

# Jackson Family Foot & Ankle Care

100 W. Veterans Highway \* Jackson, NJ 08527  
475 Route 70 \* Suite 104 \* Lakewood, NJ 08701  
(732) 833-6888 – tel  
(732) 833-6280 – fax

Dear

We are delighted to welcome you to the practice and pleased that you chose us to serve your podiatry needs. Enclosed you will find a new patient packet. Please fill out as completely as possible and return to the office ***before*** your appointment. There is a self-addressed and stamped envelope included for your convenience.

To help your appointment go smoothly, for you and the doctor, please make sure that you are prepared in the following manner:

1. Have insurance cards and medications readily available for the doctor to check.
2. Have your shoes and socks off.
3. Position yourself in a well-lighted area, preferable in a reclining chair/bed.
4. Have a small towel or paper towels available.

The office will call to remind you of your appointment, which must be confirmed.

Thank you and we look forward to seeing you.

Sincerely,

Dr. Christopher Blakeslee & Staff

# Welcome to Jackson Family Foot & Ankle Care

## Patient Information

Patient Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_ SSN: \_\_\_\_\_

Home Address: \_\_\_\_\_ Apartment: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Would you like access to your records online through our secure patient portal?  Yes  No

Sex:  Male  Female Marital Status:  Single  Married  Widowed  Divorced  Separated

Preferred Language: \_\_\_\_\_

Ethnicity:  Hispanic/Latino  Not Hispanic/Latino  Unreported/Refused to Report

Race:  American Indian or Alaska Native  Asian  Black or African American  More than one race

Native Hawaiian  Pacific Islander  White  Unreported/Refused to Report

Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Specialty Doctors: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Emergency Phone \_\_\_\_\_

## Disclosure to Designated Family/Friends Caregivers

I allow Jackson Family Foot & Ankle Care to disclose medical information as needed to the following designed individual(s) involved with my health care.

I understand that I am not required to list anyone. I also understand that I may change my list in writing at any time.

Print Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Print Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

## Insurance Information

Insurance Carrier \_\_\_\_\_ Group # \_\_\_\_\_ ID # \_\_\_\_\_

Person Responsible for Account \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ D.O.B \_\_\_\_\_ SSN \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Group \_\_\_\_\_ ID # \_\_\_\_\_

Person Responsible for Account \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ D.O.B \_\_\_\_\_ SSN \_\_\_\_\_

Is this a compensation or work relate case?  Y  N Date of Injury \_\_\_\_\_

## New Patient Review of Symptoms

Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Shoe Size: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

What type of shoes do you wear most often? \_\_\_\_\_

- What is your chief complaint you are here to address today? \_\_\_\_\_

- Description of Pain (dull, sharp, aching, etc.): \_\_\_\_\_

- Aggravating Factors (when is the pain at its worst?) \_\_\_\_\_

- How long has this bothered you? \_\_\_\_\_ Days \_\_\_\_\_ Weeks \_\_\_\_\_ Months \_\_\_\_\_ Years

- Relieving Factors:  Rest  Ice  Heat  Medications  Home Remedies  Stretching  Other: \_\_\_\_\_

- Does your foot pain limit your activities?  Yes  No Do you have difficulty/pain walking?  Yes  No

- Have you had any previous treatment for this problem?  Yes  No

If yes, please explain: \_\_\_\_\_

- Have you had diagnostic imaging for this problem?  Yes  No

If yes, when and where were they done? \_\_\_\_\_

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

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Ankle Pain  | <input type="checkbox"/> Ingrown Toenails       | <input type="checkbox"/> Leg Pain                             |
| <input type="checkbox"/> Ankle Instability (Easy Twisting Injuries)                  | <input type="checkbox"/> Athlete's Foot         | <input type="checkbox"/> Tired Feet                           |
| <input type="checkbox"/> Ankle Swelling or Stiffness                                 | <input type="checkbox"/> Corns/Calluses         | <input type="checkbox"/> Bunions                              |
| <input type="checkbox"/> Achilles Tendon Pain  | <input type="checkbox"/> Plantar Wart           | <input type="checkbox"/> Flat Feet                            |
| <input type="checkbox"/> Pale or Blue Discoloration of the Feet                      | <input type="checkbox"/> Heel or Arch Pain      | <input type="checkbox"/> Numbness in Feet/Toes or Legs        |
| <input type="checkbox"/> Swelling in Feet or Ankles                                  | <input type="checkbox"/> Cramps in Feet or Legs | <input type="checkbox"/> "Toe-in" or "Toe-out" Gait (Walking) |
| <input type="checkbox"/> Pain or Fatigue of Feet or Legs During Activity or Exercise |   |   |
| <input type="checkbox"/> Non/Poor Healing Sore, Ulcer or Gangrene on the Leg or Foot |   |   |

- Have you ever been to a podiatrist before?  Yes  No

Last Visit? \_\_\_\_\_

## Medical History

Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Please indicate with a (✓) any of the medical conditions below that pertain to you

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Abdominal Aortic Aneurysm      | <input type="checkbox"/> COPD                 | <input type="checkbox"/> High Cholesterol      | <input type="checkbox"/> Rash                |
| <input type="checkbox"/> AIDS/HIV                       | <input type="checkbox"/> CVA (Stroke)         | <input type="checkbox"/> Hypertension          | <input type="checkbox"/> Rheumatic Arthritis |
| <input type="checkbox"/> Allergies (Seasonal)           | <input type="checkbox"/> Depression           | <input type="checkbox"/> Keloids/Thick Scars   | <input type="checkbox"/> Rheumatic Fever     |
| <input type="checkbox"/> Anemia                         | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Sciatica            |
| <input type="checkbox"/> Angina                         | <input type="checkbox"/> Diverticulitis       | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Sinus Problems      |
| <input type="checkbox"/> Anxiety                        | <input type="checkbox"/> DNR                  | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Skin Disorder       |
| <input type="checkbox"/> Arthritis                      | <input type="checkbox"/> Edema                | <input type="checkbox"/> Lyme's Disease        | <input type="checkbox"/> Sleep Apnea         |
| <input type="checkbox"/> Artificial Heart Valves/Joints | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Macular Degeneration  | <input type="checkbox"/> Stomach Ulcers      |
| <input type="checkbox"/> Asthma                         | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Disease     |
| <input type="checkbox"/> Atrial Fibrillation            | <input type="checkbox"/> Fracture             | <input type="checkbox"/> Neuropathy            | <input type="checkbox"/> Tuberculosis        |
| <input type="checkbox"/> Back Problems                  | <input type="checkbox"/> GERD                 | <input type="checkbox"/> Osteopenia            | <input type="checkbox"/> Vascular Disease    |
| <input type="checkbox"/> Benign Prostatic Hypertrophy   | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Osteoporosis          | <input type="checkbox"/> Varicose Veins      |
| <input type="checkbox"/> Blood Disorder                 | <input type="checkbox"/> Gout                 | <input type="checkbox"/> Palpitations          | <input type="checkbox"/> Venereal Disease    |
| <input type="checkbox"/> Blood Clots/DVT/PE             | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Phlebitis             | <input type="checkbox"/> Varicose Veins      |
| <input type="checkbox"/> Cancer                         | <input type="checkbox"/> Hearing/Ear Problems | <input type="checkbox"/> Pneumonia             | <input type="checkbox"/> Weight Loss         |
| <input type="checkbox"/> Cardiomyopathy                 | <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Polio                 | <input type="checkbox"/> Other: _____        |
| <input type="checkbox"/> Chemical Dependency            | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Psychiatric Care      | _____  |
| <input type="checkbox"/> Circulation Problems           | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Pulmonary Nodule      | _____  |
| <input type="checkbox"/> Congestive Heart Failure       | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Radiation Treatment   | _____  |

## Surgical History

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Amputation of Foot or Toes | <input type="checkbox"/> Foot Surgery      | <input type="checkbox"/> Open Heart Surgery      |
| <input type="checkbox"/> Ankle Surgery              | <input type="checkbox"/> Fracture Repair   | <input type="checkbox"/> Organ Transplant        |
| <input type="checkbox"/> Bariatric Surgery          | <input type="checkbox"/> Hammertoe Surgery | <input type="checkbox"/> Pacemaker/Defibrillator |
| <input type="checkbox"/> Bunion Surgery             | <input type="checkbox"/> Hip Replacement   | <input type="checkbox"/> Vein Surgery            |
| <input type="checkbox"/> Colon Surgery              | <input type="checkbox"/> Knee Replacement  |  |

Please list all other surgeries: \_\_\_\_\_

## Allergies

Are you allergic or sensitive to any of the following:

- |                                     |                                  |                                  |  |  |  |                                  |                                  |
|-------------------------------------|----------------------------------|----------------------------------|--|--|--|----------------------------------|----------------------------------|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa   | <input type="checkbox"/> Tape    | <input type="checkbox"/> Latex                       | <input type="checkbox"/> No Known Drug Allergies | <input type="checkbox"/> Betadine (iodine) | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Tylenol |
| <input type="checkbox"/> Ibuprofen  | <input type="checkbox"/> Vicodin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Local or General Anesthesia | <input type="checkbox"/> Other: _____            |  |                                  |                                  |

## Medication List

Please list current medications prescribed by a doctor, including over the counter medications, vitamins, and supplements: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Social History

Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Please indicate with a (✓) any of the responses below that pertain to you

• Tobacco Use:

- Cigarettes:             Never Smoked  
                               Current Smoker    \_\_\_\_\_ Packs per day            \_\_\_\_\_ Number of Years  
                               Former Smoker    \_\_\_\_\_ Number of Years            \_\_\_\_\_ Quit Date
- Other Tobacco:        Vape             Pipe             Cigar             Snuff             Chew
- Are you interested in quitting?     Not Ready to Quit  
     Thinking about Quitting  
     Ready to Quit

- Alcohol:                     None             Rarely             Moderate     Quit

- Drug Use:                 Yes             No

- Exercise:  
 Do you exercise daily regularly:     Yes, List Activities: \_\_\_\_\_  No

## Family History

Please indicate with a (✓) for any responses below that pertain to your family members

Medical Condition	Father	Mother	Siblings	Children
Living				
Deceased				
AAA-Abdominal Aortic Aneurysm				
Cancer				
CHF – Congestive Heart Failure				
COPD				
Diabetes				
DVT				
Gout				
Heart Disease				
Hypertension				
Thyroid Disease				
Unknown				

## Authorization to Access Electronic Prescription Records

I authorize Jackson Family Foot & Ankle Care and Dr. Christopher Blakeslee to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my provider and staff here. It may include prescriptions back in time for several years and may include prescriptions to treat HIV, substance abuse and psychiatric conditions, if applicable. I understand that my prescription history will become part of my Jackson Family Foot & Ankle Care medical record.

\_\_\_\_\_ I agree to allow access to my electronic prescription records.

## Health Information Exchange (HIE)

Jackson Family Foot & Ankle Care also participates in electronic health information exchanges (HIEs) with hospitals and various other health care providers. I authorize Jackson Family Foot & Ankle Care and the HIEs with which it participates to share my health information, through the HIE networks, for purposes permitted by law, including my treatment and coordination of my care, with all health care providers that are authorized under the HIEs' policies and applicable law to access my information. I understand and agree that the information about me that may be shared and accessed through the HIEs may include information about HIV/AIDS status, sexually transmitted diseases, family planning, mental health treatment, genetic test results, use of alcohol and other substances and other sensitive categories of my health information. I understand that I have the right to "opt-out" of having my information shared through HIEs.

\_\_\_\_\_ I agree to allow access to HIE (Health Information Exchange).

## Consent to Treat

I, the underlying, voluntarily consent to and authorize Dr. Christopher Blakeslee and the employees of Jackson Family Foot & Ankle Care to provide such podiatric care and examinations, on a continuing basis, and to administer such routine diagnostic, radiological and/or therapeutic procedures, test and treatments as are considered necessary or advisable, in my diagnosis, care and treatment, in the judgement of Dr. Christopher Blakeslee, including, but not limited to, collecting and testing specimens, and administration of pharmaceutical products. I acknowledge that no guarantees have been made to me about the results of any examination or treatment.

\_\_\_\_\_ I agree to treatment as described above.

## Acknowledge and Agreement

**Please initial the following stating you have read and agreed;**

\_\_\_\_\_ I acknowledge receipt of the Notice of Privacy Practices.

\_\_\_\_\_ I have read this form, my questions have been answered, and I understand and agree to its content.

**Print Patient/Representative's Name:** \_\_\_\_\_ **D.O.B:** \_\_\_\_\_

**Patient/Representative's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**If signed by Authorized Representative, print name of Signatory Patient:** \_\_\_\_\_

**Relationship to Patient/Authority to Sign for:** \_\_\_\_\_

## Financial Policy for Jackson Family Foot and Ankle Care

Thank you for choosing our office for your medical care. We are committed to serving you with skill and quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

**INSURANCE:** We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

**MEDICARE:** We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However, that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any copayments, which are usually 20% for the allowed amount for an item or service

**SECONDARY INSURANCE:** Your medical claim will be forwarded to your secondary insurance (if any) after payment and /or explanation of benefits (EOB) is received from your primary insurance company.

**COPAYMENTS AND DEDUCTIBLES:** All copayments and deductibles must be paid at the time of services. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments or deductibles from patients can be considered fraud. Please help us in upholding the law by paying your copayment at each visit.

**SELF PAY:** Payment in full is due at the time of service if you do not have health insurance.

**NON-COVERED SERVICES:** Please be aware that some of the services that you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment of these services.

**REFERRALS/AUTHORIZATIONS:** We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of this visit. If you do not have a referral from your primary care physician at the time of a visit, you will be financially responsible for all services received due in full upon completion of the visit. Full credit will be given if a referral is presented to our office within 48 hours of this visit. You will also be given the option to reschedule your appointment

**CLAIM SUBMISSION:** We will submit you 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.

**PATIENT BILLING:** You will be sent a statement for any outstanding balance owed after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. **If a second or third statement is required, a \$10 rebilling fee will be added to your account for each subsequent statement. You will be sent up to three notices of your financial responsibility** (coinsurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. **If payment is not received after the third and last notice, your account will be forwarded to collections (with a \$50 fee) or small claims court (where additional fees will apply).** Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check or Visa/MasterCard/AMEX. An additional \$50.00 will be added to your statement if the check is returned for insufficient funds. In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it you our office to be applied to your balance.

**MISSED/CANCELED APPOINTMENTS:** If 24-hour notice is not giving for any cancellation or missed appointment, I will be subject to a \$25 fee. A \$75 cancellation fee will be charged for any missed home visits. See separate house call policies and guidelines.

**PRIVACY STATEMENT:** Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

### Assignment of Benefits

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **Jackson Family Foot and Ankle Care** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, copayments and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested by physicians to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance and acknowledge I was provided with a copy of the Notice of Privacy Practices and understand and accept its terms. **I have read the above policy regarding my financial responsibility to Jackson Family Foot and Ankle Care for medical services provided. I agree to pay Jackson Family Foot and Ankle Care any balance unpaid by my insurance carrier for myself or the below named person.**

PRINT Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

### **FINANCIALLY RESPONSIBLE PARTY**

PRINT Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_

# House Call Cancellation Policy

Cancellations are sometimes unavoidable, but we ask for at least 24 hours' notice as a courtesy to other patients who are waiting for an appointment and out of respect for Dr. Blakeslee's time. Please review our House Call Policy, then sign and date the following, stating that you have read and agreed.

- For any appointment cancelled in a timely manner (with more than 48 hr notice) you can be rescheduled in 2 weeks or at our earliest convenience and will be notified as soon as possible.
- Any cancellations made less than 24-48 hours from your scheduled appointment time, will be added to the waiting list up to 10 weeks.
- There will be a \$75 fee for cancellations made the day of your scheduled appointment or if Dr. Blakeslee arrives to find no one is home. Once your cancellation fee is paid, you will be added back on the schedule in 10 weeks. You may make an appointment at any time in the office, if you need to be seen sooner. Multiple cancellations may result in termination of house calls.

**We truly appreciate your understanding.**

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Print Patient/Representative's Name

D.O.B

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Patient/Representative's Signature

Date

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Relationship to Patient/Authority to Sign for