KAYAL ORTHOPAEDIC CENTER, P.C.

Orthopaedic Surgeons
Robert A. Kayal, MD, FAAOS
Board-Certified Orthopaedic Surgeon
Founder, President & CEO
Edward C. Friedland, MD, FAAOS
Board-Certified Orthopaedic Surgeon
E. Jeffrey Pope, MD, FAAOS
Board-Certified Orthopaedic Surgeon
Joseph M. Bellapianta, MD, FAAOS
Board-Certified Orthopaedic Surgeon
Daphne E. Pinkas, MD
Board-Eligible Orthopaedic Surgeon

Foot & Ankle Surgeon
Chad W. Rappaport, DPM, FACFAS
Board-Certified Foot & Ankle Surgeon

Podiatrist
Theresa Ronna, DPM
Board-Certified Podiatrist

Physician Assistants
Michael G. Kayal, PA-C
Chief Physician Assistant
Dean P. Mellas, PA-C
Jillian M. Dilonno, PA-C
James J. Verardi, PA-C
Roya Salimi, PA-C, CNMT

WELCOME TO KAYAL ORTHOPAEDIC CENTER, P.C.

PATIENT'S NAME:		TODAY'S DATE:	

E-MAIL ADDRESS:	
PATIENT'S DATE OF BIRTH:	

BRIEFLY DESCRIBE THE REASON FOR TODAY'S VISIT	

DATE OF ONSET OR INJURY:	
IS TODAY'S VISIT RELATED TO A WORK OR OCCUPATION INJURY?	YES NO AUTHORIZATION #:
IS TODAY'S VISIT RELATED TO A MOTOR VEHICLE ACCIDENT?	YES NO AUTHORIZATION #:
IF SO, HAS THIS INJURY ALREADY BEEN REPORTED?	YES NO

AN IMPORTANT MESSAGE TO OUR PATIENTS ABOUT YOUR INSURANCE COVERAGE

In the past few years, the number of different health insurance programs has increased at an amazing rate. Even within one company, there may be several programs with different benefits and requirements. There is absolutely NO WAY that we can possibly know or keep up to date with each program's provisions. Some programs require that you utilize a specific facility. Some require pre-authorization for services, while others do not. Some require a signed referral from your primary care physician prior to any consultations with a specialist. Finally, some programs may require a second opinion. It is your responsibility to know and advise us of your program's requirements in advance each and every time that we provide a service. We will do our best to comply with any requirements that you may have. Please understand that if we provide a service that is outside of your program, you will be responsible for the appropriate fees. These are NOT our regulations. They are your insurance company's rules, and unless you follow them carefully, your insurance company may decline all or part of your claim. Your insurance carrier should have provided you with a phone number to be used if you have any questions concerning your coverage. With respect to bill collections, please understand that unless other written arrangements are made with Kayal Orthopaedic Center, P.C., I agree to pay your final bill within 30 days of receipt. If I do not pay what I owe, I understand that I will be in default and the Kayal Orthopaedic Center, P.C. may retain an attorney to collect the balance due to it. If the Kayal Orthopaedic Center, P.C. retains an attorney who is not a salaried employee, I agree to pay the Kayal Orthopaedic Center, P.C.'s reasonable attorney fees upon placement of the claim with the law firm.

SIGNATURE OF PATIENT OR GUARANTOR OF PAYMENT:

x _____

PLEASE NOTIFY THE STAFF OF ANY CHANGES IN YOUR ADDRESS OR INSURANCE INFORMATION

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PATIENT HISTORY

NAME:		TODAY'S DATE:	

AGE:		HEIGHT:		WEIGHT:	

PAST MEDICAL HISTORY:	

PRIMARY CARE PHYSICIAN:		PHONE:	
PHARMACY NAME:		PHONE:	
PHARMACY ADDRESS:			

CURRENT MEDICATIONS

DRUG	DOSAGE	FREQUENCY

ALLERGIES (DRUG, FOOD, METALS, ETC.)

E.g. Ibuprofen, Penicillin, Shell Fish, Peanuts, Milk, Eggs, Wheat, Soy, Silver, Nickle, Latex, Chemicals in Shampoo or Cosmetics, Sun, Seasonal, Pets

ALLERGY TYPE	SIDE EFFECT / ADVERSE REACTION

☐ ***Check here if you have ever had a skin reaction while wearing jewelry including body piercings.*** ***What type of metal jewelry:*** _____

784 Franklin Avenue, Suite 250
Franklin Lakes, NJ 07417
P: 201.560.0711 • F: 201.560.0712

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Glen Rock, NJ 07452
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SURGICAL HISTORY

SURGERY	DATE	DOCTOR & HOSPITAL

SOCIAL HISTORY

MARITAL STATUS (CIRCLE)	SEX & AGES OF CHILDREN (IF ANY)	TOBACCO USAGE IF ANY & FREQUENCY	ALCOHOL USAGE IF ANY & FREQUENCY	ILLICIT DRUG USAGE IF ANY & FREQUENCY	SEXUALLY TRANSMITTED DISEASES (CIRCLE)
SINGLE MARRIED DIVORCED WIDOWED					HEPATITIS C? HIV?

PERTINENT FAMILY MEDICAL HISTORY
(i.e. CANCER, HEART DISEASE, DIABETES, ARTHRITIS, ETC.)

MOTHER	FATHER	SIBLINGS	CHILDREN	OTHER

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF KAYAL ORTHOPAEDIC CENTER, P.C.'S NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I, _____, acknowledge receipt of KAYAL ORTHOPAEDIC CENTER, P.C.'S (the "Provider") Notice of Privacy Practices dated February 16, 2006 and I consent to the Provider's use and disclosure of my health information and insurance/payment information which specifically identifies me or which can reasonably be used to identify me for treatment, payment and healthy care operations of the Provider and in accordance with the Notice of the Provider's Privacy Practices. I understand that while this consent is voluntary, if I refuse to sign this consent, the Provider can refuse to treat me.

I also consent to the restrictions contained in the Notice of Privacy Practices regarding all worker's compensation information. I understand that such information will not be disclosed to me without the written authorization of the applicable worker's compensation carrier/payor. In the event that such worker's compensation carrier/payor refuses to release any or all of such records, I hold the Practice and all of its shareholders, physicians, employees and agents harmless in connection with such refusal.

I understand that I have the right to request that the Provider restrict how my health and insurance/payment information is used or disclosed to carry out treatment, payment or healthcare operations.

I understand that I may revoke this consent at any time by notifying the Provider in writing, but if I revoke my consent, such revocation will not affect any actions that the Provider took before receiving my revocation.

_____

Signature of patient or patient's representative Date

_____

Printed name of patient or patient's representative

_____

Relationship to patient

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ASSIGNMENT OF BENEFITS FORM

Name of Insured (print): _____

Social Security Number: _____

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to the organization listed below for any equipment or services provided to me by the organization. I expressly assign all my rights in and to such insurance benefits directly to KAYAL ORTHOPAEDIC CENTER, P.C., and authorize KAYAL ORTHOPAEDIC CENTER, P.C. to endorse any and all drafts on my behalf, issued pursuant to this assignment, for the benefit of KAYAL ORTHOPAEDIC CENTER, P.C.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original authorization will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for product received.

In certain circumstances, insurance company may send check for services provided directly to the patient or the guarantor. In such cases, the patient and the guarantor agrees to endorse and forward such a check to KAYAL ORTHOPAEDIC CENTER, P.C. If the patient deposits such a check into a personal account, the patient and guarantor agrees to immediately send a check for the equivalent amount to KAYAL ORTHOPAEDIC CENTER, P.C.

KAYAL ORTHOPAEDIC CENTER, P.C.
784 Franklin Avenue, Suite 250
Franklin Lakes, NJ 07417

Name of person signing below (print): _____

Relationship to insured: _____

Signature of Insured or Parent/Guardian: _____

Date: _____

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IMPORTANT MESSAGE TO OUR PATIENTS

Recently some insurance companies decided to institute a policy that reimburses patients for services rendered by their physicians. In turn, the physician provider is then expected to bill and pursue the patient for the provided service. As such, in effort to avoid confusion and improper patient billing, if your insurance company reimburses you for services provided by the KAYAL ORTHOPAEDIC CENTER, PC, we ask that you simply:

- BRING IN ALL PAGES OF THE EXPLANATION OF BENEFITS MAILED TO YOU, ALONG WITH THE ATTACHED CHECK.
- ENDORSE THE CHECK AND BRING IT INTO OUR OFFICE. PLEASE DO NOT CASH THE CHECK AND THEN REIMBURSE THE KAYAL ORTHOPAEDIC CENTER, PC WITH A PERSONAL CHECK.
- CALL OUR BILLING DEPARTMENT IF YOU HAVE ANY QUESTIONS CONCERNING CHECKS THAT YOU MAY RECEIVE FROM YOUR INSURANCE COMPANY!

Failure to comply with this request will make you responsible for the full amount billed.

We are working in earnest to make this an easy process for both you and our billing staff. We truly appreciate your assistance in this important matter. Should you have any questions of concerns, please do not hesitate to contact me at the office.

Thank you for your cooperation in this matter.

Sincerely yours,

Billing Department

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