



Marshall L. Lukoff, DPM, FAAFAS

Board Certified in Podiatric: Surgery; Orthopedics; and Pain Management
Fellow, American Society for Laser Medicine and Surgery

Crown Colony Medical Center,
500 Congress Street, Suite 1D
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(617)479-7921 Fax: (617)774-1458

Eastbrook Executive Park
30 Eastbrook Road, Suite 104
Dedham, MA 02026
(781)326-5908 Fax: (781)461-0090
FootCareSpecialistsPC.com
(800)252-1876

WELCOME TO OUR OFFICE

First Name _____ Last Name _____ M.I. _____

Home Address _____

E-Mail Addresses _____

Home Phone (____)____ - _____ Work Phone (____)____ - _____ Cell Phone (____)____ - _____

Occupation _____ Employer _____ How long? _____ P/T___ F/T___

Social Security Number _____ - _____ - _____ Date of Birth ____/____/____ Age _____ Shoe Size _____

Male__ Female__ Single__ Married__ Divorced__ Widowed__ Veteran__ Care Giver__ Student__ Retired__

Primary Care Physician _____ Town _____ Phone (____)____ - _____

Emergency Contact _____ Relationship _____ Phone (____)____ - _____

Who may we thank for referring you to our office? _____

INSURANCE INFORMATION

Primary Insurance _____ Policy ID _____ Co-Pay \$ _____

Secondary Insurance _____ Policy ID _____

Group number (if applicable) _____

Subscriber's name _____ Subscriber's DOB ____/____/____

Subscriber's relation to patient : Self _____ Spouse _____ Child _____ Other: _____

I hereby authorize Foot Care Specialists, PC, to submit a claim to my insurance carrier for all covered services rendered by the physician(s) and authorize and direct my insurance carrier or its intermediaries to issue payment checks directly to the physician(s) rendering the covered service. I will be responsible for those charges deemed not covered by said insurance carrier so long as such insurance has not deemed such services to be medically inappropriate or unnecessary. I also understand that if my insurance company is not a contracted carrier, I am responsible for the full fee charged by my physician(s) regardless of what my insurance pays. I authorize Foot Care Specialists, PC to furnish complete information to my insurance carrier and its intermediaries regarding the services rendered. I permit a copy of this authorization to be used in place of the original. I understand that if my insurance company requires a referral and one is not provided on date of service, I may reschedule, or if I am seen, I will be responsible for the visit if the insurance company denies coverage for it. I agree to pay all copayments, coinsurance and deductibles at the time the service is rendered. I will pay by: cash__ check__ credit__

Responsible party's signature: _____ Date ____/____/____

GENERAL HEALTH QUESTIONNAIRE

Our goal is to provide you with the very best podiatric medical care by using state-of-the-art technologies combined with effective podiatric medical treatment to maximize your foot health. **You can help:** Please provide us with accurate health information and follow the personalized treatment plan or home instructions we give you. Together we will work to improve your foot health. Please **print** all information in the spaces provided. Be sure to complete and sign the statement on the last page. Thank you.

Please list any operations that you have had _____

Please list all prescription and non-prescription medications you are currently on _____

Please circle all medications you are allergic to or list them below

Demerol	Codeine	Celebrex	Novocaine	Latex	Adhesive Tape	Aspirin	Advil
Aleve	Empirin	Tylenol	Morphine	Motrin	Iodine	Merthiolate	
<i>Antibiotics:</i>	Penicillin	Sulfa	Erythromycin	Amoxicillin			

Other Allergies: _____

Height _____ Weight _____

(Women) Is there any possibility you could be pregnant? Yes _____ No _____

Date of Last Complete Physical Exam ____/____/____ by Dr. _____

Last visit to a Podiatrist ____/____/____ Reason _____

Please check any of the following ailments you have had/been treated for:

warts _____	Athlete's foot _____	corns/calluses _____	fungal nails _____
ingrown nails _____	leg or foot ulcers _____	neuroma _____	foot numbness _____
flat feet _____	broken foot bones _____	ankle sprains: left _____ right _____ both _____	
hammer/mallet toe _____	bunions _____	broken ankle: left _____ right _____ both _____	
cramps in legs/feet _____	arch pain _____	rash _____	sores _____
high arch feet _____	lower back pain _____	knee pain _____	heel pain _____
walking problems _____	childhood foot problems _____	in-toeing _____	toe walking _____
NONE OF THESE (initials) _____ other _____			

Please circle “yes” or “no” if the following applies to you:

Are your first steps out of bed painful? yes nodoes the pain subside? yes no

Do you get leg cramps? yes no ...during the day? yes noat night? yes no

List the sports/type of dance you are active in_____

Please circle “yes” or “no” if the following ailments apply to you:

Diabetes yes no	high blood pressure yes no	heart disease yes no	heart attack yes no
Phlebitis yes no	blood disorder yes no	Hepatitis yes no	Anemia yes no
high cholesterol yes no	poor circulation yes no	HIV/AIDS yes no	lung disease yes no
cancer yes no	vascular disease yes no	liver disease yes no	stroke yes no
stomach disorder yes no	thyroid problem yes no	tuberculosis yes no	muscle disease yes no
keloid/thick scar yes no	kidney disease yes no	rheumatic fever yes no	sciatica yes no
hypertension yes no	seizures/epilepsy yes no	panic attacks yes no	nerve disorder yes no
headaches yes no	mental illness yes no	osteoporosis yes no	Lyme’s Disease yes no
glaucoma/maniclar degeneration (eyes) yes no	asthma yes no	gout yes no	
sudden weight loss yes no	hearing/ear disorder yes no	Alzheimer’s yes no	arthritis yes no

NONE OF THESE (initials) _____

other: _____

SOCIAL HISTORY

Do you smoke now? Yes_____ No_____ How many packs per day? _____ For how many years? _____

If you quit, when did you do so? _____

Please indicate how much alcohol you consume: None__ Rarely__ Moderately__ Daily__ Quit__

Do you use recreational drugs? : None__ Rarely__ Moderately__ Daily__ Quit__

FAMILY HISTORY

List relationship of family members who have had..... (i.e.: mom, dad, aunt, brother)

diabetes _____	high blood pressure _____	heart disease _____	liver disease _____
HIV/AIDS _____	arthritis/gout _____	blood disorder _____	seizures/epilepsy _____
cancer _____	lung disease _____	thyroid disease _____	tuberculosis _____

WHAT ARE YOUR PRESENT FOOT PROBLEMS?



Right Foot



Left Foot

For each foot/ankle problem you have, please explain **how** and **when** problem occurred and **the difficulties** you are experiencing walking, working or wearing shoes. **Write each foot problem on a separate line (1, 2, or 3).**

Write that number on the appropriate foot diagram above (as close to the actual injury site as possible).

Problem:

How long ago did problem/pain start? How many:

- | | |
|----------|---|
| 1. _____ | days: ___ weeks: ___ months: ___ years: ___ |
| 2. _____ | days: ___ weeks: ___ months: ___ years: ___ |
| 3. _____ | days: ___ weeks: ___ months: ___ years: ___ |

Write the problem number alongside the word which best describes the pain:

shooting___ throbbing___ sharp___ burning___ itching___ aching___ tenderness___ dull___ tingling___
numbness___ Now indicate the severity of your pain with the problem number:
none___ light___ moderate___ strong___ severe___

List previous medical treatment/foot surgery or home remedies for each of your foot/ankle problems.

1. _____
2. _____
3. _____

Date of Injury: Problem 1 ___/___/___ Problem 2 ___/___/___ Problem 3 ___/___/___

If injury is work related – Date of Report to Employer: ___/___/___

For Doctor’s Use – Observations and Comments

Patient was ___ assisted in completion of this record by or was ___ unable to complete without the help of:

_____ Translation was done by: _____

___ Lab report and/or ___ previous medical records were reviewed. ___ X-rays brought by patient from

_____ were reviewed. I have reviewed the information provided above.

Signed: _____ Marshall L. Lukoff, DPM



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PRIVACY CONSENT AND ACKNOWLEDGEMENT OF MEDICAL PRIVACY NOTICE

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

Consent for treatment: I, with my signature, authorize Foot Care Specialists, PC and any employee working under the direction of the physician, to provide medical care for me, or to this patient for whom I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but limited to) preventive, diagnostic, palliative care, counseling, surgical, dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

Initials: _____

Consent for release of information: I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the Medical Privacy Notice.

Initials: _____

Consent for assignment of benefits: I consent to assign all payments for these services to this practice. I understand that I am responsible for all co-payments, amounts applied to deductibles and any co-insurance amounts, as required by my contract with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. It is my responsibility to obtain written referral from my primary care physician if required by my insurance provider. If I choose not to obtain a referral, or, if I seek care outside of my insurance contract, I am aware that I may be responsible for all charges that are incurred.

Initials: _____

Consent and acknowledgement of Medical Privacy Notice:

I have read and signed a separate copy of the HIPPA Medical Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

Initials: _____

I understand that this practice may refuse me services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at that time.

Patient/Guardian _____ Date: ____/____/____

Name Printed: _____ If not patient, relationship: _____

HIPPA NOTICE OF PRIVACY PRACTICES

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 AND SIGN THE BACK OF THIS FORM. THANK YOU.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. **Uses and Disclosures of Protected Health Information.** Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.
2. **Treatment.** We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example: we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example: your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.
3. **Payment.** Your protected health information will be used, as needed, to obtain payment for your health care services. For example: obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.
4. **Health Operations.** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example: we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as "required by law": Public Health issues as required by law; communicable diseases; health oversight; abuse or neglect, Food and Drug Administration requirements; legal proceedings; law enforcement; coroners; funeral directors and organ donation; research; criminal activity; military activity and national security; workers' compensation; inmates; required uses and disclosures. Under the law, we must make disclosures to you and, when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirements of Section 164.500.

5. **Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.**

YOUR SIGNATURE IS REQUIRED ON THE FOLLOWING PAGE

6. **You may revoke this authorization at any time, in writing,** except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.
7. **Your Rights.** Following is a statement of your rights with respect to your protected health information.
8. **You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.
9. **You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

10. **You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively i.e. electronically.
11. **You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
12. **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.
13. **Complaints** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003**

We are required by law to maintain the privacy of our patients and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

PLEASE SIGN BELOW TO ACKNOWLEDGE THAT YOU HAVE RECEIVED THIS NOTICE OF OUR PRIVACY PRACTICES:

PRINT NAME: _____ **SIGN HERE:** _____ **DATE:** ___/___/___



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Allergy and Medication Update Form

Name: _____ Date of Birth: ___/___/_____

Address: _____

Home Tel: (_____) _____ Cell: (_____) _____ Other: (_____) _____

E-mail: _____

Primary Insurance Carrier: _____

Secondary Insurance Carrier: _____

PCP/Referring Physician: _____

Other Physicians currently seeing: _____

Allergies

Reactions

_____	_____
_____	_____
_____	_____
_____	_____

<u>Medications</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Reason Taken</u>
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I understand that if I did not provide my doctor with the appropriate information I can be held responsible for payment. I also understand that if my insurance carrier requires a referral and I do not obtain one on the date of service I may reschedule my appointment or, if I am seen, I will be responsible for the cost of the visit if my insurance denies payment for it.

Please sign and date: _____ ___/___/_____