Biebel & DeCotiis Podiatry Associates

Podiatric Medicine – Foot & Ankle Surgery

721 North Beers Street
Holmdel, NJ 07733
Telephone 732-888-1717
Fax 732-888-2101

PATIENT REGISTRATION FORM

Patient:_____ SS#:_____
Last Name First Name MI

Home Phone:_____ Cell #:_____ Work#:_____

Address:_____ City:_____

State:_____ Zip:_____ E-Mail:_____

Gender: M____ F____ Birthday:_____ Marital Status: S___ M___ W ___D ___Sep ___CU___

Emergency Contact:_____ Contact phone#:_____
Relationship to patient

*Race_____ *Ethnicity_____ *Primary Language_____
*(Disclaimer, Government requires this information, you may choose not to answer)

Patient's Employer:_____ Occupation:_____

Primary Insurance:_____ Responsible Party:_____

Relationship to Patient:_____ Date of Birth:_____

Secondary Insurance:_____ Responsible Party:_____

Relationship to Patient:_____ Date of Birth:_____

How were you referred to our office?_____

Primary Care Doctor:_____ Phone#:_____

ALL CHARGES ARE PAYABLE AT THE TIME OF SERVICE. CHARGES FOR PROFESSIONAL SERVICES ARE THE RESPONSIBLILITY OF THE PATIENT REGARDLESS OF INSURANCE COVERAGE. DELINQUENT ACCOUNTS MAY BE SENT TO A THIRD PARTY FOR COLLECTION PURPOSES.

I HEREBY AUTHORIZE PAYMENT FROM MY INSURANCE COMPANY FOR SERVICES RENDERED TO BE SENT DIRECTLY TO DR. MARK BIEBEL/DR. MARK DECOTIIS/DR. GINA LAGNESE /DR. DEMETRIOS GROSSOS IF PAYMENT IS NOT MADE AT TIME OF SERVICE. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO MY INSURANCE COMPANY CONCERNING MY TREATMENT. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE COMPANY. I ALSO CONSENT TO PODIATRIC TREATMENT BY DR. BIEBEL/DR. DECOTIIS OR DR. LAGNESE/DR. GROSSOS.

"ACCOUNTS 30 DAYS PAST DUE WILL BE CONSIDERED IN DEFAULT AND IT MAY BECOME NECESSARY TO REFER YOUR ACCOUNT TO AN ATTORNEY FOR COLLECTIONS. IF YOUR ACCOUNT IS REFERRED TO AN ATTORNEY FOR COLLECTIONS, THE PATIENT AND/OR RESPONSIBLE PARTY IS RESPONSIBLE TO PAY ALL AMOUNTS, INCLUDING ATTRONEY'S FEES IN THE AMOUNT OF THIRTY (30) PERCENT OF THE DEFAULT AMOUNT PLACED FOR COLLECTIONS. THE ATTORNEY'S FEES IN THE ABOVE AMOUNT SHALL BECOME DUE AND OWING AT THE TIME THE ACCOUNT IS PLACED FOR COLLECTIONS AND MAY BE ASSESSED AND ADDED TO THE BALANCE DUE AT THAT TIME REGARDLESS WHETHER THAT AMOUNT IS ACTUALLY COLLECTED"

SIGNATURE:_____DATE:_____
RESPONSIBLE PARTY

MEMBER*_____

American College of Foot and Ankle Surgeons

Podiatric Physicians Providing Comprehensive Care

Biebel & DeCotiis Podiatry Associates

Podiatric Medicine - Foot & Ankle Surgery

Dr. Mark A. Biebel, F.A.C.F.A.S.*
Diplomate, American Board Podiatric Surgery

Dr. Mark A. DeCotiis, F.A.C.F.A.S.*
Diplomate, American Board Podiatric Surgery

Dr. Gina M. Lagnese
Foot & Ankle Surgery

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize my physician and/or administrative clinical staff to disclose the following protected health information to:

- ☐ Myself only
- ☐ My spouse, significant other or parent (specify name) _____
- ☐ Other (specify name) _____

Information to be disclosed:

- ☐ Laboratory results
- ☐ X-Ray results
- ☐ Diagnosis
- ☐ Medications
- ☐ Immunizations
- ☐ Other test results (specify) _____
- ☐ Other _____
- ☐ Dates of service _____

This protected health information is being used or disclosed for the following purposes:

- ☐ At the request of myself
- ☐ Other _____

I would like to be contacted at my:

- ☐ Home phone: _____
- ☐ Cell phone: _____
- ☐ Other: _____
- ☐ Work phone: _____
- ☐ Mail

Regarding the office staff or physician leaving information or confirming appointments on my answering machine, voice mail or with my answering service?

- ☐ Yes, I give my permission for medical information to be left on my answering systems.
- ☐ No, I do not want messages or medical information left on my answering systems.

This authorization shall be in force and effect until revoked at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer at the above address. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by the federal HIPAA Rule or state law. I acknowledge that a copy of Dr. Biebel's/Dr. DeCotiis'/Lagnese's Notice of Privacy Practices has been provided to me.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Description of Personal Representative's Authority

PATIENT
MEDICAL INFORMATION

HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITION?
PLEASE **CIRCLE** IF YES.

DIABETES	ANEMIA	GLAUCOMA
HEART DISEASE	BLEEDING PROBLEMS	VENEREAL DISEASE
HIGH BLOOD PRESSURE	SICKLE CELL	HEPATITIS
STROKE	PHLEBITIS	LIVER DISEASE
RHEUMATIC FEVER	ASTHMA	KIDNEY DISEASE
HEART MURMUR	TB	ULCERS
ARTHRITIS	SEIZURES	STOMACH PROBLEMS
GOUT	CANCER	PREGNANT NOW?
ABNORMAL SCARS		

OTHER: _____

MEDICATIONS YOU ARE TAKING NOW: _____

_____

ARE YOU **ALLERGIC** OR **SENSITIVE** TO ANY OF THE FOLLOWING?

ASPIRIN	PENICILLIN	ANTIBIOTICS	NOVOCAINE	IODINE
MOTRIN	CORTISONE	TAPE	OTHERS: _____	

FAMILY DOCTOR: _____ CITY: _____

PHARMACY: _____ CITY: _____ PHONE: _____

DESCRIBE/LIST ANY SURGERY YOU HAVE UNDERGONE: _____

_____

_____

DESCRIBE YOUR FOOT OR ANKLE PROBLEM: _____

_____

_____

_____

_____