PATIENT INFORMATION

	FIRST NAME:	MIDDLE:
		STATE: ZIP CODE
GENDER RACE:	SSN:	DOB
EMPLOYER:		STATUS:
HOME PHONE () -	CELL PHONE:	WORK PHONE:
RESPONSIBLE PARTY		
NAME:	SSN:	DOB:
	PHONE #:	
MERGENCY CONTACT INFO	RMATION	
NAME:	RELATIONSHIP:	PHONE
NSURANCE INFORMATION PRIMARY INS:	POLICY NO :	
		GROUP NO.:
		DOB:
		GROUP NO.;
POLICY HOLDER NAME:		DOB:
REFERRING / PRIMARY CARE	DOCTOR	
NAME		PHONE#
NAMEPRIMARY CARE PHYSICIAN		PHONE #
		PHONE #:
PRIMARY CARE PHYSICIAN	PLEASE READ AND INITIAL TH	PHONE #:
PRIMARY CARE PHYSICIAN CONSENT FOR MEDICAL TREATMENT: I here aware that this practice of medicine is not an exa directed to my nurse or physician. ASSIGNMENT OF BENEFITS: I hereby authorize	PLEASE READ AND INITIAL THeby authorize Lakeview Family Foot Care (The Clinic) act science and I acknowledge that no guarantees have the clinic of any and all medical benefits applicable by this assignment. I also understand that the clinic is	PHONE #:
PRIMARY CARE PHYSICIAN CONSENT FOR MEDICAL TREATMENT: I here aware that this practice of medicine is not an exa directed to my nurse or physician. ASSIGNMENT OF BENEFITS: I hereby authorize responsible to the clinic for charges not covered contract with my carrier I am responsible for payment and the payment of the pa	PLEASE READ AND INITIAL The aby authorize Lakeview Family Foot Care (The Clinic) act science and I acknowledge that no guarantees have the clinic of any and all medical benefits applicable by this assignment. I also understand that the clinic is sent of this claim. ATION: I hereby authorize the clinic to release any in authorization includes but is not limited to the release	PHONE #: The Following: It to furnish the necessary medical that they deem necessary. I am we been made to me. Any questions related to my care should be and otherwise payable to me. I understand that I am financially is filing my claims as a courtesy to me and that unless stipulated in a
PRIMARY CARE PHYSICIAN CONSENT FOR MEDICAL TREATMENT: I here aware that this practice of medicine is not an exedirected to my nurse or physician. ASSIGNMENT OF BENEFITS: I hereby authorize responsible to the clinic for charges not covered contract with my carrier I am responsible for payman. AUTHORIZATION FOR RELEASE OF INFORM, benefits on this claim. Unless noted below, this testing. I authorize any physician or institution the LIFETIME MEDICARE B SIGNATURE AUTHOR or its intermediaries or carriers, or to the billing a	PLEASE READ AND INITIAL Theby authorize Lakeview Family Foot Care (The Clinic) act science and I acknowledge that no guarantees have the clinic of any and all medical benefits applicable by this assignment. I also understand that the clinic intent of this claim. ATION: I hereby authorize the clinic to release any information includes, but is not limited to, the release at attended to me previously to furnish medical reconstitution.	PHONE #: Ite FOLLOWING: It to furnish the necessary medical that they deem necessary. I am we been made to me. Any questions related to my care should be and otherwise payable to me. I understand that I am financially is filing my claims as a courtesy to me and that unless stipulated in a information requested by this insurance company necessary to collect the of information related to the description.
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CONSENT FOR MEDICAL TREATMENT: I here aware that this practice of medicine is not an exedirected to my nurse or physician. ASSIGNMENT OF BENEFITS: I hereby authorize responsible to the clinic for charges not covered contract with my carrier I am responsible for payman. AUTHORIZATION FOR RELEASE OF INFORM, benefits on this claim. Unless noted below, this testing. I authorize any physician or institution the LIFETIME MEDICARE B SIGNATURE AUTHOR or its intermediaries or carriers, or to the billing a original, and request payment of medical benefits. I give permission to provider and provider's busing include cellular numbers connected with me or my include cellular numbers.	PLEASE READ AND INITIAL Theby authorize Lakeview Family Foot Care (The Clinic) act science and I acknowledge that no guarantees have the clinic of any and all medical benefits applicable by this assignment. I also understand that the clinic intent of this claim. ATION: I hereby authorize the clinic to release any in authorization includes, but is not limited to, the release at attended to me previously to furnish medical reconstance. RIZATION: I authorize any holder of medical or other gent of the clinic, any information needed for this claims to be made to the holder of this assignment on my liness associates to contact me via the numbers I have account.	HE FOLLOWING: It to furnish the necessary medical that they deem necessary. I am we been made to me. Any questions related to my care should be and otherwise payable to me. I understand that I am financially significantly filling my claims as a courtesy to me and that unless stipulated in a information requested by this insurance company necessary to collect se of information related to drug, alcohol, HIV antibody and/or psychial discording or other information that may be requested by the clinic. Information about me to release the Social Security Administration m. I permit a copy of this authorization to be used in place of the pehalf. I understand that I am responsible for my health deductibles a provided on issues associated with my account with provider to
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Patient Name:		ACCOUNT#:		
DOB:	Age:			
MEDICAL HISTORY				
	e if you have/or had any of the	following:		
[] AIDS/HIV	[1]	High Blood Pressure	Do you smoke? Yes or No	
[] Allergies to Anesthetics	[1]	Itching Skin	Do you dilloke: 103 Of 140	
[] Anemia	[]	Kidney Problems	If yes, how many packs?	
[] Back Problems	[1]	Liver Disease	How long?	
[] Bleeding Disorders	[1]	Low Blood Pressure		
[] Cancer, type	[]	Muscle Pain	Alcohol use? Yes or	
[] Chemical Dependency	[]	Nervous Problems	Ma	
[] Chest Pain	[]	Neuropathy/Numbness	Caffeine? Yes or No	
[] Diarrhea	[]	Respiratory Disease	Drug use? Yes or No	
[] Diabetes (pills, insulin, diet)	[]	Shortness of Breath	2149 400: 163 OI 140	
[] Ear Problems	[]	Stroke		
[] Epilepsy	[]	Swelling in Ankles and/or Feet		
[] Eye Problems	[]	Tired Feet/Weakness		
[] Fainting	[]	Tuberculosis		
[] Foot or Leg Cramps	[]	Ulcers		
[] Gout	[]	Varicose Veins		
[] Headaches	[]	Other Issues		
[] Heart Disease				
[] Heart Attack				
[] Hepatitis - type A, B or C				
List Surgeries you have ha	d in the last 2 years:			
Reason for today's visit: (L	.eft, Right, Both)			
Height:	Weight:	Shoe Size:		
Have you been treated for t	the same condition in the past	? Yes or No		
If yes, by whom?				
Allergies:				
Consent:				
			ve my permission to the doctor to	

Date

Patient Signature



ABUSE OF PRESCRIPTION DRUGS AGREEMEN

PATIENT NAME:				
I use multiple pharmacies?	Yes	or	No	
My Primary Pharmacy			My Primary Pharmacy phone #	
Pharmacy and the DEA to investigate	oity, state, ate anv no	or tederal ssible mis	armacy noted above, or any other pharmacy that I may law enforcement agency, including the State of Alabam suse, sale or other diversion of my pain medication. I agality with respect to these authorizations.	o Doord of
These complications could result in	a amount o 1 permane	could harn nt health c	reater than the prescribed rate. I understand that by tak in my body and result in medical impairments or complic conditions or even death. Using my medication at a great priod of time and no additional medication will be provide	cations.
If asked, I will bring all unused pain	medicatio	n to every	office visit at Lakeview Family Foot Care, LLC.	
If asked, I will get a drug test or have pain control medication.	/e to subm	nit to a blo	od or urine test to determine my compliance with my pro	ogram of
I agree not to harass Dr. Skaziak, s	taff or any	employee	for pain medication.	
I agree to follow these guidelines no be immediately terminated from any	oted above suspecte	e regardin d prescrip	g the drug abuse policy and I understand that I may, wi tion drug abuse.	thout cause
medication.	y today. H	lowever, it	u from Lakeview Family Foot Care, LLC, explaining the you refuse to sign this form we cannot prescribe you a	termination ny pain
Should you have any questions, ple	ase feel fr	ee to disc	uss matters with Dr. Skaziak.	
Patient Signature				Date

LAKEVIEW FAMILY FOOT CARE NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

PATIENT NAME:		PATIENT DOB:
I UNDERSTAND THAT, UNDER THE HEA ("HIPPA"), I HAVE CERTAIN RIGHTS TO UNDERSTAND THAT THIS INFORMATION	PRIVACY REGARDING MY PRO	AND ACCOUNTABILITY ACT OF 1996 TECTED HEALTH INFORMATION. I
1) CONDUCT, PLAN AND DIRECT MY TE PROVIDERS WHO MAY BE INVOLVED IN	REATMENT AND FOLLOW-UP AND TREATMENT DIRECTLY DIRECTLY AND TREATMENT DIRECTLY DIRECTLY AND TREATMENT DIRECTLY DIRECTLY DIRECTLY AND TREATMENT DIRECTLY DIRECTLY DIRECTLY DIRECTLY DIRECTLY DIRECTLY DIRECTLY D	MOUNG THE MULTIPLE HEALTHCARE ND/OR INDIRECTLY.
2) OBTAIN PAYMENT FROM THIRD-PART	ΓΥ PAYERS.	
3) CONDUCT NORMAL HEALTHCARE O CERTIFICATIONS.	PERATIONS SUCH AS QUALITY	ASSESSMENTS AND PHYSICIAN
I HAVE RECEIVED, READ AND UNDERST MORE COMPLETE DESCRIPTION OF TH UNDERSTAND THAT LAKEVIEW FAMILY PRIVACY PRACTICES FROM TIME TO THE OBTAIN A CURRENT COPY OF THEIR NO	E USES AND DISCLOSURES OF FOOT CARE HAS THE RIGHT T ME AND THAT I MAY CONTACT	F MY HEALTH INFORMATION. I O CHANGE ITS NOTICE OF THE OFFICE AT ANY TIME TO
I UNDERSTAND THAT I MAY REQUEST IN INFORMATION IS USED OR DISCLOSED OPERATIONS. I ALSO UNDERSTAND YOU F YOU DO AGREE THAT YOU ARE BOUN	TO CARRY OUT TREATMENT, I DU ARE NOT REQUIRED TO MY	PAYMENT OR HEALTH CARE REQUESTED RESTRICTIONS, BUT
PATIENT SIGNATURE OR LEGAL GUARD	AN	DATE
	OFFICE USE ONLY	
I attempted to obtain the patient's signature Acknowledgement form, but was unable to d	n acknowledgement on this Notic o so as documented below.	e of Privacy Practices
Date: Initia	als: Reason:	

MEDICAL RECORD RELEASE FORM

I w w hereby give my consent for Lakeview Family Foot Care to use and disclose protected health information about me to carry out treatment, payment, and health care operations.

diagnosis, which might include r	nedical history, treatment,	e may inform about your general m laboratory reports, x-rays, and trea buse, or sexually transmitted disea	atment and/or reference
	Relationship:		
<u> </u>	Relationship:		
9	Relationship:		
Please list the family members of diagnosis only in an emergency	or other persons, if any, we situation:	e may inform about your general m	edical condition and your
	Relationship:		
	Relationship:		
sent, if other than your home:	e you would like your billir	ng statements and/or corresponder	nce from our office to be
Please print the telephone numb and/or other health care informat	er, if any, where you want tion, if other than your hom	to receive calls about your appoin e phone number:	tments, lab, x-ray results,
Can confidential messages be le reminders?		g machine or voice mail, for examp	• •
If you do not have voice mail, ca	n a confidential message b	e left at your place of employment	?
	Yes_	No	
Patient or guardian signature		Patient's Date of Birth (mm/dd/yy)	Date signed
Proof of Guardianship	Who's your Doctor?	_	