DR. JASON BELL
ADVANTAGE FOOT & ANKLE CENTER
1 CENTURIAN DRIVE, STE. 101
NEWARK, DE 19713
PHONE: 302-994-5275 FAX: 302-994-1794

PATIENT REGISTRATION

Name: _____ Date of Birth: _____
First Initial Last

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____ SS #: _____

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

Gender: Male / Female Marital Status: Single Married Divorced Widowed Other

Emergency Contact: _____
Name Phone # Relationship

Employer _____ Occupation: _____

Primary Care Physician: _____ Phone #: _____

DOCTORS ONLY

If the patient is a minor or a dependent, please complete below:

Mother's Name: _____ SS#: _____ DOB: _____

Employer: _____ Employer's Phone # _____

Father's Name: _____ SS#: _____ DOB: _____

Employer: _____ Employer's Phone # _____

BILLING INFORMATION

Primary Insurance: _____

ID#: _____ Group #: _____

Policy Holder's Name: _____ DOB: _____ Relationship: _____

Secondary Insurance: _____

ID#: _____ Group #: _____

Policy Holder's Name: _____ DOB: _____ Relationship: _____

_____ _____
Patient's Signature (Parent or Guardian, if Minor) Date

DR. JASON BELL
ADVANTAGE FOOT & ANKLE CENTER
1 CENTURIAN DRIVE, STE. 101
NEWARK, DE 19713
PHONE: 302-994-5275 FAX: 302-994-1794

PATIENT MEDICAL HISTORY

Name: _____ DOB: _____ Sex: ____ Height: _____ Weight: _____

Chief Complaint: _____

_____

How long has it been bothering you? _____

How did this happen? _____

COMPREHENSIVE MEDICAL HISTORY:
Do you have OR have you ever been treated for any of the following?

Abnormal Bleeding	Y / N	Epilepsy	Y / N	Lung Disease	Y / N
Abnormal Healing	Y / N	Frequent Infections	Y / N	Lupus	Y / N
Anemia	Y / N	Gout	Y / N	Neurological Disease	Y / N
Arthritis	Y / N	Heart Attack	Y / N	Pacemaker	Y / N
Asthma	Y / N	Heart Murmur	Y / N	Peripheral Vascular Disease	Y / N
Auto Immune Disease	Y / N	Headaches	Y / N	Poor Circulation	Y / N
Bladder Problems	Y / N	Hepatitis, Liver Disease	Y / N	Psychiatric	Y / N
Blood Clots	Y / N	High Blood Pressure	Y / N	Rheumatoid Arthritis	Y / N
Cancer* - List Below	Y / N	High Cholesterol	Y / N	Spinal/Disc Disorder	Y / N
Cataracts	Y / N	HIV	Y / N	Stomach Ulcer	Y / N
COPD	Y / N	Intestinal Problems	Y / N	Stroke	Y / N
Diabetes - with Insulin	Y / N	Kidney Disease	Y / N	Thyroid	Y / N
Diabetes - no Insulin	Y / N	Lyme Disease	Y / N		

* Cancer: Please list any that is current or in remission: _____

_____

Other: _____

_____

PREVIOUS SURGERY:	**WHERE / WHEN:**	**DOCTOR:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____
Patient's Signature (Parent or Guardian, if Minor) Date

DR. JASON BELL
ADVANTAGE FOOT & ANKLE CENTER
1 CENTURIAN DRIVE, STE. 101
NEWARK, DE 19713
PHONE: 302-994-5275 FAX: 302-994-1794

PATIENT MEDICAL HISTORY
Page 2

Name: _____ DOB: _____

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

Novacaine / Lidocaine	Y / N	Penicillin	Y / N	Iodine or Shellfish	Y / N
Adhesive Tape	Y / N	Codeine	Y / N	Morphine / Demerol	Y / N
Latex	Y / N	Sulfa Drugs	Y / N	Aspirin / Aleve / Advil / Motrin / Ibuprofen	Y / N

NON-DRUG ALLERGIES: _____

_____

Pharmacy Name: _____ Phone #: _____

Pharmacy Address: _____
(Please Include: Street address, Shopping Center, City, State & Zip Code)

MEDICATION	DOSAGE	FREQUENCY	PRESCRIBED BY

_____
Patient's Signature (Parent or Guardian, if Minor) Date

DR. JASON BELL
ADVANTAGE FOOT & ANKLE CENTER
1 CENTURIAN DRIVE, STE. 101
NEWARK, DE 19713
PHONE: 302-994-5275 FAX: 302-994-1794

PATIENT MEDICAL HISTORY
Page 3

TOBACCO HISTORY:
Do you currently use any Tobacco products? YES or NO
Have you ever used any Tobacco products in the past? YES or NO
Please Circle the Product(s) you currently use or have used:

Cigarettes / Cigars / Pipe / Chewing Tobacco / Dipping Tobacco

How long have you used Tobacco Product(s)? _____
Daily Usage Amount: _____
Have you tried to quit using Tobacco product(s)? YES or NO

ALCOHOL HISTORY:
Do you currently drink Alcoholic beverages? YES or NO
Please Circle the type of Alcoholic beverage you drink

Beer / Wine / Hard Liquor

How often do you drink alcohol? _____

I understand that honest and complete answers to each question stated above are important to the provision of my medical care and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on the form I should ask the doctor or a member of the office staff for assistance.

_____ _____
Patient's Signature (Parent or Guardian, if Minor) Date

DR. JASON BELL
ADVANTAGE FOOT & ANKLE CENTER
1 CENTURIAN DRIVE, STE. 101
NEWARK, DE 19713
PHONE: 302-994-5275 FAX: 302-994-1794

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please call 302-994-5275 to discuss with our Billing Manager.

- As our patient, you are responsible to provide valid insurance, obtain a referral/authorization, if one is required per your insurance plan and pay your specialist copay at the time of service.

- Your Insurance policy is a contract between you and your Insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will look to you for the payment.

- All health plans are not the same and do not cover the same services. In the event, your health plan determines a service to be "not covered", or you do not have a referral/authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals, however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

- You must inform the office of all insurance changes and referral/authorizations requirements. In the event, the office is not informed, you will be responsible for any charges denied.

- There is a service fee of $35.00 for all returned checks. Your insurance company does not and will not cover this fee.

- Balances are expected to be paid timely and Advantage Foot and Ankle Center has the right to deny subsequent treatment if patient balances are not reasonably attempted to be satisfied.

WAIVER OF RESPONSIBILITY

I, _____ understand that if I do not obtain the proper referral or authorization required by my insurance company, my primary care physician, the workman's compensation carrier, my automobile insurance carrier or my personal liability insurance carrier, it will default to me and I will be financially responsible for the services performed by Dr. Jason Bell and Advantage Foot and Ankle Center.

I also understand that if I have a copay, co-insurance or deductible and had services performed by Dr. Jason Bell that I will be financially responsible to pay Dr. Jason Bell and Advantage Foot and Ankle Center.

Patient Name: _____ DOB: _____

Patient / Guardian Signature: _____ Date: _____

DR. JASON BELL
ADVANTAGE FOOT & ANKLE CENTER
1 CENTURIAN DRIVE, STE. 101
NEWARK, DE 19713
PHONE: 302-994-5275 FAX: 302-994-1794

MEDICAL RECORDS REQUESTS AND MEDICAL FORMS POLICY

Please be advised that all Medical Records Requests and Disability Forms completed by Dr. Jason Bell or the staff of Advantage Foot and Ankle Center will require 7-10 business days for completion and are subject to a fee payable by the patient and due at time of request. **NO EXCEPTIONS**. We are more than willing to provide a brief, handwritten note stating the date(s) a patient will need to be out of work or reduced activity at work due to a surgical procedure or injury.

In the event an employer or third-party disability insurance requires completion of specific forms, a $25.00 fee per document will be due. This type of documentation requires time and effort of the doctor and his staff and are not included in the reimbursement for office visits or surgical services.

Print Name_____ **Date**_____

Signature_____

DR. JASON BELL
ADVANTAGE FOOT & ANKLE CENTER
1 CENTURIAN DRIVE, STE. 101
NEWARK, DE 19713
PHONE: 302-994-5275 FAX: 302-994-1794

PRIVACY POLICY AND PATIENT CONSENT FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Advantage Foot and Ankle Center, Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction; but if we do we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Portability and Accountability Act of 1996.

The patient understands that:
Protected Health Information may be disclosed or used for treatment, payment or health care operations, including appointment reminders and messages on an answering machine or voicemail. The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice. The Practice reserved the right to change the Notice of Privacy Policies. The patient has the right to restrict the use of their information but the Practice does not have to agree to those restrictions. The patient may revoke this consent in writing at any time and all future disclosures will then cease. The Practice may condition treatment upon the execution of this consent.

May we call and leave confidential information such as treatment issues or test results or billing and payment information on an answering machine or voicemail?
PLEASE CIRCLE: YES or NO

This consent allows the Practice to disclose my information to the following people:
FAMILY MEMBERS

_____

_____

OTHER (list names)

_____

_____

PATIENT NAME _____ DATE_____

PATIENT / GUARDIAN SIGNATURE _____

DR. JASON BELL
ADVANTAGE FOOT & ANKLE CENTER
1 CENTURIAN DRIVE, STE. 101
NEWARK, DE 19713
PHONE: 302-994-5275 FAX: 302-994-1794

NOTICE OF PRIVACY PRACTICES SUMMARY

We know that medical information about you and your health is private. We do our best to protect medical information about you. The purpose of this notice is to explain to you how we protect your information and what rights you have regarding your information. You have the right to receive a Notice of Privacy that tells you in detail how we protect your rights. The actual Notice of Privacy is longer than this summary and has been offered to you in paper form if you wish to read it. It is posted in our waiting room.

We can use and give out your information to anyone who plays a role in your healthcare. This may include doctors, nurses, therapist, and many other healthcare providers. We can also give information to Medicare, Medicaid, and other insurance company, or individual who may be responsible for paying for your healthcare.

We use medical information about you to provide services. We may use your information to find ways to improve how we take care of you. Some state or federal laws require us to report certain diseases, abuse, and crimes. We may also share information to find programs or services that may benefit your health.

You have the following rights:

* To read your records and have copies made. Request to review and receive copies, should be made in writing to the Manager of Advantage Foot and Ankle Center.

* To ask for us to correct information that we have created in your medical record. This request must also be made in writing and sent to our Privacy Officer along with reason(s) that support your request.

* To know who has seen your information if we have shared it for reasons other than your healthcare and to obtain payment for services.

* To file a complaint with Advantage Foot and Ankle Center with the Manager or the Department of Health and Human Services if you believe we have not followed the law and the Notice of Privacy Practices.

I have had the opportunity to receive and review Advantage Foot and Ankle Center Notice of Privacy Practices.

Signature_____ Date_____