neptune foot care center

DR. MICHAEL A. WEINBLATT
PODIATRIC MEDICINE AND SURGERY

Diplomate, American Board of Podiatric Orthopedics and Primary Podiatric Medicine

2100 CORLIES AVENUE, NEPTUNE CITY, NEW JERSEY 07753 • Tel 732-775-4040 • Fax 732-775-4060

Welcome To Our Office!

Welcome to the office of Michael A. Weinblatt DPM of the Neptune Foot Care Center. Please find enclosed the new patient registration forms for you to fill out prior to your scheduled appointment. We want your first visit to be as pleasant an experience as possible. We feel that by letting you know in advance what you will need at the time of your visit, your encounter will be much more gratifying.

When you come to your appointment, please arrive 15 minutes early to register with our receptionist. Minors must be accompanied by a parent or legal guardian.

Please also make sure to bring the following with you to your appointment:

1. Your health insurance card.
2. Your driver's license (if the patient is a minor, then the driver's license of the parent or legal guardian).
3. Any X-ray, MRI, or other films/CD and the report (if you have had any taken).
4. **If you are covered by an insurance plan that requires a referral to see a specialist, it is your responsibility to obtain the referral from your primary care physician. In some instances, the primary care physician will send the referral to us by computer or fax. The referral must be dated no later than the date of your visit. Please phone our office before your appointment to verify that we have your referral. Managed Care Plans have instructed us not to see patients without a referral. If you do not bring the referral with you, you may be asked to re-schedule your appointment.**
5. A current list of medications which should include any over-the-counter medications, herbal and vitamin supplements. Include a list of any drug allergies.
6. A pharmacy name and phone number.
7. The name and phone number of your primary care physician.

Office co-pays and services not covered by your insurance are due at the time of your visit. You will be billed for payments applied to your deductible (if applicable). For your convenience, we accept cash, checks, VISA, Mastercard, American Express, and Discover cards.

If you have any questions regarding any of the above, please don't hesitate to contact our office at (732) 775-4040. If you need to cancel or reschedule your appointment, please give us the courtesy of a phone call 24 hours in advance.

We look forward to seeing you soon.

Sincerely,

Michael A. Weinblatt DPM

PODIATRIC REGISTRATION AND HISTORY

1 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? _____

2 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

3 PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

4 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

5 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 _____

_____

_____

6 MEDICATIONS

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

_____

_____

Pharmacy Name(s) _____

Pharmacy Phone(s) (_____) _____

Do you take oral contraceptives? ☐ Yes ☐ No

7 ALLERGIES

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

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

neptune foot care center

DR. MICHAEL A. WEINBLATT
PODIATRIC MEDICINE AND SURGERY

Diplomate, American Board of Podiatric Orthopedics
and Primary Podiatric Medicine

2100 CORLIES AVENUE, NEPTUNE CITY, NEW JERSEY 07753 • Tel 732-775-4040 • Fax 732-775-4060

CONSENT FOR TREATMENT:

I acknowledge that I have elected on my own behalf or on behalf of my dependent to receive medical services that may or may not be covered by my health plan or any number of reasons.
I understand and acknowledge that I am financially responsible for, and therefore shall pay for, all services rendered to me or my dependent that are not paid or contractually adjusted by my insurance, in whole or in part, by my health plan for any reason whatsoever.

RELEASE OF INFORMATION:

I authorize the release of all information necessary to process my insurance claims and pertinent to my medical care. This release will remain in effect until revoked by me in writing. A photocopy of this release is to be considered as valid as the original.

ASSIGNMENT OF BENEFITS:

I assign all medical and/or surgical benefits including major medical benefits to which I am entitled, including Medicare, BCBS, HMO plans, and commercial insurance to Michael A. Weinblatt DPM. This assignment will remain in effect until revoked by me in writing. I hereby authorize the above to release information to secure payment on my behalf.

I understand that I am financially responsible for all charges. I have read this information and understand it.

Patient Name: _____

DOB: _____

Signature: _____

Signature of Parent or Guardian (if patient is a minor): _____

Date: _____

neptune foot care center

DR. MICHAEL A. WEINBLATT
PODIATRIC MEDICINE AND SURGERY

Diplomate, American Board of Podiatric Orthopedics and Primary Podiatric Medicine

2100 CORLIES AVENUE, NEPTUNE CITY, NEW JERSEY 07753 • Tel 732-775-4040 • Fax 732-775-4060

PATIENT FINANCIAL POLICY

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or manager.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.

- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, Mastercard, AMEX, Discover, cash or check.

- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.

- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible (if applicable) at the time of service.

- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.

- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges for any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

- You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees, and court fees shall be your responsibility in addition to the balance due this office.

- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party: _____ **Date:** _____

_____Patient initials to indicate copy received.

neptune foot care center

DR. MICHAEL A. WEINBLATT
PODIATRIC MEDICINE AND SURGERY

Diplomate, American Board of Podiatric Orthopedics
and Primary Podiatric Medicine

2100 CORLIES AVENUE, NEPTUNE CITY, NEW JERSEY 07753 • Tel 732-775-4040 • Fax 732-775-4060

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

neptune foot care center

DR. MICHAEL A. WEINBLATT
PODIATRIC MEDICINE AND SURGERY

Diplomate, American Board of Podiatric Orthopedics
and Primary Podiatric Medicine

2100 CORLIES AVENUE, NEPTUNE CITY, NEW JERSEY 07753 • Tel 732-775-4040 • Fax 732-775-4060

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding
the HIPAA Notice of Privacy Practices

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the available link to HIPAA Notice of Privacy Practices for the person or persons whom you may contact.

MICHAEL A WEINBLATT DPM
2100 CORLIES AVE
NEPTUNE, NJ 07753
(732) 775-4040

Confidential Communication Request (HIPAA Form)

From time to time in caring for our patients, it may become necessary to contact you by telephone. Often our patients are not available when we call them and we would like to be able to leave detailed telephone messages (i.e. X-ray results) when possible. In order to protect your privacy we need your written permission to leave detailed telephone messages on your answering machine, voice mail system, or a trusted family member. Please read the following choices and tell us whether or not we van leave voice mail regarding your medical information, such as lab & X-ray results, and with whom we may leave it.

Please choose one of the following:

☐ **I DO CONSENT** for Michael A Weinblatt DPM to leave detailed messages:

I, _____ give Michael A Weinblatt DPM and his staff permission to leave telephone messages regarding my medical care with the following options: (initial each one that you want us to be able to use for leaving you telephone messages). This will remain in effect until you rescind it in writing.

☐ Home Phone _____ Initials _____

☐ Cell Phone _____ Initials _____

☐ Spouse (name) _____ Initials _____

Phone number(s) _____

☐ Other (name) _____ Initials _____

Phone number(s) _____

☐ Other (name) _____ Initials _____

Signature _____ Date _____

☐ **I DO NOT CONSENT** to leave detailed messages on my phone or answering machine or with any member of my family.

Signature _____ Date _____

☐ **REVOCATION OF PRIOR CONSENT:** I wish to rescind or stop the above authorizations.

Signature _____ Date _____

If not signed by patient, please indicate your relationship to the patient _____

Print Patient Name: _____ **Date of Birth** _____

neptune foot care center

DR. MICHAEL A. WEINBLATT
PODIATRIC MEDICINE AND SURGERY

Diplomate, American Board of Podiatric Orthopedics
and Primary Podiatric Medicine

2100 CORLIES AVENUE, NEPTUNE CITY, NEW JERSEY 07753 • Tel 732-775-4040 • Fax 732-775-4060

DIRECTIONS TO OUR OFFICE

Our office is located at 2100 Corlies Ave (Rt33) at the Neptune City Medical Arts Building, one block west of Jersey Shore University Medical Center at the intersection of 6th Ave across from the Cone Zone. You'll see Jersey Shore Imaging and Meridian Rehabilitation at this location.

The closest and most direct access to my office (Suite 11) is from 6th Ave (across from the Cone Zone). If traveling west on Corlies Ave/Rt 33, make a left onto 6th Ave. If traveling east, make a right. Then make a right into the 1st driveway which is the east parking lot. A quick right once you are in the lot is closest. The building entrance to my hallway is located **between** Meridian Rehabilitation and Jersey Shore Imaging. You will see Michael Weinblatt DPM on the glass door entrance (you cannot enter directly through Meridian Rehabilitation or Jersey Shore Imaging).

My office (Suite 11) is accessible from any building entrance, but the above directions are closest. If the east lot is filled, drive around the back to the west parking lot. Enter the west entrance and make a left into the 1st hallway (you will see a wall sign with an arrow pointing to Dr. Weinblatt's office).