Stuart Jacob,
DPM / Director

Certified: Nonsurgical Heel Pain Treatment, Extracorporeal Shockwave Therapy (ESWT), 2004 Board-Certified: American Board of Podiatric Surgery, 1996; American Board of Podiatric Orthopedics & Primary Podiatric Medicine, 1993 Fellow: American Professional Wound Care Association, American College of Foot & Ankle Surgeons, American College of Foot & Ankle Orthopedics & Primary Podiatric Medicine

William Green,
DPM / Associate

Board-Qualified: American Board of Podiatric Surgery Member: American Running & Fitness Association

Dr. Jacob and Dr. Green are both affiliated with: Lourdes Medical Center of Burlington County, Hampton Behavioral Health Center, Marcella Center, Bridges Adult Medical Daycare Center, Granville House, Burlington Woods Center

Gentle, effective foot & ankle care

- Ulcer/wound care
- Bunions
- Crooked toes/hammertoes
- Heel pain
- Sports injuries
- Joint pain & swelling
- Fractures/ankle sprains
- Neuroma
- Corns & calluses
- Warts
- Nail problems
- Arthritic, diabetic, pediatric & geriatric care

Advanced techniques for better results

- Nonsurgical shockwave therapy for heel pain
- Endoscopic foot care
- In-office diagnostic ultrasound & X-rays
- Minimal-incision techniques
- Custom-fitted orthotic inserts
- Medicare-covered diabetic shoes & inserts

Putting the patient first

- Most insurance accepted & filed
- Visa, MasterCard & Discover
- Lunchtime & evening appointments
- Same-day urgent care
- Handicapped-accessible
- Plentiful parking
- On bus & train routes

Jacob Foot and Ankle Associates

Leading-edge care to get and keep you active

609-386-0217

319 W. Broad Street
Burlington, NJ 08016
(Next to the Burlington Bristol Bridge)
Fax 609-386-2205
www.JacobFootAndAnkle.com

Your initial appointment has been scheduled with Dr. Stuart Jacob Dr. William Green Dr. Joseph Santomauro for _____ _____at_____ We ask that you arrive 15 minutes before your scheduled appointment in order to complete any necessary paperwork.

We are enclosing directions to our office, as well as a new patient forms to be completed prior to your arrival to our office. Please bring the completed forms with you to your appointment, along with your insurance card and a form of identification. Please check with your insurance carrier or Primary care doctor to see if you need a referral.

We also as that you bring the following medical information from previous treatment with you to your appointment.

*List of any medications that you are presently taking, and a list of allergies to any foods or medications that you may have.

*Xray disk or films and reports

*MRI reports

*test results, such as labs, doppler study results

**ALL PATIENTS WHOS INSURANCE REQUIRE A REFERRAL MUST HAVE A REFERRAL PRIOR TO THEIR VISIT. IN ADDITION ALL COPAYS ARE COLLECTED AT THE TIME OF YOUR SCHEDULED APPOINTMENT.

Thank you for your cooperation.

Sincerely,

Kelly Weizer, PMAC
Practice Administrator

Stuart Jacob,
DPM / Director

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DIRECTIONS TO OUR OFFICE FROM NORTH JERSEY:

RT 130 SOUTH TO RT 541 (HIGH STREET) MAKE RIGHT ONTO HIGH STREET FOLLOW TO 2ND TRAFFIC LIGHT AT RR TRACKS, MAKE LEFT ONTO WEST BROAD STREET FOLLOW UNTIL YOU SEE THE OLD RAILROAD STATION ON LEFT, WE ARE IN THE BRICK BUILDINGS ON THE RIGHT 319 WEST BROAD STREET.

TAKE RT 295 SOUTH TO EXIT 47B (RT 541/HIGH STREET) FOLLOW STRAIGHT INTO BURLINGTON CITY. AT THE INTERSECTION WITH THE RR TRACKS MAKE A LEFT ONTO WEST BROAD STREET, FOLLOW UNTIL YOU SEE THE OLD RAILROAD STATION ON LEFT WE ARE IN THE BRICK BUILDINGS ON THE RIGHT 319 WEST BROAD STREET.

DIRECTIONS TO OUR OFFICE FROM SOUTH JERSEY:

RT 130 NORTH TO RT 541 (HIGH STREET) MAKE LEFT ONTO HIGH STREET FOLLOW TO 2ND TRAFFIC LIGHT AT RR TRACKS, MAKE LEFT ONTO WEST BROAD STREET FOLLOW UNTIL YOU SEE THE OLD RAILROAD STATION ON THE LEFT, WE ARE IN THE BRICK BUILDINGS ON THE RIGHT 319 WEST BROAD STREET.

TAKE RT 295 NORTH TO EXIT 47B (HIGH STREET\RT 541) FOLLOW STRAIGHT INTO BURLINGTON CITY. AT THE INTERSECTION WITH THE RR TRACKS MAKE A LEFT ONTO WEST BROAD STREET, FOLLOW UNTIL YOU SEE THE OLD RAILROAD STATION ON THE LEFT, WE ARE IN THE BRICK BUILDINGS ON THE RIGHT 319 WEST BROAD STREET.

JACOB FOOT AND ANKLE ASSOCIATES

A DIVISON OF NEW JERSEY PODIATRIC PHYSICIANS & SURGEONS GROUP, LLC

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 coinsurance, which is 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. Obtaining referrals from your primary physician and keeping track of your visits is your responsibility. If you do not have a valid referral at the time of your visit, your appointment will be rescheduled.

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. 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 with interest accruing on balance. It is also your responsibility to pay for the interest accrued if sent 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, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, MONEY ORDER, BANK CHECK .** 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 **JACOB FOOT AND ANKLE ASSOCIATES** for medical services provided. I agree to pay **JACOB FOOT AND ANKLE ASSOCIATES** 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**, JACOB FOOT AND ANKLE ASSOCIATES, a division of New Jersey Podiatric Physicians & Surgeons Group,** 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: _____

JACOB FOOT AND ANKLE ASSOCIATES

DIVISION OF NEW JERSEY PODIATRIC PHYSICIANS & SURGEONS GROUP, LLC

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Practice's *Notice of Privacy Practices*:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

_____	_____	_____
Name of Patient	**Date of Birth**	**Signature of Patient/Parent/Guardian**

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name:_____**Last four digits SSN (required):**_____
Print Name:_____**Last four digits SSN (required):**_____
Print Name:_____**Last four digits SSN (required):**_____

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home Telephone Number: _____

____ OK to leave message with detailed information
____ Leave message with call back numbers only

Written Communication Address: _____

____ OK to mail to address listed above
____ E-mail me at:_____

Work Telephone Number: _____

___ OK to leave message with detailed information
____ Leave message with call back numbers only

Fax Number: _____

____ OK to Fax at the number listed above
____ E-mail me at:_____

Other:_____

_____
Name of Patient (Printed)

_____
Signature of Patient/Parent/Guardian

_____
Witness signature

_____
Date

JACOB FOOT AND ANKLE ASSOCIATES

DIVISION OF NEW JERSEY PODIATRIC PHYSICIANS & SURGEONS GROUP, LLC

PATIENT INFORMATION FORM

(PLEASE PRINT CLEARLY)

DATE: _____ SOCIAL SECURITY #:_____

PATIENT NAME: _____DATE OF BIRTH: _____

AGE: ___ SEX: M F PRIMARY LANGUAGE: _____RACE: _____ ETHNICITY: _____

ADDRESS: _____CITY/STATE: _____ZIP: _____

HOME PHONE: (_____) _____-_____ CELL PHONE: (_____) _____-_____

EMAIL ADDRESS: _____ (WILL NOT BE SHARED)

EMPLOYER: _____WORK PHONE: (_____) _____-_____

EMERGENCY CONTACT: _____RELATIONSHIP: _____ PHONE: (_____) _____-_____

PRIMARY CARE DOCTOR: _____DATE LAST SEEN_____

PHONE: (_____) _____-_____ ADDRESS: _____CITY/STATE: _____

PHARMACY: _____LOCATION: _____PHONE: (_____) _____-_____

WHO IS RESPONSIBLE FOR PAYMENT? _____RELATIONSHIP: _____

ADDRESS: _____CITY/STATE: _____ZIP: _____

PHONE: (_____) _____-_____ WHO REFERRED YOU TO US? _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE: (_____) _____-_____

INSURED NAME: _____DATE OF BIRTH _____ EMPLOYER _____

ID # _____ GROUP # _____

SECONDARY INSURANCE COMPANY NAME: _____

ADDRESS: _____CITY/STATE: _____ ZIP: _____ PHONE: (_____) _____-_____

INSURED NAME: _____DATE OF BIRTH _____ EMPLOYER _____

ID # _____ GROUP # _____

PATIENT NAME:_____

MEDICATIONS

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

MEDICATION NAME	DOSE	HOW OFTEN DO YOU TAKE?

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ___ PACKS/DAY FOR ___ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____

☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES: TYPE 1 OR TYPE 2 ☐ CANCER ☐ HEART DISEASE

☐ HIGH BLOOD PRESSURE ☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ BLEEDING DISORDER

☐ RHEUMATOID ARTHRITIS ☐ OTHER _____

JACOB FOOT AND ANKLE ASSOCIATES

DIVISION OF NEW JERSEY PODIATRIC PHYSICIANS & SURGEONS GROUP, LLC

PATIENT NAME: _____

YOUR MEDICAL HISTORY

ALLERGIES: ☐ MEDICATIONS _____

☐ ANESTHESIA _____ ☐ FOODS _____

☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER _____

☐ NONE KNOWN

REACTION: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES: TYPE 1 OR TYPE 2 (CIRCLE)	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:								

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

_____

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN OR SYMPTOM?

☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING

☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER _____

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES

☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE

☐ RUNNING ☐ OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES ☐ NO (DESCRIBE)_____

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

PATIENT NAME:_____

E-PRESCRIBING CONSENT

E-PRESCRIBING IS DEFINED BY A PHYSICIANS ABILITY TO ELECTRONICALLY SEND AN ACCURATE, ERROR FREE, AND UNDERSTANDABLE PRESCRIPTION DIRECTLY TO YOUR PHARMACY. CONGRESS HAS DETERMINED THAT THE ABILITY TO ELECTRONICALLY SEND PRESCRIPTIONS IS AN IMPORTANT ELEMENT IN IMPROVING THE QUALITY OF PATIENT CARE. E-PRESCRIBING GREATLY REDUCES MEDICATION ERRORS AND ENHANCES PATIENT SAFETY. THE MEDICARE MODERNIZATION ACT 2003, LISTED STANDARDS THAT HAVE TO BE INCLUDED IN AN E-PRESCRIBING PROGRAM. THESE INCLUDE: (1) FORMULARY AND BENEFIT TRANSACTIONS, WHICH GIVES THE PRESCRIBER INFORMATION ABOUT WHICH DRUGS ARE COVERED BY A DRUG BENEFIT PLAN; (2) MEDICATION HISTORY TRANSACTIONS, WHICH PROVIDES THE PHYSICIAN WITH INFORMATION ABOUT MEDICATIONS THE PATIENT IS ALREADY TAKING TO MINIMIZE ADVERSE DRUG EVENTS.
I AUTHORIZE **JACOB FOOT AND ANKLE ASSOCIATES** DIVISION OF NJPPSG, TO VIEW MY EXTERNAL PRESCRIPTION HISTORY VIA ELECTRONIC E-PRESCRIBING SERVICES. I UNDERSTAND THAT PRESCRIPTION HISTORY FROM MULTIPLE, OTHER UNAFFILIATED, PROVIDERS, INSURANCE COMPANIES, PHARMACIES AND PHARMACY BENEFIT MANAGERS MAY BE VIEWABLE BY THE PROVIDERS AND STAFF OF **JACOB FOOT AND ANKLE ASSOCIATES ,** DIVISION OF NJPPSG, AND IT MAY INCLUDE PRESCRIPTIONS BACK IN TIME FOR SEVERAL YEARS AND MAY INCLUDE PRESCRIPTIONS TO TREAT HIV, SUBSTANCE ABUSE AND PSYCHIATRIC CONDITIONS. IF APPLICABLE, I UNDERSTAND THAT MY PRESCRIPTION HISTORY WILL BECOME PART OF MY RECORD AT THIS PRACTICE. UNDERSTANDING ALL OF THE ABOVE, I HERBY PROVIDE INFORMED CONSENT TO **JACOB FOOT AND ANKLE ASSOCIATES,** DIVISION OF NJPPSG, TO ENROLL ME IN THE E-PRESCRIBE PROGRAM. THIS CONSENT WILL REMAIN ENFORCED UNTIL REVOKED OR CHANGED.

_____ _____

PATIENT SIGNATURE PARENT/LEGAL GUARDIAN SIGNATURE

I CERTIFY, TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

I GIVE PERMISSION TO THE DOCTORS AT **JACOB FOOT AND ANKLE ASSOCIATES ,** A DIVISION OF NEW JERSEY PODIATRIC PHYSICIANS AND SURGEONS GROUP, LLC, TO ADMINISTER AND PERFORM ANY DIAGNOSTIC, THERAPEUTIC AND/OR OPERATIVE PROCEDURES AS MAY BE DEEMED MEDICALLY NECESSARY IN DIAGNOSIS AND/OR TREATMENT OF MY CONDITION.

PATIENT/MINORS UNDER THE AGE OF 18, WILL NOT BE TREATED WITHOUT A PARENT OR LEGAL GUARDIAN PRESENT. IF ANOTHER FAMILY MEMBER, CARE TAKER OR FRIEND, OVER THE AGE OF 18 WILL BE PRESENT; WRITTEN CONSENT FROM THE PARENT/LEGAL GUARDIAN STATING AS SUCH MUST BE PRESENTED AT THE TIME OF THE APPOINTMENT. THANK YOU.

_____ _____

PRINT NAME OF PATIENT PRINT PARENT/LEGAL GUARDIAN

_____ _____

PATIENT SIGNATURE SIGNATURE PARENT/LEGAL GUARDIAN

_____

DATE