OFFICE USE ONLY: LAST SEEN _____

NEW PATIENT _____ UPDATED _____ REFERRAL _____

DR PHILIP OBIEDZINSKI www.DrOonline.com

PATIENT'S INFORMATION

Patient's name._____

Address _____ APT. #_____

City_____ State___ Zip_____

(PHOTO ID R EQUI RED IF POST OFFICE BOX)

Date of Birth_____Age _____ Male _____ Female_____

EMAIL _____

(necessary for portal access & appointment reminders)

□ Home Phone# _____ □ Work _____ Ext. _____

□ Cell Phone#_____ (Please check off preferred calling #)

Working _____Retired _____ Other _____ Child _____

Primary Physician: _____

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

Medicare patients: Your signature here means you have not received the same treatment in the last 61 days. If you did Medicare will not pay and you will receive a bill from our office. (this does not apply to New patients).

MEDICAID PATIENTS: WE DO NOT TAKE MEDICAID AND WILL NOT BE ABLE TO SEE YOU. PLEASE CONTACT YOUR INSURANCE COMPANY FOR A PARTICIPATING PROVIDER.

IF YOU WOULD LIKE A COPY OF OUR PRIVACY RULES PLEASE ASK AT THE FRONT DESK. A COPY WILL BE PROVIDED TO YOU OR YOU CAN GET THEM FROM OUR WEBSITE: www.DrOonline.com

Date_____Signature PATIENT/PARENT/GUARDIAN:_____

(must be 18 or over) (PLEASE SIGN)

PATIENT INFORMATION

Race: Amer. Indian/Alaska Native ___ Asian ___ African Am ___ Hispanic/Latino ___

Native Hawaiian/Pacific Island ___ White ___ Patient Declined ___

INSURANCE INFORMATION (PLEASE PRESENT CARDS TO BE COPIED)

PRIMARY INSURANCE

RELATIONSHIP TO POLICY HOLDER **SELF** SPOUSE PARTNER CHILD

NAME OF POLICY HOLDER (not ins name)

_____DATE OF BIRTH _____

Address if different from patient _____

SECONDARY INSURANCE

RELATIONSHIP TO POLICY HOLDER **SELF** SPOUSE PARTNER CHILD

NAME OF POLICY HOLDER_____DATE OF BIRTH _____

Address if different from patient _____

TERTIARY INSURANCE

RELATIONSHIP TO POLICY HOLDER **SELF** SPOUSE PARTNER CHILD

NAME OF POLICY HOLDER_____DATE OF BIRTH _____

Address if different from patient _____

Permission is needed for us to speak to another family member/friend in case of an *emergency*. Please provide us with a name for our records.

Name:_____Relationship to you:_____

If you would like to give them access to your medical records through of portal please provide an email address for them (if you know it).

_____@ _____

Philip J. Obiedzinski, D.P.M., P.A.
American Board of Foot and Ankle Surgery
Diplomate 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.

Our office tries to be respectful of your time and we try to not over-book. We would appreciate if you need to cancel that your give us 24 hours notice. We reserve the right to charge $25.00 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 secured 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 will 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 can not 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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A copy of this document is available upon request.

Billing policy changes as of Sept 1st, 2017

Our expectations of you:

1. If your specific medical plan denies payment for a covered service,
2. (ex. Deductible, co-insurance, etc.) you/guarantor, are responsible for the fees your insurance company failed to pay.
3. Copays are due at the time of service.
4. Should there be a change in your copay and it was not apparent at the time of service your will be responsible for the remainder.
5. 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.
6. 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.***
7. 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 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 with a notice that Non-negotiable fee of $12.50 will be added to your bill if not received in 14 days
    - 45 days the Non-negotiable fee will be added to your bill.
    - 60 days you will receive a final notice and our collection department will take it from there.

_____

_____ _____

(Patient/Guardian) signature Date

CIRCLE ALL THAT PERTAIN TO YOU 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
OSTEO ARTHRITIS
SPINAL STENOSIS
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
SMOKING - EVERYDAY
SMOKING - SOME
FORMER

NEVER
MORE THAN SOCIAL DRINKING YES
NO

FAMILY HISTORY

HYPERTENSION	MOM	DAD
HYPERLIPIDEMIA	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 Θ

LIST ALL SURGERIES Θ

PLEASE LIST ALL MEDICATIONSΘ

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

LIST ANY FOOD ALLERGIES & REACTIONSΘ

FEMALE PATIENTS: ARE YOU CURRENTLY PREGNANT?

NO YES Due Date _____

Complete if you know

Height _____ Weight _____

Blood Pressure _____ Pulse _____

Philp J Obiedzinski DPM PA 201-939-2774 fax 877-453-7229

HIPAA RELEASE INFORMATION Patient name: _____ D/O/B _____

The patient or patient's representative must read and initial the following statement.

A. I understand that my health care and the payment for my health care will not be affected if I do not sign this form. _____
B. I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of form after I sign it. _____

I hereby authorize Dr. Philip J. Obiedzinski &/or his staff to disclose my individually identifiable information as described below, I understand that this authorization is voluntary. I understand that the information pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Name of Person/ organization receiving the information

_____

The following information may be released. (If the patient does not wish to state the purpose leave blank)

□ Appointment information
□ Health history information
□ Insurance information
□ Diagnosis and or treatment
□ Lab results
□ Not stated above _____

I understand that this authorization will expire on _____. (initials) _____.

I understand that I may revoke this authorization at any time by notifying Dr. Obiedzinski in writing, but if I do it won't have any affect on the actions taken before receipt of my revocation. _____(initials)

Dr. Obiedzinski will not condition my treatment on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. The use or disclosure requested under this authorization will result in direct or indirect remuneration to my doctor from a third party. (If applicable because the authorization is obtained for marketing purposes)

_____ _____ _____

Signature of patient or patient's representative Date Relationship if not patient