BELANGER PODIATRY ASSOCIATES, LLC

1806 STATE ROUTE 35, SUITE 103, OAKHURST, NJ 07755

(P) 732-643-5500 (F) 732-869-4522

WWW.BELANGERPODIATRY.COM

Date: _____

Patient Name: _____ Date of Birth: _____Sex: M/F

Home Address: _____ City: _____State:_____

Zip Code: _____

Social Security Number: _____ Home Phone: _____

Cell Phone: _____E-Mail: _____

Emergency Contact: _____ Relationship:_____

Emergency Contact Phone: _____

Primary Care Doctor: _____Phone/Address: _____

Pharmacy: _____ Location: _____Phone:_____

You may authorize Belanger Podiatry Associates, LLC to share your medical information with certain individuals. You may list them below.

_____

Who is responsible for payment? _____ Relationship: _____

Address: _____City/State: _____Zip:_____

Phone: _____

How did you hear about our practice?

_____

Insurance Information:

Primary Insurance: _____

Subscriber's Address: _____ City/State: _____Zip:_____

Subscriber's Phone: _____Subscriber's Date of Birth: _____

Subscriber's Name: _____ Subscriber's Policy #: _____

Subscriber's Employer: _____ Subscriber's SS#: _____

Subscriber's Group #: _____

Secondary Insurance: _____

Subscriber's Address: _____ City/State: _____Zip:_____

Subscriber's Phone: _____Subscriber's Date of Birth: _____

Subscriber's Name: _____ Subscriber's Policy #: _____

Subscriber's Employer: _____ Subscriber's SS#: _____

Subscriber's Group #: _____

What is your foot/ankle problem today?

_____

When did this problem first start? _____

How would you rate your pain on a scale from 0-10? Can you describe your pain?_____

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

Is your pain: improving staying the same getting worse

Was your condition caused by an injury? yes no If yes, was this a work related injury? yes no

May we leave appointment reminder messages, instructions for surgery, test results, billing and/or insurance issues or other pertinent information on your answering machine?

YES_____NO_____**SIGNATURE**:_____

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Height: _____ Weight: _____Blood Pressure: _____Shoe Size: _____

Please list all of your current medications:

_____
_____
_____
_____
_____

Please list all of your medical problems (e.g., Diabetes)

_____
_____
_____
_____
_____

Please list all of your allergies:

_____
_____

Please list all of your prior surgeries:

_____
_____

Social History

Marital Status: (circle one) single married partnered separated divorced widowed
Use of Alcohol: (circle one) never no longer use history of abuse occasionally
Tobacco Use: (circle one) never quit How many packs/day_____

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the Doctor and office staff of any changes in my medical status.

_____ _____
(Print Name of Patient) Signature of Doctor

_____ _____
If other than patient, relationship Date

_____ _____
SIGNATURE Date

NOTICE OF PRIVACY PRACTICES FOR BELANGER PODIATRY ASSOCIATES, LLC

This Notice of Privacy Practices ("Notice") explains how Belanger Podiatry Associates, LLC ("BPA") uses information about you and when BPA can share that information with others. It also informs you about your rights as a valued customer. This Notice is being provided to you on behalf of BPA. BPA respects the privacy and confidentiality of your protected health information ("PHI"). The federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") sets rules about who can look at and receive your health information. This law, and applicable state law, gives you rights over your health information, including the right to get a copy of your health information, make sure it is correct, and know who has seen it.

Please review this Notice carefully.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit or interact with Dr. Belanger or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination, and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- A source of information for public health officials charged with improving the health of the nation
- A tool with which we can assess and continually work to provide the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

- Ensure its accuracy
- Better understand who, what, when, where, and why others may access your health information
- Make more informed decisions when authorizing disclosure to others

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information, however, BPA is not required to agree to such a request if the facts do not warrant it
- Obtain a paper copy of the Notice of Privacy Practices upon request
- Inspect and obtain a paper or electronic copy of your health record usually within 30 days of your request. We may charge a reasonable, cost-based fee
- Obtain a list (an accounting of disclosures) of the times we have shared your health information for six years prior to the date you asked, who we shared it with, and why. Exceptions: treatment, payment and health care operations.
- Request communications of your health information by alternative means or at alternative locations. For example, you may request that we send correspondence to a post office box rather than your home address
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken. If you pay for a service out-of-pocket in full, you can request that information not be shared for the purpose of payment or our operations with your health insurer

You will be asked to sign an acknowledgment that you have received this Notice. We are required by law to make a good faith effort to provide you with the Notice to obtain your acknowledgment. Your refusal to accept the Notice or to sign the acknowledgment will in no way affect your care or treatment in our facility.

BPA RESPONSIBILITIES

- Maintain the privacy and security of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this Notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative location

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, revisions will be available and you may request a revised copy from BPA. BPA is responsible for maintaining the Notice of Privacy Practices.

We will not use or disclose your health information without your authorization, except as described in this Notice and for treatment, payment, or health care operations.

Note: HIV-related information, genetic information, alcohol and/or substance abuse records, mental health records, or other specially protected health information may have additional confidentiality protections under applicable State and Federal law. We will obtain your specific authorization before using or disclosing these types of information where we are required to do so by such applicable State and Federal laws. However, we may be permitted to use and disclose such information to our physicians to provide you with treatment.

EXAMPLES OF PERMITTED DISCLOSURES OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

We may use your health information for **Treatment, unless your specific consent is required**.

For example: Information obtained by Dr. Belanger will be recorded in your record and used to determine the course of treatment.

We will use your health care information for payment. We will provide your physician or a subsequent health care with copies of various reports if requested.

For example: A bill will be sent to you and/or a third-party payer (Insurance company). The information on the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. We may provide copies of the applicable portions of your medical record to your insurance company in order to validate your claim.

We will use your health care information for regular **Health Care Operations**.

We will disclose your health information for certain health care operations of other entities. However, we will only disclose your information under the following condition: (a) the other entity must have, or have had in the past, a relationship with you; (b) the health information used or disclosed must relate to that other entity's relationship with you; and the disclosure must only be for one of the following purposes: (i) quality assessment and improvement activities; (ii) population-based activities relating to improving health or reducing health care costs; (iii) case management and care coordination; (iv) conducting training programs; (v) accreditation, licensing, or credentialing activities, or (vi) health care fraud and abuse detection or compliance. The sharing of your PHI for treatment, payment, and health care operations may happen electronically. Electronic communications enable fast, secure access to your information for those participating in and coordinating your care to improve the overall quality of your health and prevent delays in treatment.

OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Telehealth is the exchange of medical information from one site to another via electronic communications. If telehealth service is offered to you it will allow you to have a medical appointment with Dr. Belanger via secure and interactive video equipment. You will be able to speak in real-time with the provider during your telehealth appointment. Telehealth sessions are secure, encrypted, and follow the same privacy (i.e., HIPPA) guidelines as traditional, in-person medical appointments. Your telehealth appointments will always be kept confidential. In addition, telehealth appointments are NEVER audio or video recorded without the patient's consent.

HEALTH INFORMATION EXCHANGES

Health Information Exchanges (HIE) and Personal Health Record (PHR) are emerging health information technologies that provide individuals and providers access to health care to improve the quality and efficiency of that care. In this rapidly developing market, there are several types of PHRs and HIEs available to individuals and providers with varying functionalities. PHRs and HIEs allow patient information to be shared electronically through a secured network that is accessible to the providers treating you.

BPA participates in one or more electronic health information exchange organizations ("HIOs") designed to facilitate the availability of your health information electronically to health care providers who provide you with treatment, unless prohibited by State or Federal law.

PERSONAL HEALTH RECORD

A personal health record (PHR) is an electronic application used by patients to maintain and manage their health information in a private, secure, and confidential environment.

- Are managed by patients
- Can include information from a variety of sources, including health care providers and patients themselves
- Can help patients securely and confidentially store and monitor health information such as diet plans or data from home, monitoring systems, as well as patient contact information, diagnosis lists, medication lists, allergy lists, immunization histories, and much more
- Are separate from, and do not replace, the legal record of any health care provider
- Are distinct from portals that simply allow patients to view provider information or communicate with provider.

BUSINESS ASSOCIATES

We may disclose your health information to contractors, agents, and other associates who need this information to assist us in carrying out business operations. We ask that they protect the privacy of your health information in the same manner as we do.

COMMUNICATION WITH FAMILY

Unless your consent is specifically required, or if you do not object, your health care provider is permitted to share or discuss your health information with your family, friends, or others to the extent that they are involved in your care or payment for your care. Your provider may ask your permission or may use his or her professional judgment to determine the extent of that involvement. In all cases, your health care provider may discuss only the information that the person involved needs to know about your care or payment for your care.

TELEPHONE CONTACT/APPOINTMENT REMINDERS

Unless your consent is specifically required, we may contact you to provide appointment reminders or information about treatment alternatives or other health-care related benefits and services that may be of interest to you. We may call you after you have been a patient to ask about your clinical condition or to assess the quality of care that you received.

IMAGES

BPA may record digital or film images of you, in whole or in part, for identification, diagnosis or treatment purpose and for internal purposes such as performance improvement or education. Such images may be used for documenting or planning care, teaching, or research. BPA will obtain your authorization for any other use of your identifiable image that is unrelated to treatment, payment or health care options.

WORKERS COMPENSATION

We may disclose health information to the extent authorized and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

OCCUPATIONAL HEALTH

We may disclose your PHI to your employer in accordance with applicable law, if we are retained to conduct an evaluation relating to medical surveillance of your workplace or to evaluate whether you have a work-related illness or injury. You will be notified of these disclosures by your employers or BPA as required by applicable law.

PUBLIC HEALTH AND SAFETY

As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

LAW ENFORCEMENT

We may release PHI if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons, or similar process;

- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of the crime under certain limited circumstances;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct on our premises; and
- To report a crime, the location of the crime or the victims, or the identity, description or location of the person who committed the crime

Federal law makes provision for your PHI to be released to an appropriate health oversight agency, public health authority or attorney provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

CHANGES TO THIS NOTICE

BPA may change this Notice at any time. We will post a copy of the current Notice at our facility and on www.belangerpodiatry.com. The effective date will be indicated on the Notice.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you believe that your privacy rights have been violated, you should immediately contact Dr. Belanger at 732-643-5500. You may also file a complaint with the appropriate federal agency. There will be no retaliation for filing a complaint.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

_____ _____

Patient Name or Authorized Representative (print) **Date**

_____

SIGNATURE

FINANCIAL POLICY FOR BELANGER PODIATRY ASSOSCIATES, LLC

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 and insurance requirements (such as referrals, time between visits, etc.) is your responsibility. Please contact your insurance company with any questions you may have regarding 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% of 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 explanations of benefits (EOB) are received from your primary insurance company.

COPAYMENTS, CO-INSURANCE, AND DEDUCTIBLES: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. We are obligated to collect co-payments, co-insurance, and deductibles from patients. Please help us in upholding the law by paying your co-payment at each visit.

SELF PAY: Payment in full is due at the time of the service if you do not have health insurance. All outstanding balances are due prior to your service.

NON-COVERED SERVICES: Please be aware that some of the services 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 in full upon completion of the visit. Full credit will be given if referral is presented to our office within 48 hours of the visit. You will also be given the option to reschedule your appointment.

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can help to get your claims paid. Your insurance company may need you to supply 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 contract between you and your insurance company.

PATIENT BILLING: You will be sent up to three notices for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account may be forwarded to collections. 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. An additional $25.00 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 to our office to be applied to your balance.

I have read the above policy regarding my *financial responsibility* to Belanger Podiatry Associates, LLC for medical services provided. I agree to pay Belanger Podiatry Associates, LLC any balance unpaid by my insurance carrier for myself or the below named person.

PRIVACY STATEMENT: Any information disclosed in your records will remain confidential and will not be used for any other reason except to provide quality care and treatment, to submit your claim to your insurance company, and to contact you as needed, all in accordance with our Privacy Policy.

ASSIGNMENT OF BENEFITS

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Belanger Podiatry Associates, LLC all my insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, 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 physician 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 information and acknowledge I was provided with a copy of the Financial Policy and understand and accept its terms.

PATIENT ACKNOWLEDGMENT

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have (or had the opportunity to read if I so chose) the Notice of Privacy Practices and this Financial Policy and I understand the Notice and Policy, and agree to their terms.

_____ _____

Patient Name (print) **SIGNATURE**

FINANCIALLY RESPONSIBLE PARTY:

Print Name: _____ Relationship: _____**SIGNATURE**: _____

Effective 03/2021