ACTIVE FOOT & ANKLE CARE, LLC

RICHARD T. BRAVER, D.P.M.
PHILIP S. MESSENGER, D.P.M.
4-14 Saddle River Road, Fair Lawn, N.J. 07410 201-791-1881
44 Route 23 North, Riverdale, NJ 07457 973-831-1774

Name_____ Birth Date_____ Age_____ Weight_____ Height_____

Address_____ City_____ State_____ Zip_____

Home Phone(___)_____ Cell Phone(___)_____ Work Phone(___)_____
(Please indicate which is the best number to contact you by marking an *)

Sex at Birth M – F Gender _____ Marital Status_____ **E-Mail Address**_____

Preferred Language _____ Preferred Phone Communication Home Work Cell
(As required under the new billing insurance guidelines)

Race _____ Ethnicity_____ Shoe Size_____

Referred By (Please Circle): DrRun.com / Facebook / Google / Internet / Physician / Other

Referral Name if Known:_____ Pharmacy/Address_____

Occupation_____ Employer & Address _____

Student: Year_____ School_____ Coach_____

Sports, Activities or Hobbies_____ Family Doctor & Town _____

Medical Insurance_____ Social Security_____

Do you have or have you had any of the following: (*do not know)

	YES	NO	DNK		YES	NO	DNK		YES	NO	DNK
Foot / Leg Surgery...	☐	☐	☐	Heart Trouble.....	☐	☐	☐	Gout	☐	☐	☐
Foot / Leg Injuries...	☐	☐	☐	Diabetes.....	☐	☐	☐	Anemia.....	☐	☐	☐
Foot / Leg Cramps.	☐	☐	☐	Epilepsy.....	☐	☐	☐	Fainting Spells..	☐	☐	☐
Foot / Leg Numbness	☐	☐	☐	Liver Disease.....	☐	☐	☐	Bleeder.....	☐	☐	☐
Knee Pain.....	☐	☐	☐	Kidney Disease.....	☐	☐	☐	Blood Disease...	☐	☐	☐
Unequal Leg Length.	☐	☐	☐	Rheumatic Fever.....	☐	☐	☐	Circulation Issues	☐	☐	☐
Weak Ankles.....	☐	☐	☐	High Blood Pressure..	☐	☐	☐	Hardening Arteries	☐	☐	☐
Bunions.....	☐	☐	☐	Polio.....	☐	☐	☐	Varicose Veins...	☐	☐	☐
Foot Skin Problems .	☐	☐	☐	Bursitis.....	☐	☐	☐	Arthritis.....	☐	☐	☐
Toe Nail Problems...	☐	☐	☐	Stomach Ulcers.....	☐	☐	☐	Cancer.....	☐	☐	☐
Low Back Pain.....	☐	☐	☐	Asthma.....	☐	☐	☐	Prone to Infection	☐	☐	☐

Are you allergic to or sensitive to

	YES	NO	DNK
Novocaine.....	☐	☐	☐
Penicillin.....	☐	☐	☐
Adhesive Tape.....	☐	☐	☐
Materials.....	☐	☐	☐
Drugs.....	☐	☐	☐
Foods.....	☐	☐	☐
Stainless Steel.....	☐	☐	☐
Latex.....	☐	☐	☐
Other (if so describe)	☐	☐	☐

_____
_____

List any medical conditions you have._____

Have you had any serious illnesses or operations?_____

Have you had any injuries or operations on your feet or legs?_____

Have your or any family members been treated for diabetes?_____ If yes, who?_____

List any allergies to medications._____

Present medications being taken:_____

My chief complaint is:_____

I hereby give permission to Richard T. Braver D.P.M, and/or Associates for the examination and rendering care for my foot/ankle problem and / or related condition.

Date_____ Patient Signature (if minor, parents)_____

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4-14 SADDLE RIVER ROAD FAIR LAWN, NJ 07410
44 ROUTE 23 NORTH, RIVERDALE, NJ 07457
201-791-1881

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

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

Patient Name (please print) _____ Date _____

Patient or Authorized Representative (if applicable) _____

Signature _____

SIGNATURE ON FILE

Patient's Name (print) _____ Insured/Medicare Number _____

I request that payment of authorized insurance and Medicare benefits be made either for me or on my behalf to Richard T. Braver, D.P.M and/or Associates for any services furnished to me by him and or associates. I authorize any holder of medical information concerning me to release to my Insurance carrier or the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits to related services.

Signature of Patient _____ Date _____

Yearly renewal of signature on file as described above

Signature of Patient _____ Date _____

Signature of Patient _____ Date _____

Signature of Patient _____ Date _____

Saved as privacy act letter 2024

ACTIVE FOOT & ANKLE CARE, LLC

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PHILIP S. MESSENGER, D.P.M.
4-14 Saddle River Road Fair Lawn, N.J. 07410
44 Route 23 North, Riverdale, NJ 07457
Tel: (201) 791-1881 Fax: (201) 791-6177

WELCOME TO OUR OFFICE

PATIENT INFORMATION:
SEX: MALE [ ] FEMALE [ ]

BIRTH DATE: ____/____/_____

SOCIAL SECURITY# _____-_____-_____

LAST NAME: _____

FIRST NAME: _____ M.I. ____

ADDRESS: _____

CITY: _____ STATE: ____ ZIP: _____

HOME PHONE: ( ) _____

WORK PHONE: ( ) _____

CELL PHONE ( ) _____

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: _____ M.I. ____

ADDRESS: _____

CITY: _____ STATE: ____ ZIP: _____

HOME PHONE: ( ) _____

WORK PHONE: ( ) _____

DATE OF BIRTH: _____

SOCIAL SECURITY #: _____/_____/_____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: _____
IDENTIFICATION # _____ Group # _____

SECONDARY INSURANCE NAME: _____
IDENTIFICATION # _____ Group # _____

_____Initial ***MUST CALL 24 HOURS IN ADVANCE TO CANCEL / RESCHEUDULE APPOINTMENT, THERE WILL BE A CHARGE OF $25.***

AUTHORIZATION / RESPONSIBILITY AGREEMENT:
I HEREBY AUTHORIZE MY INSURANCE COMPANY TO PAY THE PROCEEDS OF ANY BENEFITS TO DR. RICHARD T. BRAVER, AND / OR ASSOCIATES AND WILL BE RESPONSIBLE FOR THE REMAINING BALANCE. A COPY OF THIS FORM CAN BE CONSIDERED AS AN ORIGINAL FOR INSURANCE PURPOSES.

I HEREBY AGREE I HAVE ARRANGED FOR THE DOCTOR TO BILL MY INSURANCE COMPANY ON MY BEHALF FOR SERVICES PROVIDED. I UNDERSTAND THAT THE BILL IS MY RESPONSIBILITY AND I WILL MAKE SURE THE BILL IS PAID IN A REASONABLE TIME FRAME (45 DAYS) AND AGREE TO PAY ANY OUTSTANDING BALANCE DIRECTLY TO ACTIVE FOOT & ANKLE CARE LLC.

I HEREBY AGREE ANY OUTSTANDING BILLS WILL BE SUBJECT TO A LATE FEE NOT TO EXCEED $250 WHEN SENT TO A BILLING AGENCY FOR COLLECTION.

FOR OUT OF NETWORK PATIENTS, YOUR INSURANCE CARRIER MAY BE ISSUING PAYMENT DIRECTLY TO YOU FOR ANY SERVICES RENDERED AT OUR OFFICE ALONG WITH AN EXPLANATION OF PAYMENT SUMMARY. I HEREBY AGREE PAYMENT AND EXPLANATION SUMMARY WILL BE FORWARDED TO ACTIVE FOOT & ANKLE CARE, LLC PROMPTLY. PAYMENT EXCEEDING 30 BUSINESS DAYS FROM THE DATE OF CHECK ISSUANCE MAY RESULT IN LATE FEES. IF PAYMENTS ARE NOT FORWARDED TO OUR OFFICE, YOU THE PATIENT/GUARANTOR WILL BE FULLY LIABLE FOR FULL CHARGES BILLED, INCLUDING DEDUCTIBLE, CO-PAYS AND CO-INSURANCE WHEN SENT TO A BILLING AGENCY FOR COLLECTION.

SIGNED: _____ DATE: _____

Save as: patient info sheet 2024

ACTIVE FOOT & ANKLE CARE, LLC.

CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT (UM) DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS IN UM APPEALS AND INDEPENDENT ARBITRATION OF CLAIMS

APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

You have the right to ask your insurer, HMO or other company providing your health benefits (carrier) to change its utilization management (UM) decision if the carrier determines that a service or treatment covered under your health benefits plan is or was not medically necessary.
* This is called a UM appeal. You also have the right to allow a doctor, hospital, or other health care provider to make a UM appeal for you.

There are three appeal stages if you are covered under a health benefits plan issued in New Jersey. Stage 1: the carrier reviews your case using a different health care professional from the one who first reviewed your case. Stage 2: the carrier reviews your case using a panel that includes medical professionals trained in cases like yours. Stage 3: your case will be reviewed through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI) using an Independent Utilization Review Organization (IURO) that contracts with medical professionals whose practice includes cases like yours. The health care provider is required to attempt to send you a letter telling you it intends to file an appeal before filing at each stage.

At Stage 3, the health care provider will share your personal and medical information with DOBI, the IURO, and the IURO's contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports.

You have the right to cancel (revoke) your consent at any time. Your consent to representation and release of information for appeal of a UM determination will end 24 months after the date you sign the consent.

INDEPENDENT ARBITRATION OF CLAIMS

Your health care provider has the right to take certain claims to an independent claims arbitration process through the DOBI. To arbitrate the claim(s), the health care provider may share some of your personal and medical information with the DOBI, the arbitration organization and the arbitration professional(s). Everyone is required to keep your information confidential. The DOBI reports data about the arbitration outcomes, but no personal information will be in the reports. Your consent to the release of information for the arbitration process will end 24 months after the date you sign the consent.

CONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE INFORMATION IN UM APPEALS AND ARBITRATION OF CLAIMS

I, _____ by marking ☑ (or ☒) and signing below, agree to:

☑ representation by Active Foot & Ankle Care, LLC in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:2S-11, and release of personal health information to DOBI, its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to represent and authorization of release of information expires in 24 months, but I may revoke both sooner.

☑release of personal health information to DOBI, its contractors for the Independent Claim Arbitration Program, and any independent contractors that may be required to perform the arbitration process. My authorization of the release of information for purpose of claims arbitration will expire in 24 months.

Signature: _____ Ins. ID#: _____ Date: _____

Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative (provide contact Information on separate page)

_____

*If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete the form.

Health Care Providers: The patient or his or her Personal Representative MUST receive a copy of this document after this page has been completed, signed and dated.

saved as: appeals form afac 2024

Active Foot & Ankle Care, LLC

Richard T. Braver, DPM, FACFAS
Philip Messenger, DPM

4-14 Saddle River Road, Fair Lawn, NJ 07410
44 Route 23 North, Riverdale, NJ 07457
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E-MAIL/TEXT WAIVER

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) sets standard for protecting the rights of individual (patients). *Active Foot & Ankle Care, LLC* follows the law that grant every individual the right to the privacy and confidentiality of their health information. To comply with HIPAA regulations, email correspondence that contains protected health information must be sent encrypted (secured). If you wish to have unencrypted (unsecure) email or texts sent to you for the sake of your convenience, you must sign the following wavier.

I _____ request that, for my convenience, *Active Foot & Ankle Care, LLC.* correspond with me by unencrypted (unsecure) email or text message to relay information concerning my care. I understand that emails or texts sent to me may contain protected health information. I further understand that unencrypted email, email attachments and texts are not secure and may be viewed by others. I agree to hold harmless *Active Foot & Ankle Care, LLC* it's officers, agents, employees, and contact health providers from any and all liability, loss, damages, costs or expenses which are sustained, or required arising from the transmission of unencrypted (unsecure) emails or texts correspondence and attachments.

This waiver will remain in force until revoked in writing.

Patient Name _____ DOB _____

Patient Signature _____ Date _____

SAVED AS: EMAIL WAIVER 2024