IN STEP Foot and Ankle Specialists, LLC

Dr. Thomas Cusumano
59-A Kinderkamack Road Westwood, NJ 0767 201-666-4166
26-06 Broadway Fair Lawn, NJ 07410 201-794-8200 Fax 201- 794-8201

PATIENT INFORMATION SHEET

SEX: [ ] Male [ ]Female

First Name:_____M.I._____Last Name:_____

Address:_____Home Phone: ( )_____
Cell Phone: ( )_____

City:_____Work Phone: ( )_____

State:_____Zip:_____E-mail:_____

Age:_____Birth Date: ____/____/_____ Social Security# _____-_____-_____Marital Status:_____

Occupation_____Employer _____

Employer Address_____

Student info: School_____Coach_____

Sports & Hobbies: _____

Referred by:_____Family Doctor_____
Town: _____

Medical Insurance:_____Pharmacy _____
Town _____
Phone _____

	yes	No	?		yes	No	?	Allergies	Yes	No	?
Foot or leg injuries	[ ]	[ ]	[ ]	Diabeties	[ ]	[ ]	[ ]	Novocaine	[ ]	[ ]	[ ]
Foot or leg surgery	[ ]	[ ]	[ ]	Heart trouble	[ ]	[ ]	[ ]	Penicillin	[ ]	[ ]	[ ]
Foot or leg numbness	[ ]	[ ]	[ ]	Epilepsy / Seizures	[ ]	[ ]	[ ]	Adhesive tape	[ ]	[ ]	[ ]
Foot or leg cramps	[ ]	[ ]	[ ]	Liver Disease	[ ]	[ ]	[ ]	Drugs	[ ]	[ ]	[ ]
Knee pain	[ ]	[ ]	[ ]	Kidney disease	[ ]	[ ]	[ ]	Foods	[ ]	[ ]	[ ]
Unequal leg length	[ ]	[ ]	[ ]	Rheumatic fever	[ ]	[ ]	[ ]	Contrast dye	[ ]	[ ]	[ ]
Weak ankles	[ ]	[ ]	[ ]	High blood pressure	[ ]	[ ]	[ ]	Iodine	[ ]	[ ]	[ ]
Bunions	[ ]	[ ]	[ ]	Polio	[ ]	[ ]	[ ]	Other_____			
Skin problems	[ ]	[ ]	[ ]	Bursitis	[ ]	[ ]	[ ]	_____			
Toe nail problems	[ ]	[ ]	[ ]	Stomach ulcers	[ ]	[ ]	[ ]	_____			
Lower back pain	[ ]	[ ]	[ ]	Asthma	[ ]	[ ]	[ ]]				

My chief complaint is:_____

_____

_____

I hereby give permission to, Thomas J. Cusumano, D.P.M. and /or Associates for examinations and rendering care for my problem and / or related conditions.

Date_____ Patient Signature (if minor, parents)_____
Parents Name(s)_____

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First Name:_____M.I._____Last Name:_____

Birth Date: _____

Medical History

Date _____

MEDICAL HISTORY	Yes	No	Do not know
Anxiety			
Arthritis			
Asthma			
Cancer			
C H F- Heart Failure			
Diabetes Insulin			
Diabetes Non-Insulin			
GI Ulcers			
GI Reflux			
Heart Attack / MI			
Heart Disease			
High Blood Pressure			
Low Blood Pressure			
High Cholesterol			
Hyperthyroid			
Hypothyroid			
Kidney Disease			
Liver Disease			
Murmur			
Vascular Disease			
COVID -19			

Height_____

Weight_____

Shoe size_____

Month/ Year

Flu Vaccine:_____

Covid 19 Vaccine : _____

Colonoscopy _____

SOCIAL HISTORY	No	Yes	Years	Quit
Tobacco				
Alcohol				
Marijuana				
Vaping				
Drugs				

FAMILY HISTORY

[ ] Diabetes

[ ] Heart Disease

[ ] High Blood Pressure

Other_____

MEDICATIONS { } none ....

1

2

3

4

5

6

7

8

9

10

11

Sheet attached yes no

ALLERGIES { } None

1

2

3

Surgery: (included date)

Vascular Surgery

Heart Surgery

Joint Replacement

Back Surgery

Colonoscopy

Foot & Ankle

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24-HOUR CANCELLATION
AND
"NO SHOW" FEE POLICY

Each time a patient misses an appointment without providing proper advanced notice (24 hour prior to the appointment), another patient is prevented from receiving care. Therefore, our office reserves the right to charges a fee of $45.00 for all missed appointments and "no show visits" that are not canceled within a 24-hours of the scheduled appointment.

This fee will be billed to the patient and is not covered by insurance and must be paid prior to next appointment. Multiple cancelations or no-show visits in a 12-month period may result in termination from our practice.

Thank you for understanding and your cooperation as we strive to best serve the needs of all our patient's.

By signing below, you indicate you are aware and understanding the policy.

Patient Signature_____ Date; _____

Print Name _____

DR. THOMAS J. CUSUMANO IN STEP Foot and Ankle Specialists, LLC

59A Kinderkamack Road Westwood, NJ 07675 201-666-4166
26-06 24-19 Broadway Fair Lawn, NJ 07410 201-794-8200; Fax 201-794-8201

WELCOME TO OUR OFFICE

PATIENT INFORMATION:
SEX: [ ] MALE [ ] FEMALE]

Marital status:
[ ] single [ ] married [ ] divorced [ ] widow

BIRTH DATE: _____/_____/_____

SOCIAL SECURITY# _____-_____-_____

FIRST NAME: M.I.

LAST NAME :

ADDRESS:

CITY:

STATE: ZIP:

HOME PHONE: ( )

WORK PHONE: ( )

EMAIL :

INSURED'S INFORMATION [ ] Same as Patient
SEX: [ ] MALE [ ] FEMALE

Your Relationship to patient:
[ ] Self [ ] mother [ ] father [ ] spouse [ ]Other _____

BIRTH DATE: _____/_____/_____

SOCIAL SECURITY# _____-_____-_____

FIRST NAME: M.I.

LAST NAME :

ADDRESS:

CITY:

STATE: ZIP:

HOME PHONE: ( )

WORK PHONE: ( )

Ethnicity [ ] Not Hispanic or Latino [ ] Hispanic or Latino [ ] Decline to specify
Race [ ] White [ ] Black or African American [ ]Asian [ ]Hawaiian or Pacific Islander
[ ]American Indian/ Alaskan [ ] Decline to specify

IS THIS TREATMENT RELATED TO

[ ]WORKMEN'S COMP **[ ] MVA (Car Accident Injury)**

Date of Injury _____/____/_____ Place of Injury_____

IN CASE OF EMERGENCY call _____ ( )_____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME:_____

IDENTIFICATION #_____ Group #_____

ADDRESS (if known)_____

SECONDARY INSURANCE NAME:_____

IDENTIFICATION #_____ Group #_____

ADDRESS (if known)_____

AUTHORIZATION / RESPONSIBILITY AGREEMENT;

I HEREBY AUTHORIZE MY INSURANCE COMPANY TO PAY THE PROCEEDS OF ANY BENEFITS TO DR. THOMAS J. CUSUMANO, AND / OR ASSOCIATES AND WILL BE RESPONSIBLE FOR OUTSTANDING BALANCES. A COPY OF THIS FORM CAN BE CONSIDERED AS AN ORIGINAL FOR INSURANCE PURPOSES.

I HEREBY AGREE TO PAY MY ACCOUNT AS SERVICES ARE PROVIDED. HOWEVER, IF I AM NOW OR IN THE FUTURE BECOME A MEMBER OF A HMO OR MANAGED CARE PLAN I ASSUME THE RESPONSIBILITY AS THE INSURED AND WILL PROVIDE PROPER AUTHORIZATION OR REFERRALS FOR THIS AND UPCOMING VISITS BEFORE MEDICAL CARE IS RENDERED. IF PROPER AUTHORIZATION OR REFERRALS ARE NOT OBTAINED, I AGREE TO PAY ANY OUTSTANDING BALANCE DIRECTLY TO THIS OFFICE.

UNDER CERTAIN CIRCUMSTANCES, I MAY HAVE ARRANGED FOR THE DOCTOR TO BILL MY INSURANCE COMPANY ON MY BEHALF; I CLEARLY UNDERSTAND THAT THE BILL IS STILL MY RESPONSIBILITY AND I WILL MAKE SURE THE BILL IS PAID IN A REASONABLE TIME FRAME (45 DAYS). IF FOR ANY REASON ANY PORTION OF MY BILL IS NOT PAID BY MY INSURANCE, I AGREE TO PAY PROMPTLY.

SIGNED_____DATE:_____

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ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I may request a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____
Patient Name (please print) Date

X_____
Signature of Patient

SIGNATURE OF FILE

_____ _____
Patient's Name (print) Insured/Medicare Number

I request that payment of authorized insurance and medicare benefits be made either for me or on my behalf to Thomas J. Cusumano, D.P.M and or associates for any services furnished to me by him and or associates. I authorize any holder of medical information concerning me to release to my Insurance carrier or the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits to related services.

X_____ _____
Signature of Patient Date

Yearly renewal of signature on file as described above

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient Date

Saved as privacy act letter 10-07

PATIENT FINANCIAL AGREEMENT

Understanding our financial policies is an important part of your overall experience with our office and staff. Feel free to ask any questions you may have about this financial agreement. Please read these policies carefully and sign below indicating that you have read and understand the policies detailed within.

INSURANCE PARTICIPATION

If we are participating providers in your Plan we do accept all insurance coverage and payments from all insurance carriers including coverage related to motor vehicle accidents and workers compensation type injuries. We do follow instructions stated on the EOB (explanation of benefits) and if **your Insurance makes you responsible for part of the charges YOU WILL BE BILLED FOR IT** by our office. Please read explanation below.

OUR RESPONSIBILITY TO YOU:

1. To keep up-to-date records of your insurance coverage.

2. To submit medical claims to your insurance carrier on your behalf and to make appropriate appeals when claims are initially denied by your insurance carrier.

3. To help you understand the specific details of your insurance coverage and to define any out-of-pocket expenses you may incur from receiving your care from our office.

YOUR RESPONSIBILITY TO OUR OFFICE:

1. To provide accurate and up-to-date insurance information to our office. Failure to provide us with this information may lead to denial of claims and cause you to be personally responsible for charges incurred.

2. To be responsible for any out-of-pocket expenses that are owed as dictated by **your Insurance Company coverage**. Depending on your insurance coverage this **may** include any of the following types of payments:

   a. ***"Co-Payment'***.
   b. ***"Co-Insurance"***
   c. ***"Deductibles"***

I hereby authorize and guarantee payment for all services rendered. Although fees for services are due and payment expected at the time services are rendered, if I have been granted a grace period for payments of fees, I acknowledge that payment is due and expected at the time the billing statement is received.

In the event that my account becomes delinquent for more then 30 days, I also agree to pay a finance charge of 1.5% per month on any balances due, as well as all reasonable collection costs not to exceed 50%, court costs, attorney fees and interest fees accrued with the collection of this account.

_____ _____

Signature of Patient Date