



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

Patient's 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:

Relationship to Patient (If signature is other than patient's)

2326 South Congress Ave., Suite 1-A, West Palm Beach, FL 33406
11000 Prosperity Farms Rd., Suite 206, Palm Beach Gardens, FL 33410
3347 State Rd. 7, Suite 204, Wellington, FL 33449
(561) 433-5577 Fax: (561) 275-2696



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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...

PERSONAL MEDICAL HISTORY

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 disorder
	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: _____



PODIATRIC MEDICINE & SURGERY QUESTIONNAIRE

Patient Name: _____
 FIRST, INITIAL, LAST

PRIMARY CARE PHYSICIAN: _____

Primary Physician Address: _____ Telephone: _____

REFERRED BY: _____

REASON FOR VISIT: _____

Is this a result of a Work Injury? _____ Yes _____ No Is this a result of an Auto Accident? _____ Yes _____ No

FOOT CONDITIONS OR COMPLAINTS: Have you ever been diagnosed and/or treated for any of the following conditions? If so, please mark.

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

PLEASE DESCRIBE YOUR FOOT COMPLAINT(S): _____

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: | <input type="checkbox"/> | <input type="checkbox"/> | Still using them? | <input type="checkbox"/> | <input type="checkbox"/> | Did they help? | <input type="checkbox"/> | <input type="checkbox"/> |
| Orthotics: | <input type="checkbox"/> | <input type="checkbox"/> | Still using them? | <input type="checkbox"/> | <input type="checkbox"/> | Did they help? | <input type="checkbox"/> | <input type="checkbox"/> |

Signature: _____ **Date:** _____



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

If applicable Print Name of Legal Guardian



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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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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



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



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