KINETIC
FOOT AND ANKLE

Kinetic Foot and Ankle | 1030 McBride Avenue Unit #103 | Woodland Park, NJ 07424
Office Phone: (973) 638-1555 | Fax: (877) 376-3367 | www.kineticfootandankle.com

Chart#:_____

ROS Completed: _____ INFO IN CHART: _____
INS & LIS UPLOAD: _____ INTAKE UPLOAD: _____

PATIENT REGISTRATION

FIRST NAME _____ LAST NAME _____

DATE OF BIRTH _____ Male | Female AGE _____ SS #_____

MARITAL STATUS ○ Single ○ Married ○ Divorced ○ Separated ○ Widowed ○ Partner ○ Minor

ADDRESS _____

EMPLOYER _____ OCCUPATION _____

HOME # _____ CELL # _____ WORK # _____
Can we leave a message on the home and cell numbers? ○ Yes ○ No

EMAIL _____

EMERGENCY CONTACT _____ PHONE # _____

RELATIONSHIP _____ ADDRESS _____

RESPONSIBLE FOR PATIENT ACCOUNT (put n/a if same as above)

FIRST & LAST NAME _____ CELL # _____

RELATIONSHIP _____ ADDRESS_____

INSURANCE: PRIMARY INSURANCE CARRIER INFORMATION

POLICY # _____ INSURANCE CARRIER _____

EFFECTIVE DATE_____ NAME OF INSURED_____

INSURED DOB _____ RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE CARRIER INFORMATION

POLICY # _____ INSURANCE CARRIER _____

EFFECTIVE DATE_____ NAME OF INSURED_____

INSURED DOB _____ RELATIONSHIP TO PATIENT _____

VISIT INFORMATION

Reason for Visit Today_____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

PRIMARY CARE PHYSICIAN: _____DATE OF LAST VISIT TO PRIMARY CARE PHYSICIAN: _____

PHARMACY NAME: _____ PHONE # _____

DO YOU HAVE DIABETES? ○Yes ○ No

ARE YOU PREGNANT? ○Yes ○ No |If yes, ___ # OF MONTHS |IS THERE A CHANCE YOU ARE PREGNANT? ○Yes ○No

REVIEW OF SYSTEMS

(Check the following symptoms if applicable)

CONSTITUTIONAL	○ Chills ○ Weight Gain	○ Fatigue ○ Weight Loss	○ Fever	○Weakness
CARDIOVASCULAR	○ Chest Pain ○ Heart Murmur ○ Palpitations	○ Cool Extremities ○ Heart Valve ○ Rheumatic Fever	○ Cramps in Legs/Feet ○ High Blood Pressure ○ Varicose Veins	○ Hair Loss on Legs ○ Leg/Foot Ulcers ○ Vascular Grafts
MUSCULOSKELETAL	○ Ankle Sprain ○ Broken Ankle ○ Corns ○ Childhood Foot Problems ○ In-Toeing ○ Knee Pain ○ Neuroma	○ Arch Pain ○ Broken Foot Bone ○ Flat Feet ○ Gait (Walking) Problems ○ Joint Implants ○ Lower Back Pain ○ Orthotic or Shoe Insert Use	○ Arthritis ○ Bunions ○ Gout ○ Hammer or Mallet Toes ○ Joint Pain ○ Muscle Cramps ○ Paralysis	○ Back Problems ○ Calluses ○ Heel Pain ○ High Arch Feet ○ Joint Stiffness ○ Muscle Stiffness ○ Weakness ○ Toe Walking
DERMATOLOGICAL	○ Athlete's Foot ○ Hives ○ Mole Changes	○ Dryness ○ Ingrown Nails ○ Rash	○ Eczema ○ Itching ○ Scars	○ Fungal Nails ○ Lumps ○ Warts
NEUROLOGICAL	○ Blackouts ○ Neuromas ○ Stroke	○ Burning ○ Numbness ○ Tingling	○ Charcot Neuroarthropathy ○Tremors	○ Fainting ○ Speech Problems ○ Unsteady Gait (Walking)
ENDOCRINE	○ Fatigue ○ Weight Loss	○ Goiter ○ Weight Gain	○ Thirst	○ Thyroid
HEMATOLOGIC/ LYMPHATIC	○ Anemia ○ Recent Chemotherapy	○ Bleed Easily ○ Slow Healing Clots	○ Blood Clots ○ Swollen Glands	○ Easy Bruisability ○ Transfusion Reaction
ALLERGIC/ IMMUNOLOGIC	○ Hives ○ Sneezing ○ Wheezing	○ Itchy Nose ○ Stuffy Nose	○Itchy Eyes ○Swelling	○ Runny Nose ○ Watery Eyes

ALLERGIES: (Please also note any reactions if exposed)

MEDICATION HISTORY: (Please include dosages)

Do you consent to request previous prescription history from the pharmacy database? ○ **YES** ○ **NO**

Check if applicable

FAMILY HISTORY	○ Anemia ○ Back Problem ○ COPD ○ Dermatitis ○ Glaucoma ○ Hepatitis ○ Kidney Problems ○ Stroke	○ Anxiety ○ Breast Cancer ○ Dementia ○ Diabetes ○ Gout ○ High Blood Pressure ○ Migraines ○ Thyroid Disease	○ Arthritis ○ Cancer ○ Depression ○ Epilepsy ○ Headache ○ HIV ○ Pneumonia ○ Tuberculosis	○ Asthma ○ Congestive Heart Failure ○ GERD ○ Heart Attack ○ Hypercholesterolemia ○ Prostate Issues ○ Stomach Ulcers
MEDICAL HISTORY	○ Amputation ○ Anemia ○ BPH ○ Congestive Heart Failure ○ Dementia ○ Epilepsy ○ HIV ○ Myocardial Infarction ○ Stroke	○ Anxiety ○ Back Problem ○ COPD ○ Depression ○ GERD ○ Headache ○ Migraine ○ Tuberculosis	○ Arthritis ○ Breast Cancer ○ Cancer ○ Dermatitis ○ Glaucoma ○ Hepatitis ○ Pneumonia ○ Thyroid Disease	○ Asthma ○ CAD ○ High Cholesterol ○ Diabetes ○ Gout ○ Hypertension ○ Kidney Stone ○ Ulcer (GI)

List any additional ***family*** history: _____

List any additional ***medical*** history: _____

IMMUNIZATIONS

Check which immunizations you have received: ○ MEASLES ○ MUMPS ○ TETANUS ○ POLIO ○ INFLUENZA

○ TYPHOID ○ CHICKEN POX ○ TUBERCULOSIS ○ PNEUMONIA ○ OTHER _____

SOCIAL HISTORY

CIGARETTES Date Last Used _____ Daily Usage _____ Years Smoking _____ Cessation Attempts _____ Packaging _____	**CIGARS** Date Last Used _____ Daily Usage _____ Years Smoking _____ Cessation Attempts _____ Packaging _____	**PIPES** Date Last Used _____ Daily Usage _____ Years Smoking _____ Cessation Attempts _____ Packaging _____
CHEWING TOBACCO Date Last Used _____ Daily Usage _____ Years Smoking _____ Cessation Attempts _____ Packaging _____	**DIPPING TOBACCO** Date Last Used _____ Daily Usage _____ Years Smoking _____ Cessation Attempts _____ Packaging _____	
BEER ○ Social ○ Occasional ○ Light ○ Heavy	**WINE** ○ Social ○ Occasional ○ Light ○ Heavy	**HARD LIQUOR** ○ Social ○ Occasional ○ Light ○ Heavy

Social Use: < 3 standard drinks during a social, holiday, or special event. **Occasional Use**: ≤ 3 standard drinks per week. **Light Use:** 4-7 standard drinks per week, heavy use is defined as: ≥ 7 standard drinks per week.

List any recreational drug use: _____

SURGICAL HISTORY				
	○ AAA Repair ○ Breast Reduction ○ Cesarean Section ○ ESWL ○ Gastric Banding ○ Hip Surgery ○ Knee Surgery ○ Oophorectomy Unilateral ○ Prior Surgeries ○ Shoulder Surgery ○ Thyroidectomy	○ Aortic Aneurysm ○ CABG ○ Cholecystectomy ○ Ectopic Pregnancy ○ Heart Valve ○ Hysterectomy ○ LS Spine Surgery ○ PTCA ○ Prostate Biopsy ○ Sinusectomy (Nasal) ○ Tonsillectomy	○ Appendectomy ○ Carotid Endarterectomy ○ Colectomy ○ Fracture Repair ○ Hernia Abdominal ○ Intestinal By-Pass ○ Lasik ○ PVD Procedure ○ Prostatectomy Retro ○ Splenectomy ○ Tubal Ligation	○ Breast Augmentation ○ Cataract Extract ○ Duodenal Ulcer Repair ○ Gallbladder Surgery ○ Hip Fracture ○ Knee Arthroscopy ○ Mastectomy ○ Pacemaker ○ Shoulder Arthroscopy ○ TURP ○ Vasectomy

List any additional surgical history: _____

VITALS

Height: _____ Weight: _____ Shoe size:_____

If you are a diabetic, please complete the following: Blood pressure (most recent/date): _____

HbA1C% (most recent/date): _____ Fasting Blood sugar (most recent/date): _____

WORKMAN'S COMP | AUTO ACCIDENT

Is your visit due to a job related injury or due to an auto accident? ○ YES ○ NO Date of Injury : _____

Type of Injury: ○ WORK ○ AUTO ○ OTHER Has a claim been filed? ○ YES ○ NO Claim Number: _____

Where was the claim filed? _____ Cause of Injury: _____

Attorney: _____ Contact Phone Number : _____

FINANCIAL POLICY FOR KINETIC FOOT AND ANKLE LLC

Thank you for choosing Kinetic Foot and Ankle LLC. Our goal is to keep our patients informed about our billing policies.

1. Your insurance policy is a contract that exists between you and your insurance company. Our relationship is with you, the patient, and not the insurance company. It is the patient's responsibility to know the specifics of the policy (referral requirements, in and out of network physicians and facilities, Tier 1/Tiers 2, etc.). *If you have questions about your policy, please call the phone number provided on the back of your insurance card.*
2. We are happy to help you understand your insurance benefits but encourage you to call your insurance for clarification. We are not responsible for incorrect information received which results in unexpected, out of pocket expenses. Cost and/or payment by your insurance company cannot be guaranteed by our staff. Regardless of your insurance plan, you are financially responsible for payment for services rendered by Kinetic Foot and Ankle LLC.
3. If your insurance plan requires a referral, you are responsible for providing Kinetic Foot and Ankle LLC the referral at the time of your appointment. It is the responsibility of the patient to provide Kinetic Foot and Ankle LLC with a new referral if the previous referral expired and keep track of the number of visits allowed. Failure to obtain a referral will shift the payment to you the patient and not the insurance carrier.
4. All patients are required to leave a credit card on file. Please see the next page, "Credit Card on File Agreement" for specifics.
5. All copayments and deductibles must be paid at the time of service. If your annual out of pocket expenses have not been met, you will be required to pay a $125 deposit at the time of your visit and keep a credit card on file (see last page for credit card agreement). The deposit will be applied to your account and a statement will be sent reflecting any additional monies owed following response from your insurance carrier. If it has been stated by your carrier that a deductible deposit cannot be collected at the time of service, a valid credit card will be required and stored securely. Upon claim response, your credit card will be charged and a detailed statement will be provided along with a paid receipt.
6. If you are unable to pay the full amount and a payment plan is agreed upon, a credit card must be kept on file. The card will be charged in the event that you fail to make timely payments as agreed upon in the payment plan.
7. You are responsible to inform us of all insurances in effect and of any changes**.** Failure to do so will result in the patient being responsible for the cost of services rendered. When multiple policies exist, it is the patient's responsibility to inform us which policy is the primary plan.
8. If you do not have insurance, have a non-participating plan, or are receiving services that are not covered by your plan, payment is required at the time of service.
9. If you miss or cancel an appointment less than 24 hours of the appointment time, the patient may be assessed and will be responsible for a $30 fee. A $30 fee will be assessed on all returned checks.
10. If balances are not received within 30 days from the postmark date of a mailed statement, a$12 rebilling fee will be added to each additional statement sent due to the unpaid balance. Past due accounts of more than ninety days will be turned over to our collection agency. A $35 administrative fee will be added.
11. We reserve the right to require collection of outstanding balances before your next appointment.
12. We reserve the right to charge a $15 fee for completion of disability forms/other requested documentation.

Assignment of Benefits

I, _____, (or my dependent) hereby authorize Kinetic Foot and Ankle LLC to administer such procedures and treatment as deemed necessary in the diagnosis and treatment of my feet, ankles and lower legs. I authorize Kinetic Foot and Ankle LLC to bill my insurance company on my behalf for medical services and or supplies rendered by the practice. I certify that the insurance information and medical information that I have reported is accurate and authorize the release of all necessary medical and insurance information for myself and any and all dependents for any and all claims to my insurance company or Medicare. I request that payment of authorized Medicare/Insurance company benefits be made to Kinetic Foot and Ankle LLC for any services rendered.

By signing below, I acknowledge that I have read, understand and agree to comply with Kinetic Foot and Ankle's LLC Financial Policy and all statements above.

_____	_____	_____	_____
Patient's Name	Date of Birth	Patient's Signature	Today's Date

If under 18, Parent's Name _____ Parent's Signature_____

CREDIT CARD ON FILE AGREEMENT

Leaving your credit card on file is NOT optional.

PATIENT'S NAME: _____ DOB: ____/____/_____

Kinetic Foot and Ankle LLC has implemented a new billing policy. We will securely save a credit/debit card on file for any balance due. Once the insurance benefits are applied, a statement will be mailed out to the patient. You have thirty (30) days to pay your balance.

The credit/debit card will ONLY be charged if, after thirty (30) days of the statement date, a balance remains. IF YOU PAY YOUR BILL WITHIN THIRTY (30) DAYS, YOUR CREDIT CARD ON FILE WILL NEVER BE CHARGED.

If you need a payment plan, please contact our office before your bill is due and we will be more than happy to set one up.

The credit/debit card information will be stored securely and can not be viewed once entered into our system. The credit card can not be viewed by employees, management, or our software company.

I agree to keep my credit card information saved on file with Kinetic Foot and Ankle LLC. As stated above, my credit/debit card will be charged only if my balance is not paid within thirty (30) days of the statement date. After the credit/debit card is charged, a receipt will be mailed to the patient.

Last 4 Digits of Credit Card Number: _ _ _ _

(Write the last four digits THEN…provide credit card to front desk to securely save it)

Cardholder Signature: _____ Date: ____/____/_____

PAD Patient Intake Questionnaire

Answers to the following questions will help determine if you are at risk for Peripheral Arterial Disease (PAD) and if a vascular examination can help better assess your vascular health status.

1	Do you experience any pain in your legs or feet while at rest?	Yes No
2	Do you have uncomfortable aching, fatigue, tingling, cramping or pain in your feet, calves, buttocks, hip or thigh during walking/exercise?	Yes No
3	If yes to Question 2, does the pain go away when you stop walking/ exercising?	Yes No
4	Do your feet get pale, discolored or bluish at any time during the day?	Yes No
5	Do you have an infection, skin wound or ulcer on your leg or foot that is slow to heal over the past 8-12 weeks?	Yes No
6	Are you over the age of 65	Yes No
7	Are you over the age of 50	Yes No
8	Do you have high cholesterol or other blood lipid (fat) problems or require cholesterol medication?	Yes No
9	Do you have high blood pressure or take medication to reduce blood pressure?	Yes No
10	Do you have diabetes?	Yes No
11	Do you have a history of chronic kidney disease?	Yes No
12	Do you currently or have you ever smoked?	Yes No
13	Do you have a history of stroke or mini-stroke (TIA)?	Yes No
14	Do you have a history of heart disease (heart attack, MI)?	Yes No
15	Do you have a history of carotid stenosis, AA (abdominal aortic aneurysm), and/ or stent placement?	Yes No

Acknowledgment of Receipt of Notice of Privacy Practices

Patient Name: _____ Date of Birth: _____

I have been given a copy of Kinetic Foot and Ankle, LLC *Notice of Privacy Practices ("Notice")*, which describes how my health information is used and shared. I understand that the Practice has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Practice Privacy Officer.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

_____ _____
Signature of Patient or Personal Representative *Date*

_____
Print Name

_____
Personal Representative's Title (e.g., Guardian, Health Care Power of Attorney)

For Facility Use Only: Complete this section if you are unable to obtain a signature.

If the patient or personal representative is unable or unwilling to sign this *Acknowledgment*, or the *Acknowledgment* is not signed for any other reason, state the reason:

_____

_____

Completed by:

_____ _____
Signature of Practice Representative *Date*

_____
Print Name and Title

File Original in Patient's Health Care Record

Electronic Communications Consent Form

Patient Name: _____ Date of Birth: _____

You may request that your personal health information be transmitted by alternate means, such as unsecure text messages, email, or third-party health application or software (app); however, we would like you to be aware of the risks involved with sending personal health information in this way. Kinetic Foot and Ankle, LLC will take appropriate precautions when transmitting electronically to avoid unintentional disclosures, such as verifying your contact information (email address, text number, etc.) for accuracy. If the Practice determines that your request may cause harm to our internal systems, it may be denied. The Practice is not liable for improper disclosure of confidential information that is not caused by our intentional misconduct.

The Risks of Using Electronic Communications

Transmitting patient information electronically can be risky. Please consider the following possibilities before agreeing to communicate with us in this way, or requesting that your health information be transmitted in an unsecure manner. For example, messages and health information can be intercepted, viewed, circulated, altered, forwarded, stored or used without authorization or detection. In addition, electronic communications may be misaddressed, read by employers and online service providers, easily falsified, retained after deletion, used to introduce viruses, or used as evidence in court.

Still Want To Use Electronic Communications?

If you want to use email, texting, etc. to communicate with us, we have some final instructions:

- We cannot guarantee your communications will be read promptly, so please do not use these methods for urgent matters.
- Be sure to follow-up with us by phone if you are expecting a return response from us and do not receive one within 2 business days.
- Please notify us promptly if your contact information has changed.
- Be aware that most electronic communications from patients become a part of their health record.
- Do not use these methods to share sensitive medical information, such as communications about AIDS/HIV or mental health conditions, sexually transmitted diseases or substance abuse.

I understand the risks associated with electronic communications of personal health information, and give my consent for the practice to communicate with me or transmit my health information through the following methods. If I have any questions, I will contact the Practice Privacy Officer.

___ Text Messaging, using this phone number: _____

___ Email, using this email address: _____

___ Other (such as a third-party health app): _____

Patient Signature: _____ *Print Name:* _____

Personal Representative: _____ *Print Name:* _____

Date: _____

Distribution of Copies: Original to Patient's Health Care Record, Copy to Patient.

HIPAA
Notice of Privacy Practices

Kinetic Foot and Ankle, LLC; 1030 McBride Ave., Unit 103; Woodland Park, NJ 07424
Phone: 973-638-1555 ~ www.kineticfootandankle.com
Effective Date: April 14, 2003 | Revised Date: October 27, 2020

Your Information. Your Rights. Our Responsibilities.

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. ***Please review it carefully.***

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

1. Ask for an electronic or paper copy of your health record
- You can ask to see or get an electronic or paper copy of your health record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

2. Ask us to correct your health record
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

3. Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

4. Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

5. Get a list of those with whom we've shared information
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

6. Get a copy of this Privacy Notice

You can ask for a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. We will provide you with a paper copy promptly.

7. Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

8. File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information at the end of this document.
- You can file a complaint with the U.S. Dept. of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C., 20201; calling 800-368-1019 (TDD: 1-800-537-7697); or visiting: hhs.gov/hipaa/filing-a-complaint/index.html.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

1. In the situations below, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

2. In the situations below, we never share your information unless you give us written permission:
- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

3. In the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

We typically use or share your health information in the following ways:

1. Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

2. Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

3. Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

1. We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

2. Do research

We can use or share your information for health research.

3. Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

4. We can share health information about you with organ procurement organizations.

5. We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

6. Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

7. We can share health information about you in response to a subpoena, or in response to a court or administrative order.

NEW JERSEY PRIVACY AND CONFIDENTIALITY LAW

Except as required by law, we will not share any HIV-related, genetic, mental health, cancer-related or substance abuse information without your written permission.

OUR RESPONSIBILITIES

1. We are required by law to maintain the privacy and security of your protected health information.
2. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
3. We must follow the duties and privacy practices described in this Notice and give you a copy of it.
4. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of this Notice

We can change the terms of this Notice, and the changes will apply to all information we have about you. The new Notice will be available upon request, in our office, and on our website.

Complaints: If you believe your privacy rights have been violated contact our Privacy Officer at: **Phone: 973-638-1555**

CREDIT CARD ON FILE FREQUENTLY ASKED QUESTIONS

WHY DO I NEED TO LEAVE MY CREDIT CARD ON FILE?

To be able to provide excellent patient care and for the practice to run efficiently, we must be paid for the services provided. It is a violation of our Financial Policy if you do not leave your credit card and we have the right to refuse medical treatment.

WHO CAN SEE MY CREDIT CARD NUMBER WHEN IT'S IN YOUR COMPUTER?

The only part we can view is the last 4 digits of the card. We don't ask you to write down the number. Instead, we will swipe the card in our system, charge it one dollar (refund it the same day), and it is secruley saved.

WHAT ABOUT MANAGEMENT OR THE CREDIT CARD COMPANY...CAN THEY VIEW IT?

No, staff and management can only see the last four digits as well as the credit card company we use, called TSYS.

WHAT IF I WANT TO PAY MY BILL WITH A DIFFERENT CARD WHEN I GET THE BILL?

You are welcome to pay by cash, check, or a different credit card. Just submit your payment via mail or call us **before the due date** and your card on file will not be charged.

WHAT IF I CAN'T AFFORD TO PAY MY BILL BY THE DUE DATE?

We have payment plans available. Call us **before the due date** on your bill and we will set up a payment plan.

WILL I KNOW IF MY CREDIT CARD IS BEING CHARGED?

If a balance remains after the thirty (30) days, the credit card will be charged. A receipt will then be sent to the address on file showing that your bill was paid.

REMEMBER...THE ONLY TIME YOUR CREDIT CARD WILL BE CHARGED IS IF YOU FAIL TO PAY THE BILL YOU RECEIVED IN THE MAIL BY THE DUE DATE.