FOOTCARE SPECIALISTS OF ARIZONA

Bruce B. Levin DPM PA
10503 W. Thunderbird Blvd. Suite 109
Sun City, AZ 85351
Phone (623) 977-9100 Fax (623) 977-8020

PATIENT INFORMATION

DATE: _____

NAME: _____ BIRTH DATE: _____

PHONE: _____ CELL PHONE: _____ AGE: _____

ADDRESS: _____
(P.O. BOX OR STREET) (CITY) (STATE) (ZIP)

EMAIL ADDRESS: _____

OUT OF STATE ADDRESS: _____
(P.O. BOX OR STREET) (CITY) (STATE) (ZIP)

EMPLOYER NAME: _____ WORK PHONE: _____

EMPLOYER ADDRESS: _____

SOCIAL SECURITY #: _____

HOW DID YOU LEARN ABOUT OUR OFFICE? _____

PRIMARY CARE PHYSICIAN: _____
WHICH PHARMACY DO YOU USE? _____
CROSS ROADS / LOCATION? _____

EMERGENCY CONTACT

(To be notified in case of emergency. Someone ***NOT*** living with you).

NAME: _____ HOME PHONE: _____

RELATIONSHIP: _____ WORK PHONE: _____

EMPLOYER NAME: _____ HOME ADDRESS: _____

RESPONSIBLE PARTY INFORMATION

(Person responsible for paying any balance not covered by insurance).

NAME: _____ HOME PHONE: _____

RELATIONSHIP: _____ DOB: _____ SSN #: _____

ADDRESS: _____

INSURANCE INFORMATION
PRIMARY INSURANCE

NAME OF INSURANCE COMPANY: _____

CLAIMS ADDRESS: _____
(P.O. BOX OR STREET) (CITY) (STATE) (ZIP)

POLICY #: _____ GROUP #: _____

EFFECTIVE DATE: _____ NAME OF INSURED PERSON: _____

ANNUAL DEDUCTIBLE: _____ CO-INSURANCE (%) OR CO-PAY ($): _____

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY: _____

CLAIMS MAILING ADDRESS: _____
(P.O. BOX OR STREET) (CITY) (STATE) (ZIP)

POLICY #: _____ GROUP #: _____

EFFECTIVE DATE: _____ NAME OF INSURED PERSON: _____

RELEASE OF INFORMATION/INSURANCE ASSIGNMENT

DO WE HAVE PERMISSION TO ____?	**YES**	**NO**
LEAVE A MESSAGE ON YOUR ANSWERING MACHINE?		
LEAVE A MESSAGE AT YOUR PLACE OF EMPLOYMENT?		
DISCUSS YOUR MEDICAL CONDITION WITH ANY FAMILY MEMBERS?		
IF YES, WITH WHOM?		

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS FOR SERVICES I HAVE BEEN PROVIDED. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. I AUTHORIZE BRUCE B. LEVIN, DPM, PA, TO APPLY FOR BENEFITS ON MY BEHALF FOR ANY COVERED SERVICES. I REQUEST THAT PAYMENT FROM THE INSURANCE COMPANY BE MADE DIRECTLY TO BRUCE B. LEVIN, DPM, PA. I AUTHORIZE BRUCE B. LEVIN, DPM, PA, TO CONTACT AND FORWARD ANY PERTINENT MEDICAL INFORMATION TO MY OTHER PHYSICIAN FOR THEIR RECORDS. I FURTHER UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE PAID BY MY INSURANCE COMPANY.

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT.

PATIENT SIGNATURE: _____

DATE: _____

SOCIAL HISTORY

DO YOU SMOKE?	YES	NO
DO YOU DRINK?	YES	NO

IF YES, # OF CIGARETTES YOU SMOKE PER DAY? _____
IF YES, # OF DRINKS YOU DRINK PER WEEK? _____

DOES YOUR WORK OR LIFESTYLE INVOLVE SPENDING LARGE AMOUNTS OF TIME ON YOUR FEET? (YES OR NO) _____

IF YES, PLEASE EXPLAIN: _____

WHAT IS YOUR OCCUPATION? _____

DO YOU EXERCISE? (YES OR NO) _____

IF SO, HOW MUCH AND HOW OFTEN? _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF:	YES	NO
DIABETES		
HEART DISEASE		
BLOOD CLOTS		
BLEEDING PROBLEMS		
STROKE		
GOUT		
RHEUMATOID ARTHRITIS		

MEDICATIONS

PLEASE LIST **ALL** MEDICATIONS (PRESCRIPTION AND NON-PRESCRIPTION) THAT YOU TAKE ON A REGULAR BASIS AND THE REASON FOR TAKING.

MEDICATION	MILLIGRAMS	HOW OFTEN	REASON TAKING

ALLERGIES

	YES	NO		YES	NO
PENICILLIN			ASPIRIN		
IODINE			SULFA		
ADHESIVE TAPE			NOVOCAIN		
SHELLFISH			LATEX		
CODEINE			OTHERS:		

PATIENT MEDICAL HISTORY

LOCAL PHYSICIAN: _____ LAST VISIT: _____

OTHER PHYSICIAN: _____ LAST VISIT: _____

FORMER PODIATRIST: _____ LAST VISIT: _____

HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____

WHAT TYPE OF FOOT PROBLEMS BRING YOU TO OUR OFFICE TODAY?

_____

PAST MEDICAL HISTORY

DO YOU OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

	YES	NO		YES	NO
DIABETES			COPD / EMPHYSEMA		
ABNORMAL HEART CONDITION			ASTHMA		
HEART ATTACK			STROKE		
MITRAL VALVE PROLAPSE			SEIZURE OR EPILEPSY		
VASCULAR DISEASE / BAD CIRCULATION TO YOUR FEET			KIDNEY DISEASE		
ABNORMAL BLOOD PRESSURE			LIVER DISEASE		
LUNG DISEASE			HEPATITIS (DEFINE A, B, OR C)		
STOMACH ULCERS			THYROID DISEASE		
ARTHRITIS / OSTEOARTHRITIS			RHEUMATOID ARTHRITIS		
GOUT			NEUROPATHY / NUMBNESS		
ARTIFICIAL JOINTS			DIFFICULTY IN HEALING		
CANCER			HIV		
OTHER:					

PLEASE DESCRIBE ANY OTHER MEDICAL PROBLEMS, INCLUDING FOOT PROBLEMS THAT YOU HAVE ENCOUNTERED.

_____

_____

FOR WOMEN ONLY: ARE YOU PREGNANT? _____

IF SO, HOW MANY MONTHS? _____ LAST MENSTRUAL PERIOD: _____

PAST SURGICAL HISTORY AND HOSPITALIZATIONS

PLEASE GIVE AS MUCH DETAIL AS YOU CAN:

OPERATIONS / SERIOUS INJURIES	APPROX. DATE WHEN OCCURRED	PHYSICIAN	HOSPITAL

* PLEASE, PLACE A CHECK NEXT TO ANY PROBLEMS YOU MAY BE CURRENTLY EXPERIENCING OR HAVE EXPERIENCED IN THE PAST.

CONSTITUTIONAL

___ Decrease in Appetite ___ Faintness ___Fever ___ Headache ___ Feeling Room Spinning

___ Weakness ___ Weight Loss ___ Weight Gain ___ None

COMMENTS: _____

SKIN/NAILS

___ Allergic to Chemicals ___Skin Dryness ___ Thick or Discolored Toenails ___ Skin Itching

___ Skin Cracking ___ Thick or Discolored Finger Nails ___ Skin Cancer

___ Scarring After Surgery / injury ___ None

COMMENTS: _____

MUSCULOSKELETAL

___ Joint Aches or Paints ___ Chronic Neck Pain ___ Chronic Hip or Knee Pain

___ Chronic Lower Back Pain ___ Chronic Ankle Pain ___ Stiffness ___ Swelling in Joints

___ Morning Sickness ___ Pain when rising in the Morning or at any time ___ None

COMMENTS: _____

CARDIOVASCULAR

___ Chest or arm pain ___Blood clots ___ Cramps in legs or feet when walking

___ High Blood pressure ___ Low Blood pressure ___ Heart Attack ___ Heart Murmur

___ Cramps when sleeping (in legs or Feet) ___ Heart Palpitations ___ Stroke ___ Varicose Veins

___ Mitral Valve Prolapse ___ None

COMMENTS: _____

NEUROLOGIC

___ Tingling ___Pins and Needles ___ Numbness ___ Burning ___ Radiating Pain ___ Shooting Pain

___ Increased Sensitivity to Touch ___ Decrease or Lack of Sensation to Touch

___ Decrease / Lack of Sensation in Cold or Warmth ___ None

COMMENTS: _____

ALLERGIC / IMMUNOLOGIC

___ Lumps in Groin or Armpit ___ Fever ___ Chills ___ Night Sweats ___ Sore Throat ___ Coughing

___ Wheezing ___ General Feeling of Being Sick ___ None

COMMENTS: _____

ENDOCRINE

___ Increase or Decrease in Thirst ___ Increase of Decrease in Appetite ___ Diabetes Mellitus

___ Increase or Decrease in Urination ___ Weight Loss or Gain ___ Thyroid Problem

___ Post Menopause ___ Sensitivity to Heat or Cold ___ None

COMMENTS: _____

RESPIRATORY

___ Difficulty in Breathing ___ Cough ___ Coughing Blood ___ Wheezing ___ Shortness in Breath

___ Difficulty in Breathing When Laying Flat ___ Waking Up Short of Breath ___ None

COMMENTS: _____

EARS, NOSE, MOUTH, THROAT

___ Headache ___ Convulsions ___ Dentures ___Difficulty Hearing ___ Nose Bleeds ___ Sore Throat

___ Migraines ___ Dry Mouth ___ Runny Nose ___ Difficulty Swallowing ___ Teeth or Gum Problems

___ Ringing In the Ears ___ Fainting Spells ___ None

COMMENTS: _____

EYES

___ Blurred Vision ___ Double Vision ___ Dry Eyes ___Eye Infections ___ Runny or Draining Eyes

___ None

COMMENTS: _____

GASTROINTESTINAL

___ Abdominal Cramps ___ Inflammation of Colon ___ Constipation ___Diarrhea ___ Heartburn

___ Difficulty Swallowing ___ Blood in Stool ___ Hemorrhoids ___ Jaundice or Yellow Skin

___ Black or Tarry Stools ___ Nausea ___ Vomiting ___ None

COMMENTS: _____

GENITOURINARY

___ Inability to Urinate ___ Pain or Urination ___ Burning When Urinating ___Blood in Urine

___ Dark Urine ___ Excessive Number of Times Urinating at Night ___ Inability to Hold Urine

___ Yeast Infection ___ Decrease in Amount of Urine Produced ___ None

COMMENTS: _____

PSYCHIATRIC

___ Dementia ___ Depression ___ Manic-Depression/Bipolar ___Memory Loss ___ Confusion

___Panic Attacks ___ Obsessive Compulsive Disorder ___ Paranoia ___ None

COMMENTS: _____

HEMATOLOGICAL/BLOOD

___ Hemophilia ___ Anemia ___ Bruising Easily ___Blood Transfusion Reaction

___ Sickle Cell Disease or Trait ___Leukemia ___ Weakness ___ Jaundice or Yellow Skin ___None

COMMENTS: _____

IS THERE ANYTHING YOU WISH TO TELL YOUR PHYSICIAN PRIVATELY?

_____ YES _____NO

WHICH PHARMACY DO YOU USE? _____

CROSS ROADS (LOCATION)? _____

PATIENT SIGNATURE: _____

DATE: _____

DPM REVIEWED, SIGN & DATE _____

CHANGES NOTED & DATED _____

PRACTICE REQUIREMENTS

THIS PRACTICE:

*IS REQUIRED BY FEDERAL LAW TO MAINTAIN THE PRIVACY OF YOUR PRIVATE HEALTH INFORMATION (PHI) AND TO PROVIDE YOU WITH THIS PRIVACY NOTICE DETAILING THE PRACTICE'S LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO YOUR PHI.

* UNDER THE PRIVACY RULE, MAY BE REQUIRED BY STATE LAW TO GRANT GREATER ACCESS OR MAINTAIN GREATER RESTRICTIONS ON THE USE OR RELEASE OF YOUR PHI THAN WHICH IS PROVIDED FOR UNDER FEDERAL LAW.

*IS REQUIRED TO ABIDE BY THE TERMS OF THE PRIVACY NOTICE.

*RESERVES THE RIGHT TO CHANGE THE TERMS OF THIS PRIVACY NOTICE AND TO MAKE THE NEW PRIVACY NOTICE PROVISIONS EFFECTIVE FOR YOUR ENTIRE PHI THAT IT MAINTAINS.

*WILL DISTRIBUTE ANY REVISED PRIVACY NOTICE TO YOU PRIOR TO IMPLEMENTATION.

*WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT.

EFFECTIVE DATE

*THIS NOTICE IS IN EFFECT AS OF 12/15/2007.

PATIENT ACKNOWLEDGEMENT

*BY SIGNING MY NAME BELOW, I ACKNOWLEDGE RECEIPT OF A COPY OF THIS NOTICE, AND MY UNDERSTANDING AND MY AGREEMENT TO ITS TERMS.

_____

PATIENT SIGNATURE

_____

DATE

FOOTCARE SPECIALIST'S OF ARIZONA
FINANCIAL POLICY

THANK YOU FOR CHOOSING US AS YOUR HEALTH CARE PROVIDER. WE STRIVE TO PROVIDE THE MOST UP-TO-DATE AND COST EFFECTIVE TREATMENT, THERAPY, AND PRODUCTS FOR YOUR FOOT AND ANKLE CARE. PLEASE UNDERSTAND THAT PAYMENT OF YOUR BILL IS CONSIDERED A PART OF YOUR TREATMENT.

MEDICARE PATIENTS ARE REQUIRED TO MEET A **$185.00** CALENDAR YEAR DEDUCTIBLE. IF YOU HAVE A SUPPLEMENTAL OR SECONDARY INSURANCE, PLEASE INFORM OUR STAFF PRIOR TO YOUR VISIT.

NON-COVERED MEDICAL SUPPLIES OR SERVICES MUST BE PAID IN FULL AT THE TIME OF THE VISIT.

INDEMNITY INSURANCE PLANS SUCH AS BLUE CROSS/BLUE SHIELD WILL BE BILLED. YOU WILL BE RESPONSIBLE FOR ANY CO-INSURANCE AND DEDUCTIBLE AMOUNTS. IF WE DO NOT RECEIVE PAYMENT WITHIN 90 DAYS, WE WILL TRANSFER THE BALANCE TO YOUR RESPONSIBILITY FOR PAYMENT.

PATIENTS WHO ARE COVERED BY A COMMERCIAL INSURANCE CARRIER, WITH WHOM WE ARE NOT PRACTICING PHYSICIANS, WILL REMAIN RESPONSIBLE FOR THEIR BALANCE. WE WILL COURTESY BILL YOUR CARRIER. IF WE DO NOT RECEIVE PAYMENT WITHIN 90 DAYS, WE WILL TRANSFER THE BALANCE TO YOUR RESPONSIBILITY FOR PAYMENT.

PATIENTS THAT DO NOT HAVE MEDICAL INSURANCE WILL BE REQUIRED TO PAY FOR THEIR SERVICES RENDERED IN FULL ON THE DATE OF SERVICE. WE WILL TRY TO ACCOMMODATE PATIENTS BY SUPPLYING AN ESTIMATE PRIOR TO SEEING THE DOCTOR. PAYMENT PLANS ARE NOT ACCEPTED.

WE REQUIRE PAYMENT IN THE FORM OF CASH, MONEY ORDER, CHECK, OR VISA/MASTERCARD.

CREDIT CARD GUARANTEE AUTHORIZATION IS RECOMMENDED. PLEASE ASK THE RECEPTIONIST FOR FURTHER INFORMATION OR CONCERNS.

THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICY. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS.

I HAVE READ THE FINANCIAL POLICY. I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

_____ _____

SIGNATURE OF PATIENT/RESPONSIBLE PARTY **DATE**

_____ _____

SIGNATURE OF WITNESS **DATE**

FOOTCARE SPECIALISTS OF ARIZONA
Bruce B. Levin D.P.M., F.A.C.F.A.S.
10503 W. Thunderbird Blvd., Suite 109
Sun City, AZ 85351

Advance Beneficiary Notice (ABN)
Patient agreement to pay for services not covered by insurance
(Waiver of liability statement)

Name of patient:

Insurance pays only for services that are determined to be reasonable and necessary. If a particular service is not reasonable and necessary under insurance standards, although it would otherwise be covered, insurance denies payments for that service. I will be responsible for any balances that my insurance does not cover.

Patient signature:

_____

Witness signature:

_____

Date:

_____

FOOTCARE SPECIALISTS of Arizona

BRUCE B. LEVIN D.P.M., F.A.C.F.A.S., P.A.

STEROID INJECTION

Informed Consent

Intralesional and subcutaneous steroid injections are often performed to decrease pain, swelling and inflammation. The procedure consists of a steroid suspension injected into the skin in a sterile fashion, under diagnostic ultrasound.

I understand there is a possibility of rare side effects such as atrophy (temporary or permanent depression of the skin), permanent scarring, temporary redness, and bruising, skin atrophy or hypopigmentation. There can also be a mild increase in blood sugar levels in diabetic patients for a day or so.

I also understand that multiple injections may be required before my condition improves and that my condition may not improve even after the injection(s).

I have read the above and understand it. I have been given the opportunity to ask questions and they have been answered to my satisfaction. I accept the risks and complications of this procedure as stated above, and consent to the terms of this agreement.

_____	_____	_____
Patient Name	Patient Signature	Date

_____

Witness

Diplomate, American Board of Podiatric Surgery
American Podiatric Medical Association
Arizona Podiatric Medical Association
Fellow American College of Foot Surgeons

Banner Boswell West Medical Office Bldg.
10503 W. Thunderbird Blvd., Suite 109, Sun City, Arizona 85351 • (623) 977-9100 • Fax (623) 977-8020