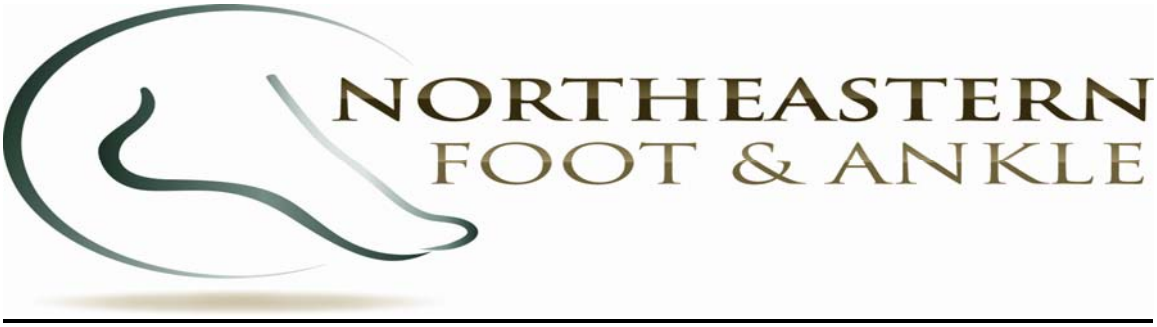

235 MAIN AVENUE, PASSAIC, NJ 07055

PATIENT INFORMATION

Date _____ Home Phone _____ Cell Phone _____

Name _____
Last First Middle

Address _____

City _____ State _____ Zip _____

Social Security # _____ Birthdate _____ Sex: □ Male □ Female

Email: _____

Employer _____ Phone _____

Employer Address _____

Emergency Contact _____ Phone _____

Whom may we thank for referring you? _____

ARE YOU DIABETIC? _____ YES _____ NO

Primary Care Physician _____ Date of Last Visit _____

Pharmacy Name and Address _____

Pharmacy Telephone _____

Please describe the foot or ankle problem(s) that brought you to the office today:

_____

ASSIGNMENT OF INSURANCE BENEFITS

I certify that I, and/or my dependents, have insurance coverage and assign directly to Northeastern Foot & Ankle Specialists 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 my insurance. I authorize the use of my signature on all insurance submissions. The above named doctor/practice 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. I further understand that all balances over 45 days are subject to a 1.5% compounded monthly interest rate (18% APR). I permit a copy of this authorization to be used in place of the original. This authorization is in force until it is either canceled or changed by me.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

As per HIPAA Act of 1996, I acknowledge that I have been given the opportunity to read the "Notice of Privacy Practices" posted in this office. I further acknowledge that I have been given the opportunity to have a copy of this policy. I grant permission to **Northeastern Foot & Ankle Specialists, P.C.** and its authorized personnel to take photographs of me for use in hospital publications or for purposes of legitimate publicity in various publications, or for helping education, or for other appropriate purposes. This permission would also apply to photographs of me or any part of my anatomy in the course of any operation or treatment that would be performed on me. I understand that video recordings are being made in the entrance, waiting room, hallway and examination rooms for security purposes, and by entering and remaining in any of those rooms, I consent to being recorded while I am there.

_____ _____
Signature of Patient, Parent or Guardian Date

_____ _____
Print Name of Patient, Parent or Guardian Relation to Patient