

Patient Name:

ACCOUNT#:

DOB:

Age:

MEDICAL HISTORY

Please put an X to indicate if you have/or had any of the following:

- | | | |
|--|---|-------------------------|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> High Blood Pressure | Do you smoke? Yes or No |
| <input type="checkbox"/> Allergies to Anesthetics | <input type="checkbox"/> Itching Skin | If yes, how many packs? |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Kidney Problems | How long? _____ |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Liver Disease | Alcohol use? Yes or No |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Low Blood Pressure | Yes or No |
| <input type="checkbox"/> Cancer, type _____ | <input type="checkbox"/> Muscle Pain | Caffeine? Yes or No |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Nervous Problems | Yes or No |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Neuropathy/Numbness | Drug use? Yes or No |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Respiratory Disease | Yes or No |
| <input type="checkbox"/> Diabetes (pills, insulin, diet) | <input type="checkbox"/> Shortness of Breath | |
| <input type="checkbox"/> Ear Problems | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Swelling in Ankles and/or Feet | |
| <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Tired Feet/Weakness | |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Tuberculosis | |
| <input type="checkbox"/> Foot or Leg Cramps | <input type="checkbox"/> Ulcers | |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Varicose Veins | |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Other Issues _____ | |
| <input type="checkbox"/> Heart Disease | | |
| <input type="checkbox"/> Heart Attack | | |
| <input type="checkbox"/> Hepatitis - type A, B or C | | |

List Surgeries you have had in the last 2 years: _____

Reason for today's visit: (Left, Right, Both) _____

Height: _____ Weight: _____ Shoe Size: _____

Have you been treated for the same condition in the past? Yes or No

If yes, by whom? _____

Allergies: _____

List all prescriptions, over the counter, or vitamins that you take: _____

Consent:

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be necessary in the diagnosis and/or treatment of my feet.

Patient Signature

Date



ABUSE OF PRESCRIPTION DRUGS AGREEMENT

PATIENT NAME:

I use multiple pharmacies? Yes or No

My Primary Pharmacy _____ My Primary Pharmacy phone # _____

I authorize Lakeview Family Foot Care LLC and my pharmacy noted above, or any other pharmacy that I may use in the future, to cooperate fully with any city, state, or federal law enforcement agency, including the State of Alabama Board of Pharmacy and the DEA to investigate any possible misuse, sale or other diversion of my pain medication. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I agree that I will use my pain medication at a rate no greater than the prescribed rate. I understand that by taking more pain medication than the prescribed amount could harm my body and result in medical impairments or complications. These complications could result in permanent health conditions or even death. Using my medication at a greater rate will also result in me being without pain medication for a period of time and no additional medication will be provided.

If asked, I will bring all unused pain medication to every office visit at Lakeview Family Foot Care, LLC.

If asked, I will get a drug test or have to submit to a blood or urine test to determine my compliance with my program of pain control medication.

I agree not to harass Dr. Skaziak, staff or any employee for pain medication.

I agree to follow these guidelines noted above regarding the drug abuse policy and I understand that I may, without cause, be immediately terminated from any suspected prescription drug abuse.

If patient is terminated then a letter will be mailed to you from Lakeview Family Foot Care, LLC, explaining the termination. We would like you to sign our policy today. However, if you refuse to sign this form we cannot prescribe you any pain medication.

Should you have any questions, please feel free to discuss 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 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPPA"), I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. I UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED TO:

- 1) CONDUCT, PLAN AND DIRECT MY TREATMENT AND FOLLOW-UP AMONG THE MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN MY TREATMENT DIRECTLY AND/OR INDIRECTLY.

- 2) OBTAIN PAYMENT FROM THIRD-PARTY PAYERS.

- 3) CONDUCT NORMAL HEALTHCARE OPERATIONS SUCH AS QUALITY ASSESSMENTS AND PHYSICIAN CERTIFICATIONS.

I HAVE RECEIVED, READ AND UNDERSTAND YOUR NOTICE OF PRIVACY PRACTICES CONTAINING A MORE COMPLETE DESCRIPTION OF THE USES AND DISCLOSURES OF MY HEALTH INFORMATION. I UNDERSTAND THAT LAKEVIEW FAMILY FOOT CARE HAS THE RIGHT TO CHANGE ITS NOTICE OF PRIVACY PRACTICES FROM TIME TO TIME AND THAT I MAY CONTACT THE OFFICE AT ANY TIME TO OBTAIN A CURRENT COPY OF THEIR NOTICE OF PRIVACY PRACTICES.

I UNDERSTAND THAT I MAY REQUEST IN WRITING THAT YOU RESTRICT HOW MY PRIVATE INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS. I ALSO UNDERSTAND YOU ARE NOT REQUIRED TO MY REQUESTED RESTRICTIONS, BUT IF YOU DO AGREE THAT YOU ARE BOUND TO ABIDE BY SUCH RESTRICTIONS.

PATIENT SIGNATURE OR LEGAL GUARDIAN

DATE

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement form, but was unable to do so as documented below.

Date:

Initials:

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.

Please list the family members or other persons, if any, we may inform about your general medical condition and your diagnosis, which might include medical history, treatment, laboratory reports, x-rays, and treatment and/or reference to any mental or nervous disorders, drug, and/or alcohol abuse, or sexually transmitted disease

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

Please list the family members or other persons, if any, we may inform about your general medical condition and your diagnosis only in an emergency situation:

_____ Relationship: _____

_____ Relationship: _____

Please print the address of where you would like your billing statements and/or correspondence from our office to be sent, if other than your home:

Please print the telephone number, if any, where you want to receive calls about your appointments, lab, x-ray results, and/or other health care information, if other than your home phone number:

Can confidential messages be left on your home answering machine or voice mail, for example, appointment reminders?

Yes _____ No _____

If you do not have voice mail, can a confidential message be 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?