Dr. Arthur Hansen Dr. Lori Lane Dr. Dina Hansen McCoy
Dr. Khoa Pham Dr. Daniel Heck Dr. Elizabeth Davis

PATIENTS' NAME: ____

FIRST ----- INITIAL----- LAST NAME

Date of Birth: ______________ Age: __________ What Name Do You Like To Be Called: ______________________

Mailing Address: ______________________ City: ______________ State: __________ Zip: __________

E-mail: ______________________ Home Telephone: ______________________

Work Telephone: ______________________ Cell Phone: ______________________

Social Security #: ______________________ Sex: ____ M ____ F Weight: ____________ Height: ________' ________"

Primary Language: ______________ Do you need a translator? Y N Race: ______________Ethnicity: Hispanic Non-Hispanic

PARENT/ GUARDIAN OF MINOR CHILD: ____

Parent or Guardian's Telephone: ______________________ (and/or) Work Telephone: ______________________

EMERGENCY CONTACT: ______________________________ Relationship: ______________________

Contact's Home Telephone: ______________________ (and/or) Work Telephone: ______________________

PATIENT'S EMPLOYER: ______________________________ Position: ______________________

Employers Address: ______________________________ Telephone: ______________________

PRIMARY CARE PHYSICIAN: ____

Primary Physician Address: ______________________________ Telephone: ______________________

PRIMARY HEALTH INSURANCE CO: ____

Primary Policy No: ______________________________

Subscriber Name: ______________________________ Subscriber's Date of Birth: ______________________

Do You Have Other Health Insurance Company: Yes _____ No ____

Secondary Health Insurance: ______________________________ Secondary Policy No.: ______________________

REFERRED BY: ____

REASON FOR VISIT: ____

Is this a result of a **Work Injury**? Yes _____ No _____ or is it a result of an **Auto Accident**? Yes _____ No ____

WORKERS COMP OR AUTO ACCIDENT CARRIER: ____

Claim Number: ______________________________ Date of Accident: ______________________

Name of Adjuster: ______________________________ Telephone: ______________________

PATIENT CONSENT FOR EXTENDED AUTHORIZATION AND TREATMENT

1.For any insurance plan that requires the authorization of a primary care physician (HMO, PPO, etc.), it is your responsibility (as a patient or guardian) to ensure that this office receives all the necessary authorizations or referrals before treatment. Professional services are rendered and billed directly to your insurance company, however you, the patient /guardian, are directly responsible for the services rendered by the physician. A health insurance policy is a contract between you (the patient or subscriber) and your insurance company. If for some reason the insurance company denies the charges, payment for services rendered will become the responsibility of the patient /guardian.

2. I hereby authorize LA Podiatry Group physicians/staff to send information to insurance companies about my illness and treatments and hereby assign to LA Podiatry Group, all payments for medical services provided for myself or your dependents. I know that it is my obligation to know the policies of my insurance company and that I am responsible for payment if they have not met their requirements. I hereby request and voluntarily consent to the attention of that office, including routine diagnostic procedures and medical treatment deemed necessary by Dr. Arthur Hansen, Dr. Lori Lane, Dr. Daniel Heck, Dr. Khoa Pham, Dr. Dina Hansen McCoy and Dr. Elizabeth Davis and staff.

3. I acknowledge that I provided a copy of the Notice of Privacy Practices and have read (or had the opportunity to read if they so choose) and understood the notice.

X ______________________________ ______________________

Signature (Parent, if patient is a minor) *Date*

LA Podiatry

Dr. Arthur Hansen | Dr. Lori Lane | Dr. Dina Hansen McCoy
Dr. Khoa Pham | Dr. Daniel Heck | Dr. Elizabeth Davis

PATIENTS' NAME: ____

First ----- Initial----- Last Name

Have you ever been diagnosed and/or treated for any of the following conditions? ________ **Yes** ________ **No**

Cardiovascular
- ☐ High Blood Pressure
- ☐ Chest Pain
- ☐ Palpitations/Arrhythmia
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ Stroke/TIA
- ☐ Other: ______________

Lung
- ☐ Shortness of Breath
- ☐ Lung Disease
- ☐ Asthma
- ☐ Emphysema
- ☐ COPD
- ☐ Other: ______________

Gastrointestinal
- ☐ Reflux / Heartburn
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Irritable Bowel Syndrome
- ☐ Bleeding Ulcers
- ☐ Other: ______________

Liver
- ☐ Hepatitis
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Other: ______________

Kidney
- ☐ Shortness of Breath
- ☐ Kidney Failure
- ☐ Recurrent Infections
- ☐ Other: ______________

Genito-Urinary
- ☐ Reflux / Heartburn
- ☐ Prostate Enlargement
- ☐ Prostate Cancer
- ☐ Other: ______________

Musculoskeletal
- ☐ Fibromyalgia
- ☐ Back / Neck Pain
- ☐ Osteoporosis
- ☐ Other: ______________

Nervous System
- ☐ Seizure Disorder
- ☐ Multiple Sclerosis
- ☐ Parkinson 's disease
- ☐ Other: ______________

Hematologic
- ☐ Bleeding Disorders
- ☐ Clotting Disorder
- ☐ History of DVT / Blood Clot
- ☐ Poor Circulation

Infectious Disease
- ☐ HIV
- ☐ Hepatitis
- ☐ Chronic Skin Infection
- ☐ Other: ______________

Endocrine
- ☐ Diabetes (insulin dependent)
- ☐ Diabetes (non-insulin dependent)
- ☐ Thyroid Disease
- ☐ Other: ______________

Other
- ☐ Keloid Thick Scar
- ☐ Psychiatric Disorder
- ☐ Cancer Type: __________
- ☐ Other: ______________

Do you have any other health problems that are not listed? ________ Yes ________ No

If yes, please explain: ____

Have you ever had a complication with anesthesia? _______Yes ________ No

If yes, please explain: ____

Foot Conditions or Complaints: Have you ever been diagnosed and/or treated for any of the following conditions? If so, please mark.

- ☐ Painful Corns / Calluses
- ☐ Leg or Foot Ulcers
- ☐ Broken Foot / Toe Bone
- ☐ Painful Bunion
- ☐ Arch Pain
- ☐ Knee Pain
- ☐ Hammer / Mallet Toes
- ☐ Cramps in Legs / Feet
- ☐ Lower Back Pain
- ☐ In-Toeing
- ☐ Athletes Foot
- ☐ Ingrown Nail
- ☐ Gait (walking) Problems
- ☐ Childhood Foot Problems
- ☐ Warts
- ☐ Foot Numbness
- ☐ Ankle Sprain
- ☐ Flat Feet
- ☐ Fungal Nails
- ☐ Neuroma
- ☐ Broken Ankle
- ☐ High Arch-Feet
- ☐ Heel Pain
- ☐ Toe Walking

Please Describe Your Foot Complaint(s): ____

____

LA Podiatry

Dr. Arthur Hansen | Dr. Lori Lane | Dr. Dina Hansen McCoy
Dr. Khoa Pham | Dr. Daniel Heck | Dr. Elizabeth Davis

PATIENTS' NAME: ____

FIRST ----- INITIAL----- LAST NAME

MY PAIN DISCOMFORT IS:

☐ Shooting Pain ☐ Itching ☐ Tingling
☐ Numbness ☐ Dull Pain ☐ Burning
☐ Tenderness ☐ Sharp Pain ☐ Aching

SEVERITY:

☐ Light
☐ Moderate
☐ Severe

DID YOU PREVIOUSLY OR DO YOU CURRENTLY WEAR:

	Y N		Y N		Y N
Shoe Inserts:	☐ ☐	Still using them?	☐ ☐	Did they help?	☐ ☐
Orthotics:	☐ ☐	Still using them?	☐ ☐	Did they help?	☐ ☐

SURGICAL HISTORY: Please list ALL SURGERIES that you have had below. Provide as much information as possible.

	SURGERY	HOSPITAL	DATE	SURGEON
1.				
2.				
3.				
4.				

MEDICATIONS: Do you currently take any medications? ________ **Yes** ________ **No** Please list **ALL current medications**.

	Medications	Dosage		Medications	Dosage
1.			5.		
2.			6.		
3.			7.		
4.			8.		

ALLERGIES: Do you have any drug allergies? ________ **Yes** ________ **No** If yes, type of reaction.

☐ Penicillin ____________________ ☐ Advil/Aleve ____________________ ☐ Tape ____________________
☐ Morphine ____________________ ☐ Aspirin ____________________ ☐ Band-Aid ____________________
☐ Codeine ____________________ ☐ Tylenol ____________________ ☐ Iodine ____________________
☐ Demerol ____________________ ☐ Motrin ____________________ ☐ Latex ____________________
☐ Novocain ____________________ ☐ Sulfa Drug ____________________ ☐ Other ____________________

TOBACCO HISTORY:

☐ I do not use tobacco products.
☐ I smoke _______ cigarettes per day.
☐ I smoke cigars.
☐ I chew tobacco.
☐ I quit smoking in _______ (year).

ALCOHOL HISTORY:

☐ I never drink alcohol.
☐ I quit drinking in _______ (year).
☐ I drink most days, ______ drink(s) per day.
☐ I infrequently drink alcohol.
☐ I drink _______ alcoholic beverages per week.
☐ I have a history of alcohol abuse.

X ______________________________________ ______________________

Signature (Parent, if patient is a minor) *Date*

Dr. Arthur Hansen | Dr. Lori Lane | Dr. Dina Hansen McCoy
Dr. Khoa Pham | Dr. Daniel Heck | Dr. Elizabeth Davis

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Patient Privacy Act (HIPPA), requires that our office obtains authorization to leave messages at your home with family members or on voice mail, email, etc. **I hereby give my consent for LA Podiatry Group, Dr. Hansen, Dr. Lane, Dr. Heck, Dr. Davis, and Dr. Dina Hansen McCoy and staff to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO) as follows:**

1. LA Podiatry Group, Dr. Hansen, Dr. Lane, Dr. Heck, Dr. Pham, Dr. Davis, and Dr. Hansen McCoy and staff's Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by writing to LA Podiatry Group at 2326 South Congress Avenue, Suite 1A, West Palm Beach, FL 33406. My protected health information means health information including, but not limited to my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer, or health clearing house, this protected health information relates to my past, present and future physical and mental health or condition and identifies me or there is a reasonable basis to believe the information may identify me.
2. **PHONE CALLS:** LA Podiatry Group, Dr. Hansen, Dr. Lane, Dr. Heck, Dr. Pham, Dr. Davis, and Dr. Hansen McCoy and staff may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.
3. **MAIL:** LA Podiatry Group, Dr. Hansen, Dr. Lane, Dr. Heck, Dr. Pham, Dr. Davis, and Dr. Hansen McCoy and staff may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements.
4. **E-MAIL/TEXT:** LA Podiatry Group, Dr. Hansen, Dr. Lane, Dr. Heck, Dr. Pham, Dr. Davis, and Dr. Hansen McCoy and staff may E-mail any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements.
5. I have the right to request that LA Podiatry Group, Dr. Hansen, Dr. Lane, Dr. Heck, Dr. Pham, Dr. Davis, and Dr. Hansen McCoy and staff restrict how they use or disclose my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.
6. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, LA Podiatry Group, Dr. Hansen, Dr. McCoy, Dr. Lane, Dr. Heck, Dr. Davis, Dr. Pham and staff may decline to provide treatment for me.
7. LA Podiatry Group, Dr. Hansen, Dr. McCoy, Dr. Lane, Dr. Heck, Dr. Davis, Dr. Pham and staff reserves the right to change its privacy practices that are disclosed

□ I AUTHORIZE   □ I DO NOT AUTHORIZE

X ______________________________   ______________________________

Signature (Parent, if patient is a minor)   *Date*

______________________________   ______________________________

Print Patients Name   *If applicable Print Name of Legal Guardian*

Dr. Arthur Hansen Dr. Lori Lane Dr. Dina Hansen McCoy
Dr. Khoa Pham Dr. Daniel Heck Dr. Elizabeth Davis

Pharmacy Information

Name of Pharmacy: ____

Address/Cross Street: ____

Phone Number: ____

LA Podiatry

Dr. Arthur Hansen Dr. Lori Lane Dr. Dina Hansen McCoy
Dr. Khoa Pham Dr. Daniel Heck Dr. Elizabeth Davis

Consent for Photography, Videotaping, or Other Imaging for Media or Educational Purposes

Patient's Name: ______________________________ Patient's Date of Birth: ____________

☐ I GIVE ☐ I DO NOT GIVE my consent to have photographs, videotaped images, or other images made of me or patient. I understand and agree that these images may be used by LA Podiatry Group for the purpose outlined below.

- Teaching purposes, which includes being shown to other patients.
- Advertisements by LA Podiatry
- Placement on LA Podiatry's website

____________________________________ ____________________________________
Signature of patient/legal representative If legal representative, relationship to patient

____
Date

Policy for Prescription Narcotic Use

It is the goal of LA Podiatry Group to provide the best care possible for our patients. In order to reach this goal, it is necessary to provide information to keep our patients informed. Although this letter probably addresses only a few of those who read it, we feel it is important to have this policy available to you.

Our office policy on the use and prescription of narcotics is as follows:

Office Visits:

- No narcotics will be prescribed for chronic pain. However, narcotics may be prescribed for acute injuries only when they are less than two weeks old.
- If you are under the supervision of a pain management physician, we expect you to disclose this information to us on your first visit. Failure to do so would be fraud, and would violate your contract with your pain management physician.

Post-operative:.

- Narcotics will only be prescribed for a period **up to two to three weeks** after a surgical procedure. There are, of course, the occasional exceptions to the rule. We may need to see you to reevaluate your condition prior to renewing your prescription.
- If you are on chronic narcotics from a pain management physician, you will need to receive your post-operative pain medicine from that physician, unless pre-arranged with us prior to your surgery.

As part of keeping our patients informed, we want to make you aware of the reasons why we limit the use of narcotics.

1. Severe postoperative/post injury pain that would require narcotics will usually reduce significantly by 2-3 days after surgery or injury and is gone by 10-14 days. Postoperative needs for narcotics longer than this period may signal complications that need more direct or specific treatment instead of covering up the problem. Typically, however, it is known that a longer need for narcotics more often than not means that you are up doing too much and “chasing” it with narcotics. Although you may desire to be active, it is possible to be “too active.” You need to listen to your body and respond to it. Overall, you will recover more quickly reducing your activities so that your pain is controllable without the need for narcotics. After all, your goal is to make the best recovery from your surgery or injury you can.
2. After 3-7 days your brain wants to and is supposed to kick in and manage the pain naturally. This is the best way to manage medium and long-term soreness and milder pain. Narcotics are known to block this normal process.
3. Narcotics are proven to be habit forming. Dependency on pain medication can start in as little as 2 weeks after beginning their use. We cannot tolerate allowing this to happen.

In addition, the Florida Department of Health and The Drug Enforcement Administration track physicians and their use of narcotics. An podiatric surgeon is not expected to prescribe narcotics long term. We agree with this policy. Therefore, if you are receiving narcotics from your previous physician or primary care physician, you will need to continue that.

We do not deny that you often have pain; however, it is necessary to be aware of your own ability to tolerate pain and the need to rely on this process in a timely manner. We have created this policy to assist in assuring that our patients receive the best care possible and we appreciate your assistance in enforcing it.

If you have any questions regarding our office policy on the use of narcotics, feel free to contact us so that we can discuss it. In addition, if you feel you need help with long-term (chronic) pain control, we will be happy to guide you to a pain management specialist.

By signing below you indicate that you have read the above information and understand our narcotic pain medication policy. Again, our concern is to provide you with the best results possible.

______________________________	______________________________	______________
Signature of Patient or Patient's Representative	**Printed Name of Patient**	**Date**

______________________________	______________________________
Printed Name of Patient's Representative	**Relationship to Patient**