Dr. Arthur Hansen Dr. Lori Lane Dr. Dina Hansen McCoy Dr. Ravi Pandey
Dr. Khoa Pham Dr. Daniel Heck Dr. Elizabeth Davis Jessica Farrone

(PLEASE COMPLETE ALL FIELDS)

Patient Name (Full legal name): **Last** ________________________ **First** ________________________ **Middle** ______________

Responsible Party (Parent, if minor): ____

Mailing Address: ______________________________________ **City, State, Zip:** ________________________________

Home Phone: (_____)_______________ **Business Phone:** (_____)_______________ **Cell Phone:** (_____)_______________

E-Mail Address: ____

Sex: Female / Male **Date of Birth:** _____/_____/_____ **Social Sec #:** ________-________-_________

Primary Language: _________________ **Do you need a translator?** Y N **Race:** _______________ **Ethnicity:** Hispanic Non-Hispanic

Marital Status: Single / Married / Widowed / Other **Please circle all that apply:** Employed Full-Time Student Part-time Student Unemployed

Employer/School: Name: ____________________ Address: __________________________ Phone: (_____)____________________

Emergency Contact : __________________________ **Relationship:** ________________ **Phone:** (_______) ____________________

Primary Insurance Co: ________________________________ **Secondary Insurance Co:** ________________________________

ID #: ____________________ **Group #:** ________________ **ID #:** ____________________ **Group #:**________________

Policy Holder Name: ________________________________ **Policy Holder Name:** ________________________________

Policy Holder's Date of Birth: ______/______/______ **Policy Holder's Date of Birth:** ______/______/______

Policy Holder's Sex: Female / Male **Policy Holder's Sex:** Female / Male

Relationship to Patient: (Self) (Spouse) (Child) (Other) **Relationship to Patient:** (Self) (Spouse) (Child) (Other)

How did you hear about us? □ Physician Referral □ Word of Mouth □ Insurance Provider □ Search Engine/Review Site □ Social Media
□ Other ____________________

Release of Medical Records and Assignments of Benefits

I hereby authorize the physicians of LA Medical Associates to release any information acquired in the course of my examination or treatment to my insurance company, hospitals or referring physician's office. I authorize assignment of benefits and payment directly to LA Medical Associates and agree to pay any and all charges that exceed or that are not covered by insurance, including any attorney and collection fees incurred for collection purposes. Photocopy of this release and assignment is as valid as the original.

Signature: ____ **Date**: __________________

____
If signature is other than the patient's, relationship to patient

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NEW PATIENT MEDICAL HISTORY FORM Today's Date: ____________________

Full Name: ____ Birthdate: ____________________ Age: _________

Reason for visit: ____

ALLERGIES □ No known medication allergies □ No environmental allergies □ No food allergies
Include name of allergy/reaction: ____

____

MEDICATIONS □ None □ Completed attached list to include routine and "as needed" prescriptions, over-the-counter, supplements, inhalers, injections, hormones, etc…

____

____

____

HEALTH MAINTENANCE SCREENING TEST HISTORY □ Never had any of the below testing

TEST	APPROX. DATE	PROVIDER/FACILITY	ABNORMAL RESULT
Colonoscopy			□ No Yes:
Cologuard			□ No Yes:
Mammogram			□ No Yes:
Pap Smear			□ No Yes:
Bone Density			□ No Yes:
PSA/Rectal			□ No Yes:

VACCINATION HISTORY □ Never vaccinated □ Received typical childhood vaccinations

Last Flu vaccine:	Last Tetanus or Tdap:
Last Shingles vaccine:	Last Pneumovax:
Other:	Last Prevnar:

WOMEN'S HEALTH HISTORY, if applicable

Date of last menstrual cycle:	Age of menopause:
Total number of pregnancies:	Total number of live births:

OTHER PROVIDERS/SPECIALISTS □ None

SPECIALIST	PROVIDER/OFFICE	SPECIALIST	NAME
Cardiology		Ophthalmology	
Dermatology		Pulmonary	
GI		Other:	
GYN		Other:	

PERSONAL MEDICAL HISTORY □ None

Check if Yes	DISEASE OR CONDITION (past or current) *write comments as needed next to disease/condition	Check if Yes	DISEASE OR CONDITION (past or current) *write comments as needed next to disease/condition
	Alcoholism/substance abuse		High cholesterol
	Anemia		HIV / AIDS
	Arthritis		Immune system disorders
	Asthma		Kidney diseases
	Bleeding disorder		Liver diseases
	Cancer, type:		Mental health issues
	COPD		Migraines/headaches
	Diabetes		Prostate
	Eye disorders		Suicide attempt in past
	Gout		Stroke
	Heart disease		Other:
	Hepatitis		Other:
	High blood pressure (hypertension)		Other

SURGERIES OR HOSPITALIZATIONS □ None

TYPE	DATE	LOCATION/FACILITY

SOCIAL HISTORY

Any history of tobacco use? □ No Yes: □ cigarettes □ pipe □ cigar □ snuff □ chew □ vape

Current: packs/day _______ # of years _______ Past: quit date ______________ packs/day _______ # of years ________

Do you drink alcohol? □ No Yes: □ beer □ wine □ liquor # of drinks per week _______

Do you use marijuana or recreational drugs? □ No □Yes: Type: ____

Occupation (or prior occupation): ____

□ retired □ unemployed □ disabled □ prior military Years of education or highest degree: ______________________

Marital status: □ single □ married □ divorced □ widowed □ partner # of daughters ________ # of sons ________

Do you have a living will, advanced directives, healthcare power-of-attorney? □ No □ Yes (please provide copy)

FAMILY HISTORY □ No family history is known □ Adopted

RELATION	AGE	STATE OF HEALTH (poor, fair, good, great)	AGE AT DEATH (if applicable)	CAUSE OF DEATH (if applicable)
Father				
Mother				
Brother				
Sister				
Child				

Any history of the following in your **FAMILY**?

Check if Yes	DISEASE/CONDITION	Check if Yes	DISEASE/CONDITION	Check if Yes	DISEASE/CONDITION
	Alcohol/Drug Abuse		Early Death		Thyroid Problems
	Asthma		Heart Disease		Other:
	Cancer		High Cholesterol		Other:
	COPD		Kidney Disease		Other:
	Depression//Anxiety		Migraines		Other:
	Dementia/Alzheimer's		Stroke		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 ____

****

To the best of my knowledge, the above information is complete and correct. I understand it is my responsibility to inform any doctor if I ever have a change in health.

Print name of patient, guardian or representative: ____

Signature of patient, guardian or representative: ____

Relationship to patient: ______________________________________ Date: ____________________

For the office staff, reviewed by: ______________________________ Date: ____________________

Dr. Arthur Hansen Dr. Lori Lane Dr. Dina Hansen McCoy Dr. Ravi Pandey
Dr. Khoa Pham Dr. Daniel Heck Dr. Elizabeth Davis Jessica Farrone

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 Medical Associates, Dr. Hansen, Dr. Lane, Dr. Heck, Dr. Davis, Dr. Hansen McCoy and Dr. Pandey 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 Medical Associates, Dr. Hansen, Dr. Lane, Dr. Heck, Dr. Pham, Dr. Davis, Dr. Hansen McCoy, Dr. Pandey and Jessica Farrone 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 Medical Associates 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 Medical Associates, Dr. Hansen, Dr. Lane, Dr. Heck, Dr. Pham, Dr. Davis, Dr. Hansen McCoy, Dr. Pandey and Jessica Farrone 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 Medical Associates, Dr. Hansen, Dr. Lane, Dr. Heck, Dr. Pham, Dr. Davis, Dr. Hansen McCoy, Dr. Pandey and Jessica Farrone 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 Medical Associates, Dr. Hansen, Dr. Lane, Dr. Heck, Dr. Pham, Dr. Davis, Dr. Hansen McCoy, Dr. Pandey and Jessica Farrone 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 Medical Associates, Dr. Hansen, Dr. Lane, Dr. Heck, Dr. Pham, Dr. Davis, Dr. Hansen McCoy, Dr. Pandey and Jessica Farrone 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 Medical Associates, Dr. Hansen, Dr. Lane, Dr. Heck, Dr. Pham, Dr. Davis, Dr. Hansen McCoy, Dr. Pandey and Jessica Farrone and staff may decline to provide treatment for me.
7. LA Medical Associates, Dr. Hansen, Dr. Lane, Dr. Heck, Dr. Pham, Dr. Davis, Dr. Hansen McCoy, Dr. Pandey and Jessica Farrone 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 *Print Name of Legal Guardian (if applicable)*

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Dr. Khoa Pham Dr. Daniel Heck Dr. Elizabeth Davis Jessica Farrone

Patient Privacy. Our practice is committed to securing the privacy of your health information. Accordingly, we have provided you with a copy of our practice's Notice of Privacy Practices. You are not required to read this notice. However, we would like your acknowledgement that you have been notified that the practice has such a Notice of Privacy Practices.

Print Name: ____

Signature ____ Date _________________

Please list names of your spouse/significant other and/or children that can receive and/or discuss your medical information with us.

NAME/RELATIONSHIP	PHONE
1____	________________________________
2____	________________________________
3____	________________________________

This notice authorizes us to leave messages concerning appointments, lab results, etc. at the numbers you listed on your registration form. This also authorizes us to release information concerning your health to the names listed above.

Print Name: ____

Signature ____ Date _________________

PHARMACY INFORMATION:

Please provide your pharmacy information:

Pharmacy Name: ____

Pharmacy Address/Location: ____

Pharmacy Phone Number: ____

Prescription refills are provided only for medications prescribed by LA Medical Associates. If you need a refill, please call your pharmacy. If your prescription is a narcotic, please call our office 72 hours prior to running out of your prescription.

Patient Signature: ____

Date: ___________________________________

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PATIENT RESPONSIBILITY POLICY:

PATIENTS ARE RESPONSIBLE **FOR CHECKING WITH THEIR CURRENT INSURANCE COMPANY** AS TO WHETHER OUR PHYSICIANS ARE CONTRACTED WITH THEIR INSURANCE PLAN. We do not contract with all insurance plans.

FEES: We must comply with insurance company regulations, consequently our fees are fixed. If your insurance DOES NOT PAY 100% of our contracted fees, you are responsible for your account balance prior to each visit. **If we are NOT contracted with your insurance plan, payment is expected at the time of service.**

COPAYS: All copays are collected when you arrive for your appointment. If you are not prepared to make your copay at the time of service, unless arrangements were made prior to your appointment with management.

SELF PAY: All visits to the doctor will require payment at the time services are rendered.

COLLECTIONS: Any patient that has been placed in **COLLECTIONS** must pay any prior balance owed to the practice as well as the collection agency fee **PRIOR** to being seen again in our practice.

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ADMINISTRATION FEE

In an effort to continue offering blood drawing, we have found it necessary to charge an administration fee of $200 per year per family. Included in this fee, our office will fill out any forms that you require at no charge. This fee will be due in full annually on you anniversary date (date of first appointment). Bear in mind that we have no control over blood laboratories and their charges or what your insurance policy pays. That is between your insurance and the laboratory.

You can elect, however, to not pay the administration fee. If this is the case, please be aware that all blood drawing will be performed by an outside drawing station. You will receive a prescription to take to the facility of your choice or per insurance requirements. Also, be aware that there will be a fee ($25 per page) for all forms that you need filled out by our office.

( ) I have elected to take advantage of all the services available by this office and pay the annual Administrative Fee.

( ) I have elected to not pay the Administrative Fee and I am aware that I will be referred to an outside facility as needed.

Patient Signature: ____

Date: ____

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Dear Patient,

Does your insurance company require you to go to an in-network laboratory for blood testing?

Yes: _______ What laboratory? ____

No: _______

I do not know: _______

This is to inform you that if you are a patient here, whether you have insurance or are without insurance and are self-paying, there may be a need to draw blood. The specimen is then sent to an outside laboratory which is not affiliated with this office, and we have no control over their prices or their contracts with insurance companies. In other words, you and your insurance are responsible for payment to these laboratories. We do have preferred laboratories that work with us for our patients whose blood we draw here in our office, but they may not work well with your insurance. We urge you to ask our staff if they can help you.

All medical expenses are subject to deductibles. After the first of the year, you will receive invoices requesting payment for that responsibility. Being an informed consumer, you obviously checked with your insurance company to see if we are in your insurance provider list. This is a responsibility you need to verify with every medical service you receive.

____

Patient Name or Responsible Party Date

____

Office Staff Date

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Policy for Prescription Narcotic Use

It is the goal of LA Medical Associates 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**	

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Dr. Khoa Pham Dr. Daniel Heck Dr. Elizabeth Davis Jessica Farrone

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 Medical Associates for the purpose outlined below.

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

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

____
Date

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