Garden State Foot & Ankle Center, LLC
Scott R. Shrem, DPM AACFAS

PATIENT REGISTRATION

Name: ____________________ Date of Birth: ____________ Date: __________

Sex: ___ M ____ F Age: _____ Martial Status: __________ Race: __________ SS # : _______--_______--___________

Street: ________________________ City: ____________ Stat: ______ Zip: __________

Phone Number: ________________ Cell Phone Number: ____________________

Pharmacy Name & Address: ______________________________ Phone: ____________

Email: ____________________ Reason for Visit: ________________________

Primary Physician: ____________________ Last Seen by Doctor: ______ Phone #: __________

Insurance Information

Responsible Party: ____________________ Address: ________________________

Birth Date: ______________ Social Security #: ______________________________

*Primary Insurance: __________________ ID #: __________ Group #: ____________

Secondary Insurance: _________________ ID #: __________ Group #: ____________

Patient Employer: ____________________ Occupation: _______________ How long: _____

Emergency Contact: __________________ Phone #: __________________

Co-pay Amount: _____________How did you learn about our office? : ____________________

ASSIGNMENT, RELEASE & CONSENT

I, the undersigned, have insurance coverage with ______________________ and assign directly to Dr. Scott R. Shrem all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid or not paid by insurance. **We Reserve the Right to Charge $40.00 for Appointments Cancelled or Broken Without 24 Hours Advanced Notice.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions. I hereby give permission to Dr. Shrem to administer and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my condition. Due to the new **"Red Flag"** law instituted by the Federal Trade Commission, all patients are **required to present a driver's license or other form of government issued picture identification**. This identification will be scanned into your account for future reference. This is required to prevent identity theft and to protect your insurance benefits. **I authorize Dr. Shrem to obtain my prescription history from my pharmacy.**
My signature below is also an acknowledgment that I have received a copy of "Notice of our Privacy Practices" Garden State Foot & Ankle Center, LLC.

Signature of Insured/Guardian: ______________________________ Date: ____________

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits to be made either to me or on my behalf to Dr. Scott Shrem for any services furnished me by that physician. I authorize any holder of medical information about me to release any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible area based upon the charge determination of the Medicare carrier.

Signature of Beneficiary: ______________________________ Date: ____________