NUTLEY FOOT & ANKLE
DR. VINCENT COPPOLA • DR. JOSEPH CIONE

242 WASHINGTON AVENUE, SUITE A, NUTLEY, NEW JERSEY 07110

Notice of Privacy Practices Acknowledgement and Consent

I understand that, under the Health Insurance Portability & Accountability Act of 1996 "HIPAA", I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my personal restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

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Patient Information Sheet - Confidential

Date	SSN		Birthdate
Last Name	First Name		Home Phone
Address			Cell Phone
City	State	Zip Code	Email
Sex ○ M ○ F	Status (Circle One) Single / Married / Divorced / Separated / Widowed / Minor		
Employer			Business Phone
Occupation			Extension
In case of emergency, who should we contact?			Phone
Who should we thank for referring you?			

Insurance Information *** please give your health insurance card(s) to our receptionist ***

Person Responsible for Account Last Name	First Name
Policy Holder Birthdate	Relationship to Patient

Medical History: Are you currently being treated or have ever been treated for ANY of the following?

CONDITION	YES	NO	CONDITION	YES	NO
Diabetes			Arthritis		
Heart Condition			Asthma		
High Blood Pressure			Rheumatic Fever		
Bleeding Condition			Kidney Condition		
Allergies			Epilepsy		
Alcohol Use			Tobacco or Other Use		

Preferred Pharmacy: _____ Pharmacy Phone: _____

I acknowledge that the above statements are true. I hereby give my permission to Nutley Foot & Ankle, Dr. Vincent Coppola and Dr. Joseph Cione to administer treatment and to perform such procedures as may be necessary in the diagnosis and/or treatment of my foot/ankle condition.

Date:	Signature:	Relationship:

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Phone: 973-667-3412 Fax: 973-667-3524

Credit Card on File Authorization

I, _____, authorize Nutley Foot & Ankle, the office of Dr. Vincent Coppola and Dr. Joseph Cione to keep my signature on file and to charge my credit card account for balances that remain unpaid after all insurance payments have been applied.

I understand the provider is offering this as a courtesy and I may pay my balance in full at any time. I am authorizing the use of this credit card for:

Patient Name: _____

Cardholder Name: _____

Cardholder Address: _____

_____

○ American Express ○ MasterCard ○ Visa ○ Discover

Credit Card Number: _____

Expiration Date: _____ Security Code: _____

Cardholder Signature: _____

Date: _____

DIPLOMAT AMERICAN BOARD OF PODIATRIC SURGERY
FELLOW AMERICAN COLLEGE OF FOOT SURGEONS