

Dr. Jill Hagen
Podiatrist
363 Grand Ave Englewood, NJ 07631

COVID-19 Screening Form

First point of contact should screen the patient/visitor and check any boxes that apply:

| | |
|--------------------------|---|
| <input type="checkbox"/> | Patient/visitor has a fever (≥ 100.4 visitor/patient > 100.0 HCP) AND signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath) |
| <input type="checkbox"/> | Patient/visitor has had close contact with a laboratory confirmed COVID-19 patient within the last 14 days |
| <input type="checkbox"/> | Patient/visitor has a fever (≥ 100.4 visitor/patient > 100.0 HCP) OR signs/symptoms of lower respiratory illness AND a history of travel from affected geographic regions within 14 days of symptom onset |
| <input type="checkbox"/> | Patient/visitor does not meet any of the above criteria |

Patients:

If any of the first three boxes are checked, the patient should not enter this building and should call their primary care doctor immediately.

Name _____ Phone _____ Date _____

Dr. Jill Hagen Dr. Lauren Grossman
PODIATRISTS
363 GRAND AVENUE • ENGLEWOOD, NJ 07631
(201)568-6977

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our **FINANCIAL POLICY** which we require you to read and sign prior to initial treatment.

- **ALL PATIENTS MUST COMPLETE OUR INFORMATION AND INSURANCE FORM BEFORE SEEING THE DOCTOR.**

- **WE ACCEPT CASH, CHECKS OR MASTERCARD/VISA.**

REGARDING INSURANCE

Your insurance policy is a contract between you and your insurance company. **We are not a party of that contract.** Please be aware that some of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare program and other medical insurance programs. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment for payment regardless of any insurance company's arbitrary determination of usual and customary rates. **You are responsible for all non-covered services, deductible, copays, and coinsurance.**

ADULT PATIENTS AND MINOR PATIENTS: Adult patients (18 or older) are responsible for payment.

The adult accompanying the minor and the parents (or guardian of the minor) are responsible for payment. For unaccompanied minors, non-emergency treatment will be denied unless payment by Cash, Check, MASTERCARD or VISA at the time of service has been verified.

PATIENT LIABILITY: If this account is assigned to an attorney for collection and/or suit, I shall pay 33 1/3% of the claim as payment for attorney's fees and cost of collection.

CHECK RETURN POLICY: For any check that is returned from the bank there will be a service charge of \$30.00 that must be paid to Podiatry Associates.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I HAVE READ THE FINANCIAL POLICY. I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

Signature of Patient or Responsible Party

Date

Signature of Co-Insurance Responsible Party

Date

Dr. Jill Hagen, DPM
Dr. Lauren Grossman, DPM

363 Grand Avenue • Englewood, NJ 07631

Phone (201)568-6977

Patient History

| | |
|--|----------------------|
| Last Name: _____ | First Name: _____ |
| Height: _____' _____" Weight: _____ | Date: ____/____/____ |
| Blood Pressure: _____/_____ | DOB: ____/____/____ |



| Medical History | No | Yes | Unknown |
|----------------------|--------------------------|--------------------------|--------------------------|
| Anxiety | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C H F | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes Insulin | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes Non-Insulin | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| GI Ulcers | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| GI Reflux | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack / MI | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| High Cholesterol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hyperthyroid | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hypothyroid | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Murmur | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Vascular Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other: _____ | | | |
| Other: _____ | | | |

| Social History | No | Yes | Quit |
|-------------------|--------------------------|--------------------------|--------------------------|
| Smoking / Tobacco | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Alcohol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| Family History | No | Yes |
|---------------------|--------------------------|--------------------------|
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Other: | <input type="checkbox"/> | <input type="checkbox"/> |

| | Medications | <input type="checkbox"/> None |
|----|-------------|-------------------------------|
| 1 | | mg |
| 2 | | mg |
| 3 | | mg |
| 4 | | mg |
| 5 | | mg |
| 6 | | |
| 7 | | |
| 8 | | |
| 9 | | |
| 10 | | |
| 11 | | |
| 12 | | |

| Surgery | Year | <input type="checkbox"/> None |
|-------------------|------|-------------------------------|
| Heart Surgery | | <input type="checkbox"/> |
| Vascular Surgery | | <input type="checkbox"/> |
| Joint Replacement | | <input type="checkbox"/> |
| Foot & Ankle | | <input type="checkbox"/> |
| Other: _____ | | |

| | Drug Allergies | <input type="checkbox"/> None |
|---|----------------|-------------------------------|
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |
| 5 | | |

Chief complaint is _____

I hereby give permission to Dr. Jill Hagen, DPM / Dr. Lauren Grossman, DPM and/or associates for the examination and rendering care for my foot problem and/or related condition.

Patient Signature (if minor, parents)

____/____/____
Date

Dr. Jill Hagen, DPM
Dr. Lauren Grossman, DPM
363 Grand Avenue • Englewood, NJ 07631
Phone (201)568-6977
Fax (201)568-7567

WELCOME TO OUR OFFICE

Patient Information:

Sex: Male Female
Date of Birth: ___/___/_____
Social Security# _____ - _____ - _____
Last Name: _____
First Name: _____ Middle Initial: _____
Address: _____
City: _____
State: _____ Zip Code: _____
Home Phone: (____) _____ - _____
Work Phone: (____) _____ - _____
Cell Phone: (____) _____ - _____
Email Address: _____
Referred By: _____

Insured's Information:

Employer of Insured: _____
Your relationship to Insured:
Self Spouse Child Other
Insured Person: Male Female
Insured's Name (If other than self)
Last Name: _____
First Name: _____ Middle Initial: _____
Address: _____
City: _____
State: _____ Zip Code: _____
Home Phone: (____) _____ - _____
Work Phone: (____) _____ - _____
Social Security# _____ - _____ - _____

INSURANCE INFORMATION

Primary Insurance Name: _____
Identification # _____
Address: _____
Secondary Insurance Name: _____
Identification # _____
Address: _____

Group # _____

Group # _____

How will you be paying today?

Check Cash Visa MasterCard Copay Amount: \$ _____
Credit Card # _____ Expiration Date: ___/___/_____
CSV: _____
(Visa & MasterCard have 3 digits, American Express has 4 digits)

If other than the above, please discuss payment with the office receptionist.

SIGNATURE ON FILE: _____
(Authorization to file claims / release insurance information / appeal claims / charge balances on credit card on file.)