Dr. Jill Hagen
Dr. Lauren Grossman
Podiatrist
363 Grand Ave Englewood, N.J 07631

COVID-19 Screening Form

First point of contract should screen the patient/visitor and check any boxes that apply:

☐	**Patient/visitor has a fever (?100.4 visitor/patient > 100.0 HCP) AND signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath)**
☐	**Patient/visitor has had close contact with a laboratory confirmed COVID-19 patient within the last 14 days**
☐	**Patient/visitor has a fever (?100.4 visitor/patient > 100.0 HCP) OR signs/symptoms of lower respiratory illness AND a history of travel from affected geographic regions within 14 days of symptom onset**
☐	**Patient/visitor does not meet any of the above criteria**

Patients:

If any of the first three boxes are checked, the patient should not enter this building and should call their primary care doctor immediately.

Name _____ Phone _____ Date _____

Dr. Jill Hagen Dr. Lauren Grossman
PODIATRISTS
363 GRAND AVENUE • ENGLEWOOD, NJ 07631
(201)568-6977

WELCOME TO OUR OFFICE

PATIENT INFORMATION:
SEX: MALE [ ] FEMALE [ ]

BIRTH DATE _____/_____/_____

SOCIAL SECURITY #_____-_____-_____

LAST NAME: _____

FIRST NAME: _____M.I.____

ADDRESS: _____

CITY_____

STATE_____ ZIP_____

HOME PHONE: (____)_____

WORK PHONE: (____)_____

CELL PHONE: (____)_____

EMAIL:;_____

POLICYHOLDER'S INFORMATION:

YOUR RELATIONSHIP TO POLICYHOLDER:

SELF [ ] SPOUSE [ ] CHILD [ ] OTHER [ ]

LAST NAME: _____

FIRST NAME: _____M.I.____

ADDRESS: _____

CITY_____

STATE_____ ZIP_____

HOME PHONE: (____)_____

WORK PHONE: (____)_____

BIRTH DATE OF POLICYHOLDER
_____/_____/_____

REFERRED BY_____

INSURANCE INFORMATION --- *DO YOU NEED A REFERRAL?* YES OR NO

PRIMARY INSURANCE NAME:_____
IDENTIFICATION #: _____Group #_____
ADDRESS (if known)_____

SECONDARY INSURANCE NAME:_____
IDENTIFICATION #:_____Group #_____
ADDRESS (if known)_____

HOW WILL YOU BE PAYING TODAY?
CHECK [ ] CASH [ ] VISA/MASTERCARD [ ]VENMO [ ] COPAY AMOUNT_____

Credit Card #:_____
Exp Date_____CSV_____

SIGNATURE ON FILE: _____
AUTHORIZATION TO FILE/APPEAL CLAIMS/ RELEASE INFORMATION/ AND CHARGE CC ON FILE FOR BALANCES DUE

Dr. Jill Hagen, DPM
Dr. Lauren Grossman, DPM
363 Grand Avenue ● Englewood, NJ 07631
Phone (201)568-6977

Patient History

Last Name: _____ First Name: _____

Height: _____ ' _____" Weight: _____

Blood Pressure: _____ / _____

Date: ____ / ____ / _____

DOB: ____ / ____ / _____

Medical History	No	Yes	Unknown
Anxiety	☐	☐	☐
Arthritis	☐	☐	☐
Asthma	☐	☐	☐
Cancer	☐	☐	☐
C H F	☐	☐	☐
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	☐	☐	☐
Other: _____			
Other: _____			

Social History	No	Yes	Quit
Smoking / Tobacco	☐	☐	☐
Alcohol	☐	☐	☐

Family History	No	Yes
Diabetes	☐	☐
Heart Disease	☐	☐
High Blood Pressure	☐	☐
Other:	☐	☐

	Medications	☐ None
1		mg
2		mg
3		mg
4		mg
5		mg
6		
7		
8		
9		
10		
11		
12		

Surgery	Year	☐ None
Heart Surgery		☐
Vascular Surgery		☐
Joint Replacement		☐
Foot & Ankle		☐
Other: _____		

	Drug Allergies	☐ None
1		
2		
3		
4		
5		

Chief complaint is _____

_____

I hereby give permission to Dr. Jill Hagen, DPM / Dr. Lauren Grossman, DPM and/or associates for the examination and rendering care for my foot problem and/or related condition.

_____ ___ / ___ / _____

Patient Signature (if minor, parents) Date

Dr. Jill Hagen Dr. Lauren Grossman
PODIATRISTS
363 GRAND AVENUE • ENGLEWOOD, NJ 07631
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FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our **FINANCIAL POLICY** which we require you to read and sign prior to initial treatment.

- **ALL PATIENTS MUST COMPLETE OUR INFORMATION AND INSURANCE FORM BEFORE SEEING THE DOCTOR.**

- **WE ACCEPT CASH, CHECKS OR MASTERCARD/VISA.**

REGARDING INSURANCE

Your insurance policy is a contract between you and your insurance company. **We are not a party of that contract.** Please be aware that some of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare program and other medical insurance programs. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment for payment regardless of any insurance company's arbitrary determination of usual and customary rates. **You are responsible for all non-covered services, deductible, copays, and coinsurance.**

ADULT PATIENTS AND MINOR PATIENTS: Adult patients (18 or older) are responsible for payment.

The adult accompanying the minor and the parents (or guardian of the minor) are responsible for payment. For unaccompanied minors, non-emergency treatment will be denied unless payment by Cash, Check, MASTERCARD or VISA at the time of service has been verified.

PATIENT LIABILITY: If this account is assigned to an attorney for collection and/or suit, I shall pay 33 1/3% of the claim as payment for attorney's fees and cost of collection.

CHECK RETURN POLICY: For any check that is returned from the bank there will be a service charge of $30.00 that must be paid to Podiatry Associates.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I HAVE READ THE FINANCIAL POLICY. I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Signature of Co-Insurance Responsible Party Date