ADVANCED PERFORMANCE AND REHABILITATION CENTER
532 Old Short Hills Road
Short Hills, New Jersey 07078
973-467-9011

Name: _____ **Today's date:** _____

Address: _____
Residence and Mailing City State Zip Code

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

E-mail address: _____

Height: _____ **Weight:** _____ **Shoe size:** _____ **Male:** _____ **Female:** _____

Social Security Number: _____ **Date of Birth:** _____ **Age:**____

Single: _____ **Married:** _____ **Divorced:** _____ **Widowed:** _____

If a minor, print the name of your Parent/Guardian: _____

Insured Name: _____ **Date of Birth:** _____

Employer name and address: _____

What is the name of your primary care physician: _____

Address: _____

Telephone #: _____ **Fax#:** _____

When was the last time you saw your primary care physician:_____

Who may we thank for referring you to our office?

_____

INITIAL PODIATRY INTAKE FORM AND HEALTH ASSESMENT

Please describe your primary issue of concern today:

_____

_____

What foot and/or ankle problems do you currently have?

_____

_____

When did your problem begin? Please give approximate date, if possible:_____

Please describe how the problem began:

_____

_____

How would you describe your pain?

- ☐ Sharp
- ☐ Dull
- ☐ Ache
- ☐ Soreness
- ☐ Stiffness
- ☐ Weakness
- ☐ Throbbing
- ☐ Spasm
- ☐ Numbness
- ☐ Tingling
- ☐ Burning
- ☐ Shooting

How would you rate the intensity of your pain? (please circle)

0 (no pain) 1 2 3 4 5 6 7 8 → 9 10 (terrible/unbearable pain)

How often is the pain present?

- ☐ Constant (80-100%)
- ☐ Occasional (25-50%)
- ☐ Frequent (50-80%)
- ☐ Intermittent (25% or less)

What makes your problem better?

- ☐ Nothing
- ☐ Moving around/exercise
- ☐ Medication _____
- ☐ Walking
- ☐ Ice/Heat
- ☐ Standing
- ☐ Lying down
- ☐ Sitting
- ☐ Inactivity

What prior treatments have you received for this problem?:

_____

Did the treatment help? Yes: _____ No: _____

Have you ever been treated by a podiatrist before? Yes: _____ No: _____

If yes, what for?: _____

Are you currently under the care of a physician?: Yes: _____ No: _____

If yes, what for?: _____

Have you been hospitalized in the past five years?: Yes: _____ No: _____

If yes, what for?: _____

Have you have any surgeries?: Yes: _____ No: _____

If yes, what for?: _____

Are you currently taking any medications?: Yes: _____ No: _____

Please list all *medications*:

1)_____ 2)_____ 3)_____ 4)_____

5)_____ 6)_____ 7)_____ 8)_____

Are you allergic to any food or medication? YES ☐ NO ☐

If YES, please list what you are allergic to and the type of reaction it causes:

_____

_____

_____

Below is a list of symptoms and conditions. Please check all those that apply.

Past	Present		Past	Present	
☐	☐	Heart Trouble	☐	☐	High Blood Pressure
☐	☐	Circulation Problems	☐	☐	Heart Condition
☐	☐	Execessive Bleeding	☐	☐	Phlebitis
☐	☐	Anemia	☐	☐	Diabetes
☐	☐	Hypothyroid	☐	☐	Pneumonia
☐	☐	Hyperthyroid	☐	☐	Asthma
☐	☐	Emphysema	☐	☐	Gastritis
☐	☐	Stomach Ulcers	☐	☐	Sinus Condition
☐	☐	Intestinal Problems	☐	☐	Kidney Disease
☐	☐	Liver Disease	☐	☐	Cancer
☐	☐	Swelling/Stiffness in Joints	☐	☐	Stroke
☐	☐	Eye Disease	☐	☐	Arthritus
☐	☐	Infections	☐	☐	AIDS
☐	☐	Steroid Therapy	☐	☐	Hormone Therapy
☐	☐	Birth Control Pills	☐	☐	Drug Reactions

Please list any other medical conditions not listed above:

_____

_____

Any family history of the above medical conditions? Please list all that apply:

_____

_____

Are you pregnant? Yes ☐ No ☐
Have you ever been pregnant: Yes ☐ No ☐

Please check all that apply. Do you:

☐ **Use Tobacco.** If so, how many packs per day: _____ For how long: _____

☐ **Consume Alcohol.** If so, how often: _____

☐ **Consume Caffeine.** If so, how often: _____

Patient Print Name: _____ **Date:** _____

Patient Signature _____

Parent /Guardian Print Name: _____ **Date:** _____

Parent/Guardian Signature: _____

FINANCIAL AGREEMENT

We will attempt to provide you with information necessary to determine the type of care you will require and the financial information you may need to determine how you wish to handle your financial obligation to our office.

We wish to make it very clear that your health is the sole responsibility of you, the patient or your guardian.

These policies apply only to the services actually performed and in no way obligates the patient to continue the course of treatment recommended. If care is discontinued, the balance due for care received up to that date is due in full within 30 days of discontinuance of care.

I have elected to use the following payment method to finance my care at the Advanced Performance and Rehabilitation Center. (APRC) ***PLEASE INITIAL SELECTION BELOW***

___ 1. NO INSURANCE COVERAGE – Payment is due at time of service

___ 2. MEDICARE – APRC will submit your secondary insurance if you have one. I may be responsible for a co-payment after Medicare and my secondary have paid the office.

___ 3. PERSONAL INJURY PROTECTION (PIP) – I understand I am totally responsible for charges I may incur in this office. Although my insurance or lawsuit may eventually pay the APRC in full for service rendered, I will pay this office the balance in full for any payments not made.

___ 4. INSURANCE POLICY COVERAGE – I understand I am completely responsible for charges I may incur in this office. (All payments are due at time of service) It is my responsibility to know my insurance plan and to know if a referral is needed before the start of my care. If my insurance fails to pay its share, I will pay the balance in full. I am aware the APRC verifies my benefits prior to my appointment, however, this does not guarantee coverage or payment.

NOTE: APRC will refund any overpayments made to us upon completion of care.

THERE IS A 24-HOUR CANCELLATION POLICY. A $50.00 CHARGE WILL BE BILLED FOR MISSED APPOINTMENTS OR APPOINTMENTS NOT CANCELLED PRIOR TO 24-HOURS IN ADVANCED OF THE SCHEDULED TIME.

THERE IS A $50.00 ADDITIONAL CHARGE FOR ANY EMERGENCY VISIT OR OFFICE VISITS OUTSIDE OUR NORMAL OFFICE HOURS.

In the event that my account becomes delinquent for more than 30 days, I agree to pay a finance charge of 1.5% per month on my balance due, as well as all reasonable collection costs not exceed 50%, as well as court costs, attorney fees and interest fees accrued with the collection of this account.

PATIENT'S SIGNATURE _____ DATE _____

WITNESS _____

Advanced Performance and Rehabilitation Center, LLC • 532 Old Short Hills Road • Short Hills, NJ 07078
973-467-9011 • 973-467-9012 (Fax)

Privacy Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. **THIS IS AN OVERVIEW OF YOUR RIGHTS; A DETAILED COPY IS AVAILBLE AT YOUR REQUEST.**

YOUR RIGHTS-You have the right to:

- Get a copy of your paper or electronic record: According to NJ law code 8.43G-4.1 you must submit a written request and we are required to provide you with a copy within 30 days.
- Correct your paper or electronic medical record
- Request confidential communication: You may inform us of your preferred method such as Home Phone, Cell Phone or Email. Please advise us whether a detailed message is permissible.
- Ask us to limit the information we share: we may say "No" if it would affect your care. You can ask us not to share out-of-pocket payments with your insurer and we will agree unless a law requires us to do so.
- Get a list of those whom we've shared your information outside the purposes of treatment, payment and at your request. We reserve the right to charge a reasonable fee for more than one copy within a 12 month period.
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated: You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/provacy/hipaa/complaints/.
- Get a copy of Privacy Notice

YOUR CHOICES- You have some choices in the way that we use and share information

If you are unable to tell us your preference we may share your information if we believe it is in your best interest.

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care

The following are cases in which we NEVER *share your information*

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

We may contact you for fund raising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES- We may use and share information as we:

- Treat you: we may share your information with other medical professionals treating you
- Run our organization
- Bill for services
- Help with public health and safety issues: To view a list of scenarios in which the law requires our cooperation go to www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html
- Do research
- Comply with the law
- Work with a medical examiner or funeral director
- Address workers compensation, law enforcement, and other government requests
- Respond to lawsuits and legal action: Only in cases of a court order or subpoena

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information
- We will let you know promptly if a breach occurs the may have compromised the privacy or security of your information
- We must follow the duties and privacy practices described in this notice and provide a copy of it
- We will not share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

We can change the terms of this notice, and the changes will apply to all the information we have about you. The new notice will be available upon request, in our office, and on our website.

Signature_____Print Name _____Date_____

APRC HIPAA Officer
Michelle Kelly
973-467-9011 • Admin@APRCNJ.com

Emergency Contact Form

Patient Name _____ Date _____

Please list the contact information of whom APRC should contact in case of an emergency

IMPORTANT: I am filling out this form for the first time (please mark):

Yes ☐ No ☐ I am updating from a previous form

FIRST EMERGENCY CONTACT:	SECOND EMERGENCY CONTACT:
_____ (name: first, middle initial, last)	_____ (name: first, middle initial, last)
_____ (address 1: street, city, state, zip)	_____ (address 1: street, city, state, zip)
_____ (address 2: street, city, state, zip)	_____ (address 2: street, city, state, zip)
_____ (home phone)	_____ (home phone)
_____ (cell phone)	_____ (cell phone)
_____	_____

Signature: _____ Date: _____

Home Phone: _____ Cell Phone: _____ Email: _____

In the event of an emergency you hereby acknowledge the listed person(s) to act on your behalf. The contact information that you provide APRC is strictly confidential and will not be used for any other sole purpose other than as set forth herein.