Foot Care Specialists, PC

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
Quincy, MA 02169
(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_____Town_____Zip _____

E-Mail Address_____

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

Occupation _____ Employer_____

Social Security Number_____-____-_____ Date of Birth____/____/_____ Age _____ Shoe Size _____

Male__ Female__ Single__ Married__ Divorced__ Widowed__ Veteran__ Care Giver__ Student__ Retired__

Primary Care Physician_____ Date last seen (Medicare requires) ___/___/_____

Address: _____ Phone (____)_____-_____

Emergency Contact _____ Relationship_____ Phone (____)_____-_____

INSURANCE INFORMATION

Primary Insurance_____ Policy ID_____ Co-Pay $_____
Secondary Insurance _____Policy ID_____
Group number (if applicable) _____
If Patient the Subscriber? YES: ____ NO: _____ Name of Subscriber: _____
Subscriber's DOB ___/___/_____ Subscriber's Phone: (_____)_____-_____
Subscriber's relation to Patient: Self_____ Spouse_____ Parent_____ 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 cost of 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.

Responsible Party's Signature: _____ Date ___/___/_____

PRINT NAME: _____
If not patient, what is your relationship to patient? _____

HOW DID YOU FIND US? (please check all that apply)

Google: ___ ZocDoc: ___ Doctor.com: ___ Healthgrades: ___ Health Insurance Website: ___ Yelp: ___
RateMDs: ___ Visiting another doctor in building: ___ Bing: ___ Vitals: ____ Friend: _____

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. Please provide us with accurate health information and follow the personalized treatment plan and home instructions we will provide. 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.

Height: _____feet _____ inches Weight _____ lbs Temp _____

SMOKING HISTORY: Current Every Day Smoker ____ Current Some Day Smoker ___ Former Smoker ___

Never Smoker ____ Heavy Tobacco Smoker ___ Light Tobacco Smoker ____

Please indicate how much Alcohol you consume: None____ Rarely____ Moderately____ Daily____ Quit_____

Do you use Recreational Drugs?: None____ Rarely____ Moderately____ Daily____ Quit_____

Please list any operations that you have had and the year they occurred:

_____

_____

Please list all prescription and non-prescription medications you are currently on (or attach a list) _____

_____

_____

Please check off all medications you are allergic to and add any others:-

Demerol **Codeine** **Celebrex** **Novocaine** **Latex** **Adhesive Tape** **Aspirin** **Advil**

Aleve **Empirin** **Tylenol** **Morphine** **Motrin** **Iodine** **Merthiolate**

Antibiotics: **Penicillin** **Sulfa** **Erythromycin** **Amoxicillin**

Other Allergies: _____

(Women) Is there any possibility you could be pregnant? Yes___ No___

Are your first steps out of bed painful? Yes ___ No___ Does the pain subside? Yes___ No___

Do you get leg cramps? Yes___ No___ During the day? Yes___ No___ At night? Yes___ No___

List the sports or other athletic activities you are active in _____

Do the following ailments apply to you?:

NONE of these ailments apply to me (initials) _____

Diabetes: Yes___ No___ High blood pressure: Yes___ No___ Heart disease: Yes___ No___ Heart attack: Yes___ No___

Hepatitis: Yes___ No___ High cholesterol: Yes___ No___ Poor circulation: Yes___ No___ HIV/AIDS: Yes___ No___

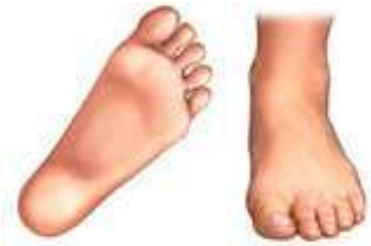
Vascular disease: Yes___ No___ Liver disease: Yes___ No___ Stroke: Yes___ No___ Muscle disease: Yes___ No___

Kidney disease: Yes___ No___ Nerve disorder (Neuropathy): Yes___ No___ Osteoporosis: Yes___ No___

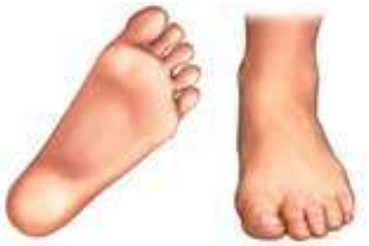
Lyme's Disease: Yes___ No___ Gout: Yes___ No___ Alzheimer's: Yes___ No___ Arthritis Yes___ No___

PRINT NAME OF PATIENT: _____

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: ___/___/____

PLEASE SIGN: (Patient or Guardian) _____ Date: ____/____/_____

<u>For Doctor's Use – Observations and Comments</u>

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.

INITIAL: _____

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.

INITIAL: _____

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.

INITIAL: _____

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.

INITIAL: _____

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.

PLEASE SIGN: Patient or Guardian _____ Date: ____/____/_____

Print name: _____ If not patient, relationship to: _____

Foot Care Specialists, PC

HIPPA NOTICE OF PRIVACY PRACTICES

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:** ____/___/_____