Podiatric Medicine, Surgery & Sports Medicine

John F. Connors, DPM and Ana J. Sanz, DPM

DoctorConnors.com | ConnorsPodiatry@gmail.com
3 East 74th Street | New York, NY 10021 | 212.861.1995
200 White Road | Little Silver, NJ 07739 | 732.741.2300

Patient Information

Today's Date:____/____/____

Last:_____ First: _____

Address:_____ City: _____

State:_____ Zip Code:_____ Date of Birth:____/____/____ SSN: _____

Home Phone:_____ Work:_____ Cell: _____

Email address: _____

Referred by:_____

Primary Care Physician:_____ Office Phone Number: _____

Primary Insurance: _____

Policy Number:_____ Group Number: _____

Policy Holder's Name:_____

Policy Holder's Date of Birth:_____ Relationship to Patient: _____

Secondary Insurance: _____

Policy Number:_____ Group Number: _____

Policy Holder's Name:_____

Policy Holder's Date of Birth:_____ Relationship to Patient: _____

I authorize the release of medical information necessary to process any claim. I authorize payment to John F. Connors, DPM as agreed upon at the time of treatment for services rendered.

Signature:_____ Date: _____

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Patient Medical Information

Chief Complaint: _____

_____

Duration: _____ Location of Pain: _____

Shoe Size: _____ Height: _____ Weight: _____

Medical History

Food Allergies: _____ Allergies to Medication: _____

Arthritis: _____ Asthma: _____ Diabetes: _____ High Blood Pressure: _____ Leg Cramps: _____

Are you taking any medications? _____

Preffered Pharmacy: _____

Sports History

Do you participate in any sports activities? _____

Type of sneakers: _____

Have you had any sports related injuries? _____

_____

Demographics

The Federal Government requires all medical practices to collect the following information from patients.
There is a provision in the law that allows patients to not answer these questions.
Please answer the following three questions or select the "I decline to provide this information" answer.

1.) Ethnicity: (Please Select One)

☐ Hispanic or Latino ☐ Not Hispanic or Latino

2.) Race: (Please select all that apply)

☐ American Indian/Alaskan Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Pacific Islander ☐ White/Caucasian ☐ Other

3.) Preferred Language: (Please Select One)

☐ English ☐ Spanish ☐ Other: _____

☐ I decline to provide this information.

PF-1000 Notice of Privacy Practices

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.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Dr. John F. Connors D.P.M & Associates. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Fund raising. Unless you request us not to, we will use your name and address to support our fund-raising efforts. If you do not want to participate in fund-raising efforts, please check off the following box.

[ ] Please do not use my information for fund raising purposes.

Individual Rights
You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

Dr. John F. Connors D.P.M & Associates' Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the designated staff or Compliance Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Dr. John F. Connors D.P.M & Associates LLC

200 White Road, Suite #214

Little Silver, NJ 07739

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person
The name and address of the person you can contact for further information concerning our privacy practices is:

Dr. John F. Connors D.P.M & Associates LLC

200 White Road, Suite #214

Little Silver, NJ 07739

Effective Date: This Notice is effective on or after January 1, 2019.

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Acknowledgement of Receipt of Notice of Privacy Practices

Dr. John F. Connors / Dr. Ana J. Sanz reserve the right to modify the privacy practices outlined in the office. By signing below, you are indicating that you have received a copy of the Notice of Privacy Practices for Dr. John F. Connors / Dr. Ana J. Sanz.

Signature:_____ Date: _____

Name of Patient (Please Print): _____

Signature of Patient Representative: _____
(Required if the patient is a minor or an adult who is unable to sign this form.)

Relationship of Patient Representative to Patient: _____

DR. JOHN F. CONNORS, D.P.M.
DR. ANA SANZ, D.P.M.

200 White Road, Suite #214
Little Silver, NJ 07739
Phone: (732)741-2300
Fax: (732)741-0469

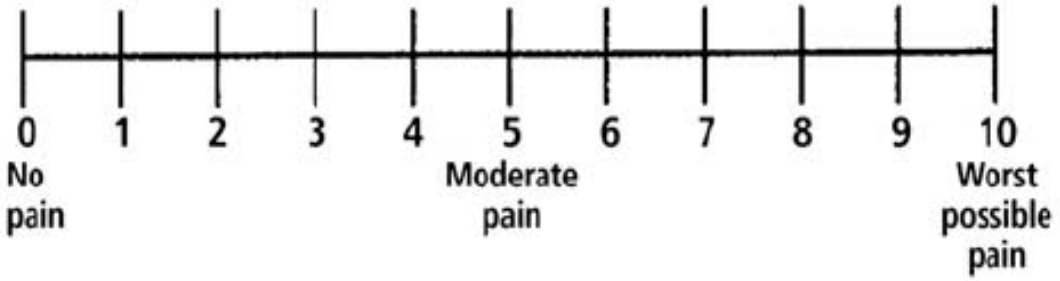
Name:_____

DOB:_____

Date:_____

Location of Pain:_____

Numeric Pain Rating Scale



Wong-Baker FACES Pain Rating Scale

DR. JOHN F. CONNORS, D.P.M.
DR. ANA SANZ, D.P.M.
200 White Road, Suite #214
Little Silver, NJ 07739
Phone: (732)741-2300
Fax: (732)741-0469

Employer Insurance Information Sheet

1) Do you get Insurance Coverage through your Employer?

Yes / NO

a. If **YES**, what is your Employer's name, address, and phone number?

Employer Name: _____
Employer Address: _____
Employer Phone Number: _____

b. If **NO**, do you get Insurance through a spouse or family member's Insurance?
Yes / No

Insurance Carrier Name: _____
Insurance Policy Holder: _____

2) What is your relationship to that spouse or family member and what is your spouse or family member's employer's name, address, phone number?

Relationship with Spouse or Family Member: _____
Employer Name: _____
Employer Address: _____
Employer Phone Number: _____

3) If you don't have Insurance through any of the above, please explain how you receive medical coverage?

_____
_____
_____

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Out-of-Network Waiver

I acknowledge that I have been advised that John F. Connors, DPM and Associates L.L.C. are not participating providers of my primary and/or secondary health insurance plan. As a result, benefits for any services that I may receive from John F. Connors, DPM and Associates L.L.C. will not be paid at in-network rates.

I acknowledge that I have chosen to receive services from John F. Connors, DPM and Associates L.L.C. as an out-of-network patient. I understand that if I receive payment from insurance, I will forward that to Dr. John Connors.

By signing below, I understand that my insurance will be billed for my surgery, and that I will be financially responsible for any charges unpaid or owed in advance of surgery.

Signature:_____ Date: _____
(Patient or person authorized to sign for patient)

Patient Name (Please Print):_____

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Health Insurance Waiver for Non-Covered Services

I understand that my health insurance may not cover certain services provided by any of the physicians at John F. Connors, DPM and Associates L.L.C. John F. Connors, DPM and Associates L.L.C. is unable to verify each patient's health insurance coverage. Should you have any questions regarding your coverage, it is my responsibility to verify my benefits with my insurance company prior to may schedule appointment.

Authorization for Health Plan to Pay Directly to Physician

I authorize payment from my insurance carrier directly to the health care providers at John F. Connors, DPM and Associates L.L.C.

Managed Care Plan Participants

I understand that I have an obligation to obtain a referral for specialty services from my Primary Care Physician prior to any scheduled appointment. I hereby agree to be responsible for full payment for services received if my specialist does not receive a referral and my insurance plan denies payment.

Signature:_____ Date: _____
(Patient or person authorized to sign for patient)

Patient Name (Please Print):_____

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Payment Policy

We are committed to providing you with the best possible care. Please read carefully and sign this to acknowledge your understanding and acceptance of our policies and procedures.

Payment is due at the Time of Service

We accept cash, checks, Visa, Master Card, American Express and Discover.

As a courtesy, we will be happy to file your insurance claim for you. If you receive a check, kindly forward it to us and we will make the appropriate adjustments and issue a refund to you, if applicable.

We must emphasize that as health care providers, our relationship with you, not your insurance company. All charges are your responsibility from the date services are rendered. If you have any questions, feel free to ask and we will be glad to help.

PLEASE NOTE: If surgery is needed, we will call to verify that it is a covered expense. Unfortunately, **this is not a guarantee** for payment and you might owe additional money.

Regardless of any insurance coverage that I may have, I agree that it is my responsibility to pay my balance and my balance due.

Print Name: _____

Signature: _____ Date: _____