ADVANCED PERFORMANCE AND REHABILITATION CENTER

532 Old Short Hills Road
Short Hills, New Jersey 07078
Phone: 973-467-9011 / Fax: 973-467-9012

Today's Date: ___/___/_____

Patient Name: _____ Age: _____

Date of Birth: ___/___/____ Social Security #:_____-____-_____ Male _____ Female ____

Height: _____ Weight: _____ Shoe Size: _____

Single _____ Married _____ Divorced _____ Widowed _____

Mailing address: _____

City: _____State: _____ Zip Code: _____

E-mail Address: _____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Mobile Phone: (_____) _____-_____ Mobile Provider: _____

May we send you text reminders for future appointments? ____ YES ____ NO

If yes, how far in advance of the appointment? _____ 1 hour ____4 hours ____24 hours

_____Employed _____ Full-Time Student ____Unemployed
_____Self–Employed _____ Part-Time Student ____ Retired

Occupation: _____ Employer Name: _____

If the patient is a minor, name of parent/guardian: _____

Contact Number: _____

What is the name of your **Primary Care Physician:** _____

Address: _____ Phone: (_____) _____-_____

When was the last time you saw your Primary Care Physician: _____

Do you have health insurance: _____YES _____ NO

If yes, Provider: _____Policy Number: _____

Policy holder: _____Self _____Other

If other, full name of policy holder: _____

Policy Holder Date of Birth: ___/___/____

Patient's relationship to the Policy Holder: _____

Who may we thank for referring you to our office? _____

Name: _____ Age: _____ Today's Date: _____

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 1 2 3 4 5 6 7 8 9 10

(no pain) ⟶ (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
☐	☐	Excessive 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: _____

Any additional information:

_____

_____

_____

_____

_____

_____

_____

_____

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

Patient Signature_____

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

Parent/Guardian Signature: _____

FINANCIAL AGREEMENT

Dear Patient:

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.

Verification of Benefits / Authorizations / Notice of Collection Action

APRC will try and verify my insurance benefits prior to my appointment. However, I understand I am solely responsible for knowing the benefits my insurance plan provides. Furthermore, it is my responsibility to ensure APRC has my current insurance coverage information and a copy of my valid identification card on file at all times in order to verify my coverage and ensure timely and accurate processing of all claims.

I understand all co-payments are due at the time services are rendered and I am responsible to pay any additional amounts due in full; including, but not limited to, annual deductibles, co-insurance, and any other charges denied for payment by my insurance company for any reason.

In the event my account balance is unpaid for longer than 30 days, I agree to pay a finance charge of 1.5% per month on all overdue charges. Additionally, should my account remain delinquent and/or be turned over to a collection agency, I am responsible to pay for any and all additional fees incurred (i.e. late fees, collection agency fees, attorney fees, court fees, etc.) not to exceed 50% of the balance due.

NOTE: The Advanced Performance and Rehabilitation Center will refund any overpayments made to us upon receipt of insurance payment.

THERE IS A 24 HOUR CANELLATION POLICY. A $60.00 CHARGE WILL BE BILLED FOR MISSED APPOINTMENTS OR APPOINTMENTS NOT CANCELED WITHIN 24 HOURS PRIOR TO THE SCHEDULED TIME.

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

I AGREE THIS AUTHORIZATION SHALL REMAIN VALID UNLESS I RESIND IN WRITING.

PRINT PATIENT NAME: _____ Date: _____

GUARANTOR/PATIENT SIGNATURE: _____

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 the information. ***Please review it carefully.***

Under new federal regulations, Advanced Performance and Rehabilitation Center, LLC along with all health care providers are required and obligated to maintain the privacy of your protected health information (PHI). This information may identify you & relates to your health, your conditions, and health care related services whether physical or mental.

This notice describes how we may use and disclose PHI information to other parties for the purpose of treatment, dispensing medications, and disclosing information to your health care provider or your physician via mail, phone or directly. We may use and disclose medical information so that services received at Advanced Performance and Rehabilitation Center, LLC may be billed to and payment may be collected from your insurance company, pharmacy benefit managers (PBM) or a third party.

We ***may*** use or disclose your PHI in accordance with the privacy rules without obtaining your consent or authorizations in the following instances. Contracted business associates rendering services for us in which PHI must be disclosed in order to perform their job (such as third party billing of your prescription drug benefits). Our business associates are required to protect your PHI in accordance to law. Discussions with individuals involved with your care or payment of your care if deemed appropriate by the health care professional. F.D.A. requirements to prevent serious health or safety threats to the public. Health oversight authorized by law including audits, investigations and inspections required for licensure and government monitoring of health care programs and civil rights issues. Workman's compensations claims. *As required by law.*

We are permitted to use and disclose PHI for the following purposes *In accordance to law*: Coroners, Medical & Funeral Directors to carry out their functions, Organ or Tissue procurement organizations, Judicial or administrative proceedings, law enforcement purposes, governmental authorities, and national security. Victims of abuse, neglect and domestic violence to protective service agencies. Military authorities.

You have the right in writing, to request restriction of certain uses & disclosures of PHI with regards to the nature of your treatment, payment, and health care operations to a family member, relative or representative. We are, however, not required by federal law to comply. If you request a copy of your PHI, you have the right to send it to a different location and by alternate means.

Further information or questions relating to your privacy rights may be addressed to *Dr. Jason Levy* (privacy officer). Please address any complaints regarding your privacy rights to our privacy officer or with the secretary of health & human services.

To be assured you received or read this notice *please sign and return* this notice at your earliest convenience.

*Signature*_____ *print name*_____

Recipient___Authorized Rep.___Family Member___Care Giver___

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Health Insurance Portability & Accountability Act (HIPAA)

*** PRIVACY NOTICE ACKNOWLEDGEMENT ***

Under new federal regulations, Advanced Performance and Rehabilitation Center, LLC along with all health care providers are required to maintain the privacy of your **protected health information "PHI."**

This notice describes how we may use and disclose your PHI.

To be assured you received and/or read this notice, please sign:

I have received and/or read Advanced Performance and Rehabilitation Center's Privacy Notice.

Signature _____ Date _____

Print Name _____

Recipient _____ *Authorized Rep.* ____ *Family Member* ____ *Care Giver* ____

Emergency Contact Form

Patient Name: _____

Phone Number _____

IMPORTANT: I am filling out this form for the first time: ____YES ____NO, I am updating my information

Special Instructions:

In the event of a medical emergency, are there any emergency procedures or restrictions on medications of which emergency personnel should be aware? If yes, please explain.

_____

Emergency Contacts:

Primary Contact in case of emergency:

Name _____ Relationship _____

Address _____ Phone Number _____

_____ Alternate Phone Number _____

Secondary Contact in case of emergency:

Name _____ Relationship _____

Address _____ Phone Number _____

_____ Alternate Phone Number _____

Physician Contact:

Doctor's Name _____ Address _____

Phone Number _____ _____

Patient Authorization

I have voluntarily provided the above contact information and authorize APRC and its representatives to contact any of the above individuals on my behalf in the event of an emergency.

_____ _____

Employee signature *Date*

Directions to APRC

532 Old Short Hills Road, Short Hills, NJ 07078
973-467-9011

From Millburn: Take Old Short Hills Road towards St. Barnabas Hospital. Cross over South Orange Avenue and continue for approximately ¼ mile. We are a home office on the right, one home office past a street called Puritan (on your right), just before the brick garden apartments. You'll see a black sign. The number is 532. There is a side parking lot and side entrance.

From JFK Parkway: Take JFK Parkway away from the mall, towards Livingston. Make a right at the first traffic light onto South Orange Avenue. Continue on South Orange Avenue through 2 lights, at the first light you'll see an Exxon gas station on your left & Tutor Time on your right. Continue to the 2nd traffic light, which is Old Short Hills Road, and turn left at the light onto Old Short Hills Road. Continue for approximately ¼ mile. We are a home office on the right, one home office past a street called Puritan (on your right). The office is just before the brick garden apartments on your right. You'll see a black sign. The number is 532. There is a side parking lot and side entrance.

From the Livingston Mall on South Orange Avenue: Take South Orange Avenue through 2 lights, at the first light you'll see an Exxon gas station on your left & Tutor Time on your right. Continue to the 2nd traffic light, which is Old Short Hills Road, and turn left at the light onto Old Short Hills Road. Continue for approximately ¼ mile. We are a home office on the right, one home office past a street called Puritan (on your right). The office is just before the brick garden apartments on your right. You'll see a black sign. The number is 532. There is a side parking lot and side entrance.

From South Orange: Take South Orange Avenue to Old Short Hills Road. Make a right at the light onto Old Short Hills Road. Continue for approximately ¼ mile. We are a home office on the right, one home office past a street called Puritan (on your right). The office is just before the brick garden apartments on your right. You'll see a black sign. The number is 532. There is a side parking lot and side entrance.

From West Orange: Take Northfield Avenue to the traffic light at Old Short Hills Road. You will see the Livingston Diner on the far left corner, the Northfield Cleaners on the closest corner on the left, and Master Pizza on your right. Make a left onto Old Short Hills. Continue on Old Short Hills Road, through approximately 3 traffic lights; pass St. Barnabas Hospital on your right. We are the 1st home office on the left just past the brick garden apartments on your left. You'll see a black sign. The number is 532. There is a side parking lot and side entrance.

From Livingston (Northfield Avenue): Make a right onto Old Short Hills Road. Continue on Old Short Hills Road, through approximately 3 traffic lights; pass St. Barnabas Hospital on your right. We are the 1st home office on the left just past the brick garden apartments on your left. You'll see a black sign. The number is 532. There is a side parking lot and side entrance.

From 280 East: Take 280 East to exit 6A (Laurel Avenue). Follow the blue and blue "H" signs for St. Barnabas Hospital. Bare left at the fork in the road onto Shrewsberry Drive. Continue straight on Shrewsberry Drive. Cross over Mt. Pleasant Avenue (Route 10). Shrewsberry Drive will change its name to East Cedar Lane. Just continue straight. Cross over Northfield Avenue and continue to go straight. The road merges into Old Short Hills Road. Continue on Old Short Hills Road, through approximately 2-3 traffic lights; pass St. Barnabas Hospital on your right. We are the 1st home office on the left just past the brick garden apartments on your left. You'll see a black sign. The number is 532. There is a side parking lot and side entrance.