Stuart L. Jablon, DPM
Welcome to Our Office

Patient: ____ Date____________________
(Full name)
Street: ________________________________ City: ___________ State: _____ Zip: ___________
Home Phone: (______) __________________ Date of Birth: _________________ Age: __________
E-mail address (will not be shared in any way): ____
Gender: __M __F Occupation:__________________________ Cellular #: (____)________________
Employer: ____________________________________ Work Phone: (_____) _________________
Business Address: ____
Spouse's Full Name: _____________________________ Occupation: ______________________
Your Pharmacy: ______________________ Town: _____________ Phone #: ________________
Emergency Contact - Name: ____________________________ Phone: (_____) ________________

SS#: _______________________ Medicare #: ____
Primary Ins. Co.: ____________________________________ Policy #: ____________________
Name of Insured: _______________________________ Group #: _________________________
Soc. Sec. # of Insured: ______________ D.O.B of Insured: ____/____/____ Relationship: __________
Secondary Ins. Co.: _____________________________________ Policy #: __________________
Name of Insured: ______________________________ Group #: __________________________
Soc. Sec. # of Insured: _______________ D.O.B of Insured: ____/____/____ Relationship: _________
Referred by: ____________________ Date of Last Physical: ________ By Whom: _____________
Family M.D. ____________________ Address: ____

What is your foot problem(s):
____
____
Height______ Weight______ Blood Pressure ____/___ Shoe Size: ___________
Do you smoke? ___Y___N # of packages _________
Marital Status: __Single __ Married __ Widow __ Divorced
Illnesses: **(Check those which apply):**
____Poor Circulation ____Heart Disease ____Liver Disease ____Diabetes ____Arthritis ____Anemia ____Kidney Problem____Hepatitis ____Lung Problems ____Back Problems ____Bleeding Disorders ____Asthma ____ Gout ____ High Blood Pressure ____Rheumatic Fever ____Stroke _____Back Pain _____Neck Pain ____ Numbness in Feet

Allergies to Medications: **(Check those which apply):**
____Penicillin ____Aspirin ____Codeine___ Adhesive Tape ____Iodine
____Sulpha ____Sea Food ____Local Anesthetic ____Other: _______________

Medication Taking: **(Prescription and non-prescription)** ______________________________________
____
____
____

Prior Surgery or Illnesses:
____
____

I certify that the above information is true and correct to the best of my knowledge.
I hereby give my permission to Stuart L. Jablon, DPM to administer and perform diagnostic, therapeutic and/or operative procedures as may be deemed necessary in diagnosis and/or treatment of my foot condition.

PATIENT SIGNATURE: _________________________ DATE: __________________

FINANCIAL POLICY FOR STUART L. JABLON, DPM

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

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 is your responsibility. Please contact your insurance company with any questions you may have regarding your 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 co-payments, 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 explanation of benefits (EOB) is received from your primary insurance company.

COPAYMENTS AND DEDUCTIBLES: All co-payments and deductible must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. 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 service if you do not have health insurance.

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 due in full upon completion of the visit. Full credit will be given if a referral is presented to our office within 48 hours of this 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 to help get your claims paid. Your insurance company may need you to supply certain 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 a 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 Stuart L. Jablon, DPM for medical services provided. I agree to pay Stuart L. Jablon, DPM any balance unpaid by my insurance carrier for myself or the below named person.

Assignment of Benefits

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Stuart L. Jablon, DPM and all 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.

PRINT Patient Name: ________________________________ Signature:____

FINANCIALLY RESPONSIBLE PARTY:

PRINT Name: _____________________________________ Signature: ____

Relationship to Patient: _____________________________ Date: ________________

STUART L. JABLON, DPM
PODIATRIC PAIN ANALYSIS SURVEY

Name: ____

Phone: ___________________________________ Age: ____________________

Please check any of the following conditions you are currently experiencing or suffering from:

☐ Flat Feet
☐ Poor coordination
☐ Heel or Arch Pain
☐ Leg pain (shin splints)
☐ Achilles tendon pain
☐ "Toe-in" or "Toe-out" gait (walking)
☐ Ankle swelling or stiffness
☐ Neck Pain
☐ Back Pain
☐ Ankle instability (easy twisting injuries)
☐ Pain in feet or legs at rest
☐ Pain in feet or legs with exercise or activity
☐ Feet/Toes feel numb
☐ Foot/Toes/Legs burn
☐ Difficulty/Pain
☐ Discoloration of toes/foot
☐ Pain legs occurs at the same distance every time
☐ Coldness in the legs or feet that is uncomfortable
☐ Non / Poor healing sore on the leg or foot
☐ Do your legs feel heavy, tired, restless, or achy
☐ Have you had a Deep Vein Thrombosis (DVT) and are experiencing pain, swelling,
☐ Change in skin color, cellulites, or non-healing ulcers?

Please answer the following about the above conditions:
Do the above conditions disrupt your lifestyle and activities of daily living? Yes / No

Is this condition causing or are you suffering with any of the following:

Tingling/Numbness in:	**Pain radiating into:**	**Weakness of the:**	**Difficulty with:**
☐ Legs R / L	☐ Ankle R / L	☐ Legs R / L	☐ Standing
☐ Ankle R / L	☐ Feet R / L	☐ Ankle R / L	☐ Walking
☐ Feet R / L	☐ Toes R / L	☐ Foot R / L	☐ Sitting
			☐ Bending
			☐ Lifting
			☐ Kneeling

How long have you been suffering with this condition? Days / Weeks / Months / Longer

Is this condition affecting your ability to perform daily tasks? Yes / No

Would you like to get rid of or reduce this problem? ☐ Yes ☐ No

There may be treatment options or solutions for the pain you are experiencing. Please let us know what you would like to do today.

☐ I would like to discuss the above conditions with the Doctor so I can make an educated decision about my health.

☐ If it were available, I would be interested in receiving treatment for this condition in this office.

☐ If available, I would be open to have a medical test to further evaluate my problem.

_________________________ _________________________ _________________________
Patient Signature Physician Signature Date

Office Policies Regarding Managed Care Insurance Plans

We understand that the many changes in the health care system have made it quite confusing for our patients. The following are guidelines that have been established by the insurance companies to allow reimbursement for services we provide:

- You are responsible for obtaining and bringing referrals at the time service is rendered.
- Be aware that referrals may be for one visit or more. This is clearly indicated on the referral form.
- Referrals do expire. Most are good for either sixty or ninety days. This is also indicated on the referral form.
- A consultation report will be sent to your primary care doctor after the first visit and follow-up reports will be provided as necessary.
- You are responsible for your co-pay at the time your treatment is rendered.
- If you do not have a referral for a visit, you are responsible for full payment.
- Primary care physicians have indicated that they can not be called with a patient in the office for a referral for that particular visit. Referrals must be obtained before your visit to our office. Primary care physicians often need several days to provide you with a referral.

We are always available to help you with any questions regarding your insurance and treatment in our office.

Thank you.

Stuart L. Jablon, DPM