NEW PATIENT ___ ROS UPDATE____

(OFFICE USE ONLY)

DR PHILIP J OBIEDZINSKI

PATIENT'S NAME ----------

ADDRESS ---------- APT# ____

CITY ---------- STATE ___ ZIP _____

DATE OF BIRTH _____ AGE ___ MALE __ FEMALE ____UNDEFINED ____

EMAIL ----------

(NECESSARY FOR PORTAL ACCESS, BILLING, APPOINTMENT REMINDERS)

PLEASE LET US KNOW WHICH NUMBER YOU WISH TO BE CONTACTED ON.

o HOME PHONE# ---------- o WORK ---------- EXT.

o CELL PHONE# ----------

ARE YOU : WORKING __ Retired ___ Other ___ Child __

Primary Physician name ----------

Your signature on this form authorizes us to use this signature on file for all commercial and Medicare insurance. It authorizes Dr. Obiedzinski to release and request any and all medical information needed to provide services to me.

If you have ***MEDICAID*** we are not participating with this insurance and can not see you.

If you would like a copy of our PRIVACY RULES, PLEASE ASK AT THE FRONT DESK. A COPY WILL BE PROVIDED TO YOU.

DATE __ SIGNATURE OF PATIENT/PARENT/ GUARDIAN _____ _

(PLEASE SIGN)*

*(PATIENT MUST BE OVER 18 TO BE SEEN WITHOUT PARENT OR GUARDIAN

Insurance and HIPAA information

Primary insurance

(please list the name of the person the policy belongs to) **Self** **Spouse** **Partner** **Child**

Name of person _____ Date of Birth ___

(if address is different) _____

Secondary Insurance

(please list the name of the person the policy belongs to) **Self** **Spouse** **Partner** **Child**

Name of person _____ Date of Birth ___

(if address is different) _____

Tertiary Insurance

(please list the name of the person the policy belongs to) **Self** **Spouse** **Partner** **Child**

Name of person _____ Date of Birth ___

(if address is different) _____

In case of an EMERGENCY who can we contact?

Name _____ Phone# _____

Relationship: _____

Do you want the above-mentioned person to have access to your records? (circle): Yes No

will not speak to anyone unless you have listed them above. IF YOU WOULD LIKE A COPY OF OUR PRIVACY NOTICE PLEASE LET US KNOW.

Philip J. Obiedzinski, D.P.M., P.A.

Diplomate American Board of Foot and Ankle Surgery

Board Certified in Foot and Ankle Surgery
Hackensack University Medical Center –Senior Attending – Department of Podiatry
50 Orient Way – Rutherford, NJ 07070-2036
201 939-2774 Fax 877-453-7229 Email: droonline@hotmail.com Website: DROonline.com

Patients Responsibility

We accept credit cards and cash for 1st time patients. (Credit cards there will be 2.6% + 10 charge applied. This is what the card companies charge us. Flex/benefits cards are not effected with this charge.

Our office tries to be respectful of your time and we try not to over-book. We would appreciate if you needed to cancel that your give us 24 hours notice. We reserve the right to charge $30.00 for a missed appointment.

Patient/Parent/Guardians responsibility to have valid insurance card, referral (if necessary) and co-pay at the time of the visit.

If a referral is required by your insurance company, you are expected to have one at the time of the visit. If you are unable to do so, please reschedule your appointment. Referrals can be faxed to our office at the above-mentioned fax #.

Our office has a secure Portal for you to use. Please give us your email for secured communications for copies of your records, lab results, prescription renewals and making appointments.

It is our office policy that to receive **a paper copy** of your chart, we must have the request in writing. Please provide the name, date of birth and a phone number should we need to call you. Paper copies are $1.00 per page and will require 3 days notice. Payment must be made before we print. We will contact you with the amount and you can pay using a credit card. We can fax paperwork to a doctor's office within three business days at no additional cost.

The office will do their best to obtain the preauthorization for procedures and medications if required by insurance, but we do not guarantee the positive outcome in all cases since different insurance plans have their own rules that we would not be able to change. We cannot be responsible for any incorrect information your insurance company gives out. Should you want to appeal any decision by your insurance company we will be happy to assist you.

Any verbal or physical expression of aggression towards office staff or Doctor is cause for immediate discharge from the practice.

A copy of this document is available upon request.

_____ _____

(Patient/Parent/Guardian Signature) (Date)

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Billing policy changes as of January 1st, 2024

1. If your specific medical plan denies payment for a covered service, (ex. Deductible, co-insurance, etc.) you/guarantor, are responsible for the fees your insurance company failed to pay.
2. Copays are due at the time of service.
3. Should there be a change in your copay, and it was not apparent at the time of service, you will be responsible for the remainder.
4. Realize that insurance policies restrict payment for some services, use restricted fee schedules, and exclude some procedures. All restrictions are based on the contract between the insurance company, your employer and you.
5. Should you receive a check from your medical insurance it is your responsibility to pay this to our office. ***Please deposit the check and send us your check in the amount. Make a copy of the explanation of benefits and send it to us with your payment.***
6. We understand that your deductible can be a large one. Our billing procedure is as follows:

   You will receive an initial billing from our office and payment is due upon receipt. If you have a Health spending account (FSA OR HSA) please call our office and we will accept payment over the phone.

   - If you need to work out a payment plan, please DO NOT HESITATE to call our office, we will be willing to work with you.
   - 30 days you will receive a second bill. If you have a Health spending account (FSA OR HSA) please call our office and we will accept payment over the phone.
   - **45 days a fee will be added to your bill. The fee of $12.50 will be added to your bill if not received in 14 days.**

60 days - We will NOT accept your FSA or HSA card. Any BILL PAID by credit card/debit card) WILL HAVE A 3.5% + .15¢ CONVENIENCE FEE APPLIED TO THE PAYMENT. Chase Pay/ZELLE (DrOonline@hotmail.com) or Venmo @Philip-Obiedzinski. We will give you a receipt to submit to your Health account.

_____ _____

Patient/Guardian signature Date

CIRCLE ALL THAT APPLY DAILY.

FEVERS
WEAKNESS
WEIGHT CHANGES
DIZZINESS
HEADACHES
MIGRAINES
BLOODY NOSE
SINUS PROBLEMS
DENTURES
HEARING PROBLEMS
TROUBLE SWALLOWING
PERSISTENT COUGH
ASTHMA
SHORTNESS OF BREATH
EMPHYSEMA
PALPITATIONS
HIGH BLOOD PRESSURE
SWELLING OF LEGS
HEART MURMUR
EXTREMITY DISCOLORED
CARDIAC A FIB
CARDIAC MI
HEART FAILURE
ANEURSYM
THROMBOSIS
EMBOLISM (PULMUNARY)
CHEST PAIN
ANKLE SWELLING
FOOT SWELLING
CARDIAC PACEMAKER
DEFIBRILLATOR
RHEUMATIC FEVER
VOMITING
HEPATITIS
HEARTBURN/GERG
RECTAL BLEEDING
NAUSEA
HERNIA
GERD
STOMACH ULCER
LEG CRAMPS
ARTHRITIS
GOUT
JOINT STIFFNESS
JOINT PAIN
BACK PROBLEMS

CALF **PAIN**
ARTHRITIS RHEUMATOID
PHLEBITIS
OSTEOARTHRITIS
SPINAL STE NOSIS
SCIATICA
HERNIATED/BULG DISC BACK
HERNIATED DISC (NECK)
BULGING DISC (NECK)
PSYCHIATRIC DISABILITY
ALZHEIMERS
EASY BRUISING
CHRONIC SKIN RASH
NEUROPATHY
TREMORS/PARKINSON'S
SEIZURES/ EPILEPSY
MEMORY LOSS
STROKE/MINI STROKE
THYROID DISEASE
URINE FREQUENT
ANEMIA
TRANSFUSION REACTIONS
BLEEDING EASILY
SEASONAL ALLERGIES
VD
URINE BLOODY
BLADDER UREGENCY
BLADDER STONES
KIDNEY STONES
KIDNEY DISEASE
VISION LOSE
CATARACTS
EXCESSIVE TEARING
GLAUCOMA
BLURRED VISION
DOUBLE VISION
SENSITIVE TO LIGHT
DO YOU WEAR GLASSES
BLINDNESS PARTIAL
MACULAR DEGENERATION
DRY EYE

SMOKJNG - EVERYDAY
SMOKING- SOM
FQRM1:R
NEVER

MORE THAN SOCIAL DRINKING YES NO

FAMILY HISTORY

HYPERTENSION	MOM	DAD
HYPER LI PI DEMIA	**MOM**	DAD
HEART DISEASE	MOM	DAD
DIABETES TYPE 1	**MOM**	DAD
DIABETES TYPE 2	**MOM**	DAD
COPD	**MOM**	DAD
THYROID DISEASE	**MOM**	DAD
BREAST CANCER	**MOM**	DAD
COLORECTAL CANCER	MOM	DAD
OTHER CANCER	**MOM**	DAD
ALCOHOLISM	MOM	DAD
BUNIONS	MOM	DAD
FOOT PROBLEMS	MOM	DAD
HEEL PAIN	MOM	DAD
HAMMER TOES	MOM	DAD
GOUT	MOM	DAD
MENTAL ILLNESS	**MOM**	DAD
OTHER		
ADOPTED		

LIST ANY MEDICAL CONDITION NOT MENTIONED 0

LIST ALL SURGERIES 0{1F YOU HAVE A LIST I CAN COPY)

PLEASE LIST ALL MEDICATIONS0{1F YOU HAVE A LIST I CAN COPY)

PLEASE LIST ALL **MEDICATION** *ALLERGIES & REACTIONS:* (ex. Latex, tape, lodine)0

LIST ANY FOOD ALLERGIES & REACTIONS0

FEMALE PATIENTS: ARE YOU CURRENTLY PREGNANT?

NO YES Due Date _ _ _ _ _

Complete if you know

Height _ _ _ Weight _ _

Blood Pressure _ _ Pulse _ _ _