PATIENT INFORMATION:

Patient name: _____
First Name Middle Name Last Name

Date of birth: _____/_____/_____ Gender: __Male __Female Social Security #:_____

CONTACT INFORMATION:

Address: _____

City:_____ State: _____ Zip Code: _____

Home Phone: _____ Leave Message? ___Y ___N	Cell Phone: _____ Leave Message? __Y __N Text Message? ___Y __N	Work Phone: _____ Leave Message? __Y __N
Email Address:		
May we confirm your appointment via email? _____Y _____N		
Would you like to be registered to our online portal (Patient Ally)? _____Y _____N		

Primary Care Physician:_____

PCP Phone #:_____

Preferred Laboratory: ____Quest ____ Labcorp ____Other: _____
Preferred Imaging Center: ____Simon Med ____Orlando Health Imaging ____ Other: _____

INSURANCE INFORMATION:

Are you the primary insured? _____No _____ Yes

If NO, please provide the primary insured information:
Name:_____ Date of Birth:_____ Relationship: _____

Who Referred You To Our Practice: _____

Emergency Contact: _____ Phone:_____ Relationship:_____

Release of Protected Health Information (PHI)

Permission to release Your Protected health Care Information to Family Members or Others Please mark whether you choose to authorize us to release medical and/or insurance information to family or others:
__ No __ Yes (If yes, please indicate the individual name(s) below.)

Name:_____ Relationship:_____ Phone #:_____
Name:_____ Relationship:_____ Phone #:_____
Name:_____ Relationship:_____ Phone #:_____

West Orange Podiatry has the right to refuse to treat you if you refuse to sign this consent or if, at any time, you choose to revoke this consent.
Your signature below acknowledges:

- You are permitting the release of your PHI to the persons noted above.
- You are aware that you may now or at any time request restrictions to the use and disclosure of your PHI.

_____ _____
Signature of Patient or Patient's Representative Date Signed
(If Representative signs include legal document and print name below)

Assignment Authorization and Policies

I hereby authorize Dr. Laliberte and staff to release to my insurance company's representatives and my primary care physician or any physician referred by Dr. Laliberte, medical information including test results, the diagnosis, and the records of any treatment or examination rendered to me during the period of such medical or surgical care by Dr. Laliberte

I authorize and request that my insurance companies pay directly to Dr. Laliberte the amount due for my pending claims for medical or surgical treatments or services rendered to me. I understand I am financially responsible for non-covered charges at all times, including all co-pays, co-insurance, and annual deductibles which are payable at the time of service. Our office does not bill you for these. Co-pays, co-insurance and outstanding account balances are due before your appointment with the doctor.

It is **YOUR** responsibility to inform and provide our office with all correct information and any changes in your current and active medical insurance plan(s), billing address, and phone numbers. Failure to do so results in you being responsible for the cost of the visit. There are **NO** exceptions. All insurance changes must be given to us at the time of service. If your insurance coverage changes and we are not notified, you will be responsible for all charges. We will be unable to bill your insurance for any prior changes before the change notification.

I understand that it is my responsibility to pay any deductible amount, co-insurance, or any other balances not paid for by my insurance. Any unpaid balances are subject to collection so please pay all past due amounts before your next visit. A **$25.00** fee will apply to all NSF returned checks in addition to the amount due.

Our office makes concerted efforts to provide care within the scope of services covered by your insurance policy and that your test is performed in the properly designated facility. If you are concerned that your insurance company may not cover services you will receive, please consult your insurance company before the date of service. In the event your health insurance plan determines a service to be not covered, you may be responsible for this charge.

Medication refills take at least (2) business days to process. Please call your pharmacy to request your refill. They will fax our office your request which needs to be approved by Dr. Laliberte. Allow two days, and then check with your pharmacy for the medication before calling the office. We no longer accept refill requests from patients. Some insurance companies may not pay for certain medications. Our office does not pre-certify or pre-authorize prescriptions.

Dr. Laliberte will review your test to be discussed at your follow-up appointment. If you do not have an appointment please call the office to schedule.
We see patients with scheduled appointments only. We do not see walk-in patients without an appointment, except for emergencies.
I understand that there will be a **$55.00** fee for not showing up to my appointment when it has been confirmed by Dr. Laliberte's staff._____(initials)

I understand that there will be a **$100.00** fee for not showing up to my in-office surgery appointment when it has been confirmed by Dr. Laliberte's staff._____(initials)

The office will try their very best to give a reminder call before each appointment, but I understand that it is still my responsibility to remember my appointments and Dr. Laliberte or its office staff is not responsible for missing appointments.

Lack of effort to cooperate with medical advice may be considered grounds for discharge from the practice. No foul language or mistreatment of the doctor or staff will be tolerated and grounds for immediate discharge of practice.

Laboratory and Radiology Services
Laboratory test and radiology services are provided by a separate business. You will receive a separate bill for these services, We will make every effort to make certain that your services are covered by your insurance policy. If you are concerned that your insurance company may not cover services you will receive, please consult your insurance company before the date of service. In the event your health insurance plan determines a service not covered, you will be responsible for this charge.
Copies of Medical Records
Medical records can be copied and sent to another provider at no cost to you. This includes 7 years of clinical notes, and 7 years of test results; if for your personal use, there is a $1 a page fee for all clinical documentation.
A $25 charge will be incurred for Dr. Laliberte to complete any medical forms (insurance policies, physical forms, Family Medical Leave Act, Disability applications, etc) you will be responsible for this charge.

I have read and understand and agree to the policies listed above.

_____	_____	_____
Print Name	Signature of patient or legal representative	Date

A photographic copy of this authorization shall be as valid as the original.

1. PERSONAL MEDICAL HISTORY

CHECK YER OR NO	YES	NO
ANEMIA		
ARTHRITIS		
ARTIFICIAL JOINTS		
ASTHMA		
BLEEDING DISORDER		
CANCER		
CHOLESTEROL		
COMMUNICABLE DISEASE		
DIABETES		
EPILEPSY		
HEART AND VALVE PROBLEMS		
HEART SURGERY		
HIGH BLOOD PRESSURE		
KIDNEY DISEASE		
LIVER DISEASE		
NERVOUS DISORDER		
PULMONARY PROBLEMS		
RHEUMATIC FEVER		
STOMACH PROBLESMS		
STROKE		
THYROID PROBLEMS		
TUBERCULOSIS		
OTHER:		

2. DO YOU HAVE ANY ALLERGIES: NO_____ / YES_____(LIST ALLERGIES)

_____

3. WHAT OPERATIONS HAVE YOU EVER HAD?

_____

4. DID YOU HAVE ANY COMPLICATIONS FROM SURGERY OR ANESTHETICS?

_____

5. WHAT IS YOUR PRESENT FOOT OR ANKLE SYMPTOM?

_____

6. WHEN DID IT FIRST OCCUR?

_____

7. HAVE YOU BEEN TREATED FOR THE SAME CONDITION IN THE PAST? ___ YES ___ NO
(What has been done?)_____

8. IS IT THE RESULT OF AN INJURY SUSTAINED AT WORK OR AUTO ACCIDENT? ___ YES ___ NO
(IF YES, STOP AND LET THE FRONT DESK KNOW AS WE DO NOT WORK WITH THESE TYPES OF CASES)

9. AT WORK, DO YOU PRIMARILY _____ SIT _____ STAND? RETIRED _____ DISABLED____

10. DO YOU SMOKE? ____ NO ___ YES 12. DO YOU DRINK ALCOHOL? ____ NO ___ OCCASIONALLY __ A LOT

11. DO YOU PARTICIPATE IN ANY SPORTS? _____ NO _____ YES (IF YES WHAT ARE THEY):
_____

MEDICATION LIST

Patient Name: _____ Date of Birth:_____

Please list all drugs you are currently taking. Drugs include prescription and over-the-counter medications, herbal products, nutritional supplements, and recreational drug.
IF YOU HAVE A LIST WE CAN MAKE A COPY

Name of Drug?	Strength of Drug?	Why Do You Take This Drug?	Who Prescribed Drug?

Preferred Pharmacy Name: _____
Phone #: _____
Address: