WELCOME

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____
all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to _____
Name of

_____ for any services furnished to me by that provider.
Doctor or Clinic

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____
Signature of Beneficiary, Guardian or Personal Representative

_____
Please print name of Beneficiary, Guardian or Personal Representative

_____ _____
Date Relationship to Beneficiary

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)

_____

_____

_____

Have you ever been to a Podiatrist before?
☐ Yes ☐ No

If yes, please list.

Name _____

Last visit _____

Is there any personal or family history of diabetes?
☐ Yes ☐ No

Your occupation _____

Cigarette/Tobacco use _____

Years smoked _____

Athletic activities in which you participate (please list and indicate frequency)

_____

_____

_____

Please indicate which foot problems you now have or have had in the past.

Ankle Pain	☐ Yes	☐ No
Athlete's Foot	☐ Yes	☐ No
Bunions	☐ Yes	☐ No
Corns and Calluses	☐ Yes	☐ No
Cramps or Numbness in Feet or Legs	☐ Yes	☐ No
Flat Feet	☐ Yes	☐ No
Foot or Leg Cramps	☐ Yes	☐ No
Heel Pain	☐ Yes	☐ No
Ingrown Toenails	☐ Yes	☐ No
Plantar Warts	☐ Yes	☐ No
Swelling in Ankles or Feet	☐ Yes	☐ No
Tired Feet	☐ Yes	☐ No

MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Rash	☐ Yes	☐ No
Allergies to Anesthetics	☐ Yes	☐ No	Eye Problems	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Allergies to Medicine or Drugs	☐ Yes	☐ No	Fainting	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Foot or Leg Cramps	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Artificial Heart Valves or Joints	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Swelling in Ankles, Feet	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis or Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Tired Feet	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Varicose Veins	☐ Yes	☐ No
Chronic Diarrhea	☐ Yes	☐ No	Neuropathy	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Phlebitis	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
Ear Problems	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No			

Surgeries you have had _____

_____

_____

Hospitalization other than for the surgeries listed _____

_____

_____

Family physician _____ Last visit date _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? ☐ Yes ☐ No

If yes, please explain _____

_____

_____

MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins _____

_____

_____

Pharmacy Name(s) _____

Pharmacy Phone(s) (_____) _____

Do you take oral contraceptives? ☐ Yes ☐ No

ALLERGIES

☐ Adhesive/Tape
☐ Anticoagulant Therapy
☐ Aspirin
☐ Codeine
☐ Demerol
☐ Iodine
☐ Local Anesthetics
☐ Novocaine
☐ Penicillin
☐ Seafoods
☐ Sulfa

Other _____

TREATMENT CONSENT

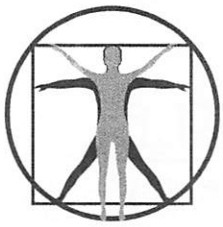
I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient



FOOT & ANKLE Specialists

Frank Tursi, D.P.M., F.A.C.F.A.S. - Joseph Donnelly, D.P.M., F.A.C.F.A.S. - Mandi Stranix, D.P.M.
Lisa Dreyfuss, D.P.M., - Kevin Lyons, D.P.M. - Danielle Seiler, D.P.M.

OFFICE POLICY

It is the intention of the personnel of our office to provide you with the optimum in foot and ankle healthcare. We pledge to you modern proven techniques to correct your foot and ankle problems.

Your feet are the foundation of your body and should be examined periodically to control and prevent foot disorders. Common foot problems treated in this office include sports injuries, fractures, sprains, arch disorders, warts, bunions, hammertoes, heel and bone spur, pediatric problems and reconstructive foot and ankle surgery.

The initial appointment is spent conducting a thorough examination. It includes a clinical evaluation of the foot and a comprehensive medical history. Every effort will be made to relieve your discomfort on the first visit. Our charge for an initial office visit starts at $200.00. Follow up visits start at $80.00. Additional services and their respective fees will be discussed at your request.

As a courtesy to our patients we will submit your claims to your insurance company provided your plan is one Foot & Ankle Specialists of South Jersey participates with. **Patients covered by medical insurances requiring a co-payment will be required to submit payment at the time of your visit. Patients not covered by insurance, or for a procedure not covered by your particular insurance, will be required to submit payment In full at the time of service.**

I have read and fully understand this office policy. I authorize the Foot & Ankle Specialist of South Jersey to undertake treatment in regard to any injuries that I may have incurred. I am aware that I am financially responsible to this office for amounts due and not covered by insurance carrier, and/or provider with whom I have coverage. Additionally, I recognize that if litigation becomes necessary to collect for services rendered and/or materials supplied to me that I will be liable for any amounts due and owing as well as any reasonable court t cost and attorney fees that are necessary to collect this debt.

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

117 White Horse Road • Voorhees, NJ 08043 • Phone (856) 435-4000 • Fax (856) 435-6866

205 Tuckerton Road
Medford, New Jersey 08055

728 Marne Highway
Moorestown, New Jersey 08057

1 Brace Road, Suite B
Cherry Hill, New Jersey 08034

Vincera Institute, 1200 Constitution Ave
Philadelphia, Pennsylvania 19112

3 Myers Drive
Mullica Hill, NJ 08062

footandanklespecialists@gmail.com • www.footandanklesj.com

FOOT & ANKLE
Specialists of South Jersey

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Lisa Dreyfuss, D.P.M. • Florence Tursi, D.P.M. • Kevin Lyons, D.P.M.

PAYMENT ORDER SHEET

I HEREBY AUTHORIZE YOU TO PAY DIRECTLY TO DR. FRANK J. TURSI AND/OR JOSEPH V. DONNELLY AND/OR MANDI F. STRANIX AND/OR FOOT AND ANKLE SPECIALISTS OF SOUTH JERSEY BENEFITS DUE TO ME OUT OF INDEMNITY UNDER THE TERMS OF MY POLICY ISSUED BY YOUR COMPANY.

PAYMENT IS AUTHORIZED UPON YOUR RECEIPT OF THIS ITEMIZED STATEMENT FOR SERVICES RENDERED TO ME. THIS POLICY WAS IN EFFECT AT THE TIME THESE SERVICES RENDERED. PAYMENT OF THIS AMOUNT HEREIN DIRECTED, IN WHOLE OR PART, SHALL BE CONSIDERED THE SAME AS IF PAID, BY YOUR COMPANY, DIRECTLY TO ME. PLEASE ALLOW THIS FORM, WHEN COPIED, TO SERVE AS THE ORIGINAL.

INSURED: _____ POLICY NUMBER: _____

ADDRESS: _____

LEGAL SIGNATURE: _____ DATE: _____

I FURTHER AUTHORIZE THE PAYMENT OF _____, MY SECONDARY AND/OR MEDIGAP MEDICAL BENEFITS TO DR. FRANK J. TURSI AND/OR DR. JOSEPH V. DONNELLY AND/OR DR. MANDI F. STRANIX AND/OR FOOT AND ANKLE SPECIALISTS OF SOUTH JERSEY.

INSURED: _____ POLICY NUMBER: _____

ADDRESS: _____

LEGAL SIGNATURE: _____ DATE: _____

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Patient Name: _____

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Foot & Ankle Specialists of South Jersey to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

With this consent, Foot & Ankle Specialists of South Jersey may call your home or other alternative locations and leave a message on voicemail or to a person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including test results, among others.

With this consent, Foot & Ankle Specialists of South Jersey, may mail or e-mail to my house or other alternative locations any items that assist the practice in carrying out TPO, such as appointment reminder and patient statements.

By signing this form, I am consenting to allow Foot & Ankle Specialists of South Jersey to use and disclose my PHI to carry out TPO.

Furthermore, I allow my protected health information to be discussed with the following persons: Please print.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Patient or Legal Guardian: _____

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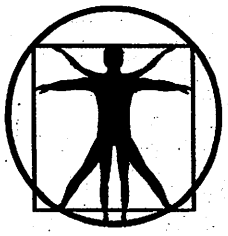

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I have received and read a copy of the Joint Notice of Privacy Practices under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) from the Foot and Ankle Specialists of South Jersey **(PLEASE SEE ATTACHED).**

_____ _____

Signature Date

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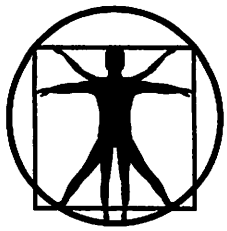

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COVID-19 Screening Form

Patient Name: _____

DOB: _____

Today's Date: _____

Please circle answer to the following questions:

1. Do you have a new onset of cold symptoms such as a cough and runny nose?
   YES or NO

2. Have you received a dose of the COVID-19 vaccine?
   YES or NO

3. Which vaccine did you receive?
   Pfizer Moderna J&J

4. How many did you receive:
   1 or 2

5. Did you receive your Booster Shot:
   YES or NO

6. Have you been in close contact with a person known to have the COVID-19 Virus?
   YES or NO

7. Do you currently have fever or lower respiratory symptoms such as a cough or shortness of breath?
   YES or NO

Patient Signature:_____

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Foot & Ankle Specialists (F.A.S.) Joint Notice of Privacy Practices
Effective Date April 14, 2003

This notice describes how personal health information about you may be used and disclosed and how you can get access to this information. Please review carefully.

This Joint Notice of Privacy Practices is provided to you pursuant to the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA") It is designed to tell you how we may, under federal law, use or disclose your protected health information. It covers all F.A.S. facilities, physicians, employees, medical students & residents. This joint notice applies to all Protected Health Information maintained by F.A.S., including all records of your care.

How we may use or disclose your Protected Health Information.
Federal and State Law Implications:

HIPAA is a federal law, which places limitations on the types of uses and disclosures health care providers, and others may make of Protected Health Information. F.A.S. will abide by these regulations as they pertain to Protected Health Information.

Uses & Disclosures under HIPAA:

1. We may use or disclose your Protected Health Information for the purposes of treatment, billing and to receive payment, or healthcare operations without obtaining your prior authorization.
2. Protected Health Information will also be used without prior authorization in the following circumstances: To notify and/or communicate with your family. As required by Law, in response to subpoenas or for judicial and administrative proceedings, for research, for worker's compensation, for appointment reminders, and to appraise your physicians of your podiatric and medical care.
3. Required uses and Disclosures: Under the law, disclosures must be made to you, upon your request and when required by the Secretary of the Department of Health and Human Services to investigate or determine compliance with HIPAA regulations.
4. For all other circumstances, we may only use or disclose your Protected Health Information after you have signed an authorization.

Your rights with Respect to your Protected Health information:

1. You have the right to request restrictions on the uses and disclosures of your Protected Health Information. This means you may ask us not to use or disclose any part of your Protected Health Information for treatment, payment, or healthcare operations. You may also request that any part of your Protected Health Information not be disclosed to family members or friends who may been involved in your care or for notification purposes as described in this Joint Notice, Your request must be in writing and addressed to our privacy officer and state the specific restrictions.
2. You have the right to request, in writing your Protected Health Information through confidential means.
3. You have the right to inspector obtain a copy of our Protected Health Information and F.A.S. Will charge a reasonable fee for copying the records.
4. You have the right to obtain an accounting of disclosures of your Protected Health Information made by us except that we do not have to account for disclosures made prior to April 14. 2003. The right to receive an accounting of this subject to exceptions, restrictions, and limitations.
5. If you would like a more detailed explanation of these rights or if you would like to exercise one or more of these rights, please contact our Privacy Officer.

Our Duties to You:

We are required by law to maintain the privacy of your Protected Health Information and to provide you with a copy of this notice.

We are also required to abide by the terms of this notice.

We reserve the right to amend this notice at any time in the future and to make the new notice provisions applicable to all your Protected Health Information-even if it *was* created prior to the change in this notice. If such an amendment is made, we will immediately display the revised notice in our office and will provide you with a copy of this at any time upon request.

How to Complain to the Government about our Privacy Practices:

You may make complaints to the Secretary of the Department of Health and Human Services if you believe your rights have been violated. You may contact DHHS at:

The Department of Health and Human Services
200 Independence Avenue, S.W.
Washington. D.C. 20201
1 (202) 619-0257 or Toll free 1(877) 696-6775

We promise not to retaliate against you for any complaint you make to a governmental agency pertaining to or about our privacy practices.

How You May Contact Us about our Privacy Practices:
Please contact our privacy officer at (856) 435-4000.