Heart Attack ◻ Seizures ◻ Scar Former ◻ High Blood Pressure
◻Angina/Chest Pain ◻ Phlebitis ◻ Thyroid Disorder ◻ Angioplasty ◻ Hepatitis
◻Kidney Disorder ◻ Bleeding Disorders ◻ Stroke/TIA's ◻ Ulcers ◻ Asthma
◻Mitral Valve Prolapse ◻ Circulation Disorder ◻ Anemia ◻ Hiatal Hernia ◻ Cirrhosis
◻Human Immunodeficiency Virus (HIF) ◻ Other: _____

ALLERGIES:

☐ Penicillin ☐Aspirin ☐ Codeine ☐ Novocain ☐ Iodine ☐ Tape
Other:_____

MEDICATIONS: (Please include Aspirin, Tylenol, Vitamins and Birth Control Pills).

1._____ 2._____ 3._____ 4._____
5._____

PREVIOUS SURGERIES & HOSPITALIZATIONS:

1. _____ 2._____ 3. _____
4. _____

FAMILY HISTORY: ◻ Diabetes ◻ High Blood Pressure ◻ Bleeding Tendencies ◻ Other
SOCIAL HISTORY: ◻ Smoking ◻ Alcohol ◻ Recreational Drugs

Do you currently (or in the past) suffer from any of the following?

Podiatric History:

◻ Flat Feet
◻ Pain or fatigue in feet & legs with activity
◻ Heel or arch pain (child or adult)
◻ Numbness and tingling in feet & Toes
◻ Pain in feet getting out of bed
◻ Bunions (prominent foot bones)
◻ Crooked toes (hammertoes)
◻ Ankle swelling & stiffness
◻ Ankle instability (easy twisting injuries)
◻ Leg pain (shin splints)
◻ Growing pains
◻ Difficulty running
◻ Poor coordination with sports
◻ Intoe or out-toe gait
◻ Abnormal foot posture (clubfoot, metadductus)
◻ Achilles tendon pain

Orthopaedic History:

◻ Neck pain (cervical diskogenic pain)
◻ Lower back pain (lumbar pain or sciatica)
◻ Shoulder pain (bursitis) (rotator cuff tendinitis) (impingement)
◻ Shoulder (rotator cuff) tear
◻ Shoulder instability (labral tear) (dislocation)
◻ Tennis elbow/Golfer's elbow
◻ Chronic wrist pain
◻ Carpal tunnel syndrome (numbness and tingling)
◻ Trigger finger (catching or locking fingers)
◻ Hip or knee arthritis
◻ Knee pain and swelling (cartilage or meniscal tear)
◻ Knee instability or looseness (ACL ligament tear)
◻ Bursitis (shoulder, elbow, hip or knee)
◻ Thigh (hip) pain (that refers down the leg)
◻ Kneecap (patella) instability (subluxation)

Please complete for Worker's Compensation Injury

Describe Injury: Type of Job:

How did accident happen? Date of Accident:

FOR WORKER'S COMPENSATION INJURIES ONLY. You must report your injury to your employer and he must then report it to his insurance carrier.
If we do not receive Worker's Compensation forms to fill out within 60 days, you will be billed and held responsible for payment.

NJC
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PLEASE PRINT CLEARLY

FIRST/*NOMBRE*_____MI____LAST/*APELLIDO*_____

ADDRESS/*DIRECCIÒN*_____ _____SUITE/APT_____

CITY/*CUIDAD*_____ _____STATE/*ESTADO*_____ _ZIP/*CÒDICOPOSTAL*_____

E-MAIL ADDRESS _____

HOME/*CASA*: (_____WORK/*TRABAJO*: ( ) _____ _____

CELL/*CELULAR: (*) _____ _____ _____DATE OF BIRTH/*FECHA DE NACIMIENTO*_____

SOCIAL SECURITY/ *NÙMERO SOCIAL #*: _____

FAMILY PHYSICIAN/*MÈDICO DE CABECERA* _____ _____

PHONE/*TELÈFONO* ( ) _____ _____

WHO MAY WE THANK FOR THIS REFERRAL? _____

¿QUIÈN LO REMITIO USTED A NUESTRA OFICINA? _____

MARITAL STATUS/ ESTADO CIVIL:

SINGLE/*SOLTERO(A)* MARRIED/*CASADO(A)* *DIVORCED/DIVORCIADO(A)* WIDOWED/*VIUDO(A)* PARTNERSHIP/ *PAREJA*

EMERGENCY CONTACT/*CONTACTO DE EMERGENCIA* _____ _____

PHONE/*TELÈFONO* ( ) _____ _____

EMPLOYER/*EMPLEADOR*: _____ _____

I hereby authorize my insurance company to pay directly to NJC FOOT & ANKLE any and all medical and/or surgical fees otherwise payable to me for their professional services.

I acknowledge that I am personally responsible and liable to NJC FOOT & ANKLE, for any and all surgical and/or medical fees billed by them. Should NJC FOOT & ANKLE accept payment directly from my insurance company; I understand that I am responsible and liable for any and all deductible/co-pay expenses for the insurance company. If in the event NJC FOOT & ANKLE are required to retain the services of an attorney/collection agency to collect his bills I agree to pay JNJC FOOT & ANKLE fees up through and including appellate fees.

A copy of our office's Privacy Practices is available from the front desk upon request.

Por la presente autorizo a mi compañía de seguros a pagar directamente a NJC FOOT & ANKLE, cualquier y todos los gastos médicos y / o quirúrgicos de otro modo pagadero a mí por sus servicios profesionales. Reconozco que soy personalmente responsable y obligado a NJC FOOT & ANKLE, de cualquier y todos los honorarios quirúrgicos y / o médicos facturados por ellos. En caso de NJC FOOT & ANKLE aceptar el pago directamente de mi compañía de seguros, yo entiendo que soy responsable y responsable por cualquier y todos los gastos deducibles / co-pago de la compañía de seguros. Si en el caso de NJC FOOT & ANKLE están obligados a contratar los servicios de una agencia de abogado / colección para recoger sus cuentas Acepto pagar NJC FOOT & ANKLE, honorarios de DPM arriba hasta e incluyendo los honorarios de apelación.

Una copia de las prácticas de privacidad de nuestra oficina está disponible en la recepción bajo petición.

SIGNATURE/ *FIRMA* _____ _____ DATE/ *FECHA* _____

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Payment Policy

Thanks for choosing our practice. Below is information to answer frequently asked questions regarding patient and insurance responsibility for services rendered. Please read it and ask us any questions that you may have before signing in the space provided. A copy will be provided to you upon request. Thanks for being our patient.

PAYMENTS ARE DUE AT THE TIME OF SERVICE UNLESS PAYMENT ARRANGEMENTS HAVE BEEN REQUESTED AND APPROVED IN ADVANCE. YOU ARE EXPECTED TO PAY ACCORDING TO THE ARRANGEMENT.

Insurance: We participate with most insurance plans. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility.

Claims Submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

Referrals: Certain insurance plans with which we are contracted require referral authorization from your primary care physician/ pediatrician. If we have not received a referral prior to your arrival at the office, we have a telephone for you to use to call your primary care /pediatrician physician to obtain it. If you are unable to obtain the referral at that time, you will be rescheduled.

Co- payments and Deductible All co-payments, deductibles & co-insurances must be paid at the time of service. This arrangement is part of your contract with your insurance company.

Proof of Insurance All patients must complete the patient information form before seeing a provider. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. Failure to provide the correct insurance information in a timely manner may result in the balance of a claim being transferred to your personal responsibility.

Coverage Changes If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Methods of Payment We accept payment by cash, check, Visa, MasterCard, American Express and Discover.

Patient Statements If you have unpaid balance you will receive a statement by mail every two weeks. The statement amount is due and payable when the statement is issued, and past due if not paid upon receipt. Balances over 90 days will be turned over to a collection agency for collections. All payments go towards the oldest outstanding balance.

No Show Fee Please cancel/reschedule your visits with 24 hours notice. At our discretion, a fee equal to the cost of your office visit will be charged.

Collection Fees: Balances that have not had a payment made within 90 days will be turned over to collections. Guarantor will be responsible to pay all costs of collections including reasonable interest, reasonable attorney's fees and reasonable collection agency fees not to exceed 33.33%.

Patient's Name:

_____

Responsible Party:

_____

Signature: _____ **Date:** _____

Office Use: Received By: _____ **Date:**_____

NJC
Foot & Ankle

CREDIT CARD ON FILE POLICY

At **NJC** FOOT & **ANKLE**, we ask to keep your credit or debit card on file as a convenient method of payment for the portion of services that you are responsible for. Without this authorization, a billing fee of $25 will be added to your account for any balances that we must attempt to collect through mailing weekly statements.

Your credit card information is kept confidentially and securely in your Electronic Health Record, and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account. All charges will be accompanied by an explanation of benefits from your insurance company.

I authorize NJC FOOT & **ANKLE to charge the portion of my bill that is my financial responsibility to the following credit or debit card:**

☐**Amex** ☐**Visa** ☐**Mastercard** ☐**Discover**

Credit Card Number _____

Expiration Date _____/_____/_____ **CCV** _____

Cardholder Name _____

Signature _____

Billing Address _____

City _____ **State**_____ **Zip** _____

I (we), the undersigned, authorize and request **NJC** FOOT & **ANKLE** to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by **NJC** FOOT & **ANKLE**.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give notification to **NJC** FOOT & **ANKLE** in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____

Date: _____/_____/_____

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PATIENT HISTORY

*** Please fill out all forms to the best of your ability. The staff will go over the form and answer any questions you may have**

Full Name: _____ Height: _____ Weight: _____

1) What is the main problem with your feet or ankles? _____

2) When did you FIRST notice the condition? _____

3) Is this an injury? ____Yes ____No If Yes, when did it occur? _____/_____/_____

If Yes, did it happen at work? __Yes No Are you claiming Workman's Comp? __Yes __No

4) Check all of the following that apply:

Type of Pain __Burning __Tingling __Sharp __Dull Ache __Throbbing __Shooting __Stabbing

When Painful ___Upon Standing __During Walking __After Walking __During Sports

__Worse with Activity __Better as Activity Continues ___Worse when standing __With Shoes __Without Shoes ___A.M ___P.M

___Lying in Bed ___Always

5) How painful is your condition? If **0** = "no pain" and **10** = "the worst pain you have ever experienced", please circle your pain level: **0**

1 2 3 4 5 6 7 8 9 10

6) Have you had foot care before? __Yes __No By whom and when: _____

SURGICAL HISTORY

Procedure or Hospitalization	Date	Complications

MEDICATIONS (Please list all current prescription, over the counter, and supplements you are taking)

Medication	Dosage	How Often	Medication	Dosage	How Often
1.			4.		
2.			5.		
3.			6.		

Pharmacy: _____ Number: _____ _____ _____

MEDICAL HISTORY

Please place a **CHECK MARK** next to which of the following you suffer from and if indicated, please write in the space following what type.

Anemia		Foot Deformity	
Arthritis		Frost Bite	
Artificial Joint		Gout	
Asthma		HIV/AIDS	
Back Pain		Headaches/Migraines	
Bleeding Disorder		Heart Disease	
Blood Clots		Hepatitis	
Cancer		Hernia	
Coronary Artery Disease		Hypertension	
DVT		Kidney Disease	
Diabetes		Leg/foot ulcer	
Dialysis		Liver Disease	
High Cholesterol		Lung Disease	
Swelling		Organ Transplant	
Fibromvalgia		Osteoporosis	
Pacemaker		Seizures/Epilepsy	
Peripheral Vascular Disease		Stroke	
Polio		Substance Abuse	
Pulmonary Embolism		Thyroid Problems	
Raynaud's Disease		Tuberculosis	