PATIENT INFORMATION FORM

DATE: __/__/__ First: _____ Last:_____

DOB:___/___/___ AGE: ____ SEX: __M __F SS#:_____

Email: _____

Primary Dr: _____ Phone# _____Last Visit: _____

Pharmacy: _____ Pharmacy #: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Alternate phone #_____

Employer: _____ Occupation:_____

Spouse's Name: _____

Primary Insurance: _____ ID#: _____ Group#: _____

Cardholder: _____ SS#: _____ DOB: __/__/__

Secondary Insurance: _____ ID#: _____ Group #: _____

Cardholder: _____ SS#: _____ DOB: __/__/__

Emergency Contact: _____
Is this Workers Comp or Accident related? YES / NO _____
_____
Have you recently been seen another podiatrist: __Y___N When: _____
Dr: _____

Current Problems:
_____

Length of time for current problem: ___Days ___Weeks ___Months ___Years

CURRENT MEDICATIONS

_____ _____ _____

_____ _____ _____

Are you currently taking any of the following:

__ Echinacea __Garlic __Ginger __Gingko Biloba __St. John's Wort __Ginseng __Feverfew __Ephedra

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Immunization Status: __Polio __DPT/DtaP __Measles __MMR __Hep B __Varicella

Tetanus Status: __Current __Over 5 years __Over 10 years __Unknown

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Vital Signs Height __ft __in Weight _____ BP _____ Temp. _____

Allergies:

	Penicillin		Sulfa Drugs		Aspirin		Codine
	Shellfish		Tape		Anaesthetic		Latex
	Antibiotics						

Other _____

Environmental Allergies: _____

Previous Injuries: _____ _____

Previous Surgeries: _____ _____

Previous Hospitalizations: _____ _____

PATIENT HISTORY:

	Major Disease:		**RESPIRATORY:**		**VASCULAR:**		**Miscellaneous**
	Diabetes		Asthma		Anemia		Epilepsy
	Hypertension		Bronchitis		Sickle Cell		Thyroid Disease
	Angina		Frequent Colds		Bleeding Disorder		Muscle Disease
	Heart disease		Lung Disease		Poor Circulation		Kidney Problems
	Heart Attack		Shortness of Breath		Night Cramps		Prostate Problems
	Arrhythmia		Tuberculosis		Leg Pain if Walking		Venerial Disease
	Murmur		Emphysema		Vein Problems		Skin Condition
	Stroke				Spider Veins		Cancer History
	Chest Pain		**ARTHRITIS:**		Varicous Veins		Hepatitis
			Osteoarthritis		Swelling Problem		
	GASTROINTESTINAL:		Rheumatoid		Leg Ulceration		**Psychological:**
	Ulcers		Gout		Blood Clots		Anxiety
	Stomach Problem		Sero-negative		Transfusions		Depression
	Histal Hernia						Psychiatric Condition
	Bowel Disorder		**HEENT:**				Drug Dependence
	GI or Renal Bleeding		Headaches		Hospice		Alcohol Dependence
	Acid Reflux		Eye Problems				OTHER:
			Hearing Problems				

FAMILY HISTORY:

_____

SOCIAL HISTORY:__ Married __ Single __ Divorced __Widow
Occupation: _____
Athletic Activities: _____
Alcohol ___ oz/day __oz/week Tobacco ___ pks/day __yrs

Permission to Treat

I hereby authorize Dr. Michael Lyons, P.C. to examine, diagnose, and treat my extremity condition and to perform any procedures deemed medically necessary. This authorization includes the dispensing of Durable Medical Equipment (DME) as part of my treatment.

I authorize my insurance company to pay medical benefits directly to Dr. Michael Lyons, P.C. I understand that insurance benefits are **not a guarantee of payment** and that I am financially responsible for **all charges**, including but not limited to deductibles, copayments, coinsurance, non-covered services, and any remaining balance not paid by my insurance.

I understand that services rendered and medical equipment dispensed are **non-refundable**, regardless of insurance coverage or payment outcome.

Signature of Responsible Party Date

_____ _____

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

Patient Name: _____ DOB: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____

Date: _____

Relationship to Patient: _____

(Dear Patients: This Privacy Statement means that we have told you that your medical and personal information will not be given to anyone unless you allow us to do so. Please do so in writing. If you have any questions, please feel free to ask.)

PRIVATE INSURANCE POLICY HOLDERS

Dr. Michael Lyons, P.C. participates with many private and employer-sponsored insurance plans. Coverage and benefits vary by plan and employer contract.

While we make every effort to verify insurance information and submit claims accurately, insurance benefits and benefit verification are not a guarantee of payment. Patients are financially responsible for all services provided, including deductibles, copayments, coinsurance, non-covered services, services requiring authorization or referral, and any charges not paid by the insurance carrier.

It is the patient's responsibility to provide current and accurate insurance information prior to each visit and to notify our office of any changes or termination of coverage. Failure to do so may result in charges being billed directly to the patient.

For questions regarding coverage, referrals, authorizations, or benefit limitations, patients are encouraged to contact their insurance carrier directly.

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT FINANCIAL RESPONSIBILITY AS DESCRIBED.

Signature of Responsible Party Date

_____ _____

MEDICARE PATIENTS

I request that payment of authorized Medicare benefits be made on my behalf to Dr. Michael Lyons, P.C. for services furnished to me by said physician. I authorize the release of any medical information necessary to process Medicare claims and determine benefits payable for related services.

Signature of Beneficiary or Authorized Representative Date

_____ _____

Foot Health Centers

Michael Lyons, DPM

P#662-449-3663

F#662-449-3676

Robert Wenzler, DPM

P#662-470-4608

F#662-470-4610

Authorization for Use and Disclosure of Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that information used or disclosed pursuant to the authorization may be disclosed by the recipient and may no longer be protected by the Federal Privacy Regulations.

Patient Name: _____

Person/Organization authorized to use or release the information: Foot Health Centers/Dr. Michael Lyons PC

Purpose of use or disclosure of health information: billing/continuity of care

I understand this authorization will expire: 1 year after above date

I understand that I may revoke this authorization at any time by notifying Foot Health Centers; however, if I revoke this authorization, my revocation is not effective to the extent Foot Health Centers has relied on this authorization before receiving my revocation.

I understand that Foot Health Centers/Dr. Michael Lyons PC will not condition my treatment, payment or enrollment in a health plan on whether I provide authorization for the use and disclosure described above except:

-If my treatment is related to research

-If healthcare is provided to me solely for the purpose of creating protected health information for disclosure to a third party

Patient's signature: _____ Date: _____

OR Patients representative: _____

Relationship to patient: _____

Office Manager

662-449-3663

Foothealthbilling@gmail.com