Patient Information Record

Please Print

Patient's Name_____
First **Middle** **Last**

Date of birth _____/_____/_____ Gender: Male _____ Female____ SS Number: _____

Address _____ City _____

State: _____ Zip Code:_____

Mailing address if different:_____

Email address:_____

Home phone: _____Cell phone :_____

Occupation: _____ Employer: _____ Business Phone _____

Preferred Language:_____ Ethnicity: _____ Hispanic: ___ No ___ Yes

Who may we contact in an emergency? _____ Tel: _____

Relationship to Patient: ____ Spouse ___ Other (Son, Daughter, Friend, etc): _____

May we leave a message for you at home ? ___No ___ Yes At work? ___ No ___ Yes

To whom do you authorize us to discuss your medical information:_____

Relationship to you? _____

How did you hear about Dr. Laliberte or who referred you? _____

Insurance Information

Do you have insurance? ___ No ____ Yes : Please present your insurance card(s) and a valid photo ID

Are you the primary insured? ___ No ___ Yes

If no, please provide the primary insured information:
Name_____ Date of Birth____/____/_____ Relationship:_____

Assignment Authorization and Policies

I hereby authorize Dr. Laliberte and staff to release to my insurance companies representatives and to my primary care physician or any physician referred by Dr. Laliberte, medical information including test results, the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care by Dr. Laliberte.

I authorize and request that my insurance companies pay directly to Dr. Laliberte the amount due for my pending claims for medical or surgical treatments or services rendered to me. I understand I am financially responsible for non covered charges at all times, including all co-pays, co-insurance and annual deductibles which are payable at the time of service. Our office does not bill you for these. Co-pays, co-insurance and outstanding account balances are due prior to you visit with the doctor.

It is **YOUR** responsibility to inform and provide our office with all correct information and any changes in your current and active medical insurance plan(s), billing address and phone numbers. Failure to do so results in you being responsible for the cost of the visit. There are **NO** exceptions.

You are required to present your insurance card every visit. We must have a copy of your card to file any insurance for your family. All insurance changes must be given to us at the time of service. If your insurance coverage changes and we are not notified, you will be responsible for all charges. We will be unable to bill your insurance for any prior changes before the change notification.

I understand that it is my responsibility to pay any deductible amount, co- insurances or any other balances not paid for by my insurance. Any unpaid balances are subject to collection so please pay all past due amount prior to you next visit. A **$25.00** fee will apply to all NSF returned checks in addition to the amount due.

Our office makes concerted efforts to provide care within the scope of services covered by your insurance policy and that your test are performed in the properly designated facility. If you are concerned that your insurance company may not cover services you will receive, please consult your insurance company prior to the date of service. In the event your health insurance plan determines a service to be not covered, you may be responsible for this charge.

Medication refills take at least (2) business days to process. Please call your call your pharmacy to request your refill. They will fax our office your request which need to be approved by Dr. Laliberte. Allow two days, and then check with your pharmacy for the medication before calling the office. We no longer accept refill request from patients. Some insurance companies may not pay for certain medications. Our office does not pre-certify or pre-authorize prescriptions.

Dr. Laliberte will review your test to be discussed at your follow up appointment if you do not have an appointment please call the office to schedule

I understand and agree to these policies

_____	_____	_____
Print Name	Signature of patient or legal representative	Date

A photographic copy of this authorization shall be as valid as the original.

Office Policies

We see patients with scheduled appointments only. We do not see walk in patients without an appointment, except for emergencies. Please call (407)523-9993 to schedule. If you are unable to keep your scheduled appointment please call at least 24 hours in advance. We understand that there are times when you need to miss an appointment at the last minute so please call as soon as you know you are unable to make your appointment or if you are running late. **If you miss your appointment without calling to cancel, you will be charged a $55 missed appointment fee and if you miss your in office surgery you will be charged a $100 fee.** This amount will not be billed to your insurance and you will bear complete financial responsibility for this fee. Repeated missed appointments may result in dismissal from our practice.
Established patients please arrive at least 10 minutes prior to your appointment time so we can check you in. New patients are asked to arrive 20 minutes prior to their scheduled time to allow for registration and form competition. **If you arrive 20 minutes past your scheduled appointment time you have missed your appointment and will be asked to reschedule.** Your visit will be considered a "missed appointment". Late arrivals disrupt the flow of patients who arrive on time for their appointment.

Cooperate with your doctors recommendations by scheduling an appointments to discuss any changes in your treatment plan, informing the clinical staff if you are having difficulties with a treatment plan or about to run out of medicine.
Lack of effort to cooperate with medical advice may considered grounds for discharge from the practice.

Laboratory and Radiology Services

Laboratory test and radiology services are provided by a separate business. You will receive a separate bill for these services, We will make every effort to make certain that your services are covered by your insurance policy. If you are concerned that your insurance company may not cover services you will receive, please consult you insurance company prior to the date of service. In the event your health insurance plan determines a service not covered, you will be responsible for this charge.

Copies of Medical Records

Medical records can be copied and sent to another provider at no cost to you. This includes 7 years of clinical notes, and 7 years of test results; if for your personal use, there is a $1 a page fee for all clinical documentation. A $25 charge will be incurred for Dr. Laliberte to complete any medical forms (insurance policies, physical forms, Family Medical Leave Act, Disability applications, etc) you will be responsible for this charge.

I understand and agree to these policies

_____	_____	_____
Print Name	Signature of patient or legal representative	Date

A photographic copy of this authorization shall be as valid as the original.

West Orange Podiatry
Dr. Michael Laliberte
1554 Boren Dr.,
Suite 400
Ocoee, Florida 34761
Phone: 407-523-9993 Fax: 407-347-0690

NOTE:

If your insurance doesn't pay for **A.** below, you may have to pay **C.** Your insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your insurance may not pay for the **A.** below.

A.	B. Reason Insurance May Not Pay:	C. Estimated Cos	
Orthoses	**Non – Covered Services**	L3000	$385
Rem. Cast (WALKING BOOT)		L4361	$140
Surgical Shoes		L3260	$30
Dept. Shoe		A5500	$135
Medically Necessary Foot Care		99213	$78
Cast		29580	$40

WHAT YOU NEED TO DO NOW:

Read this notice, so you can make an informed decision about your care.

Ask us any questions that you may have after you finish reading.

Choose an option below about whether to receive the **A.** listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but your insurance cannot require us to do this.

D. OPTIONS: Check only one box. We cannot choose a box for you.
☐OPTION 1. I want the **A.** listed above. You may ask to be paid now, but I also want my Insurance billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if my insurance doesn't pay, I am responsible for payment, but I can appeal to my insurance by following the directions on the MSN. If your insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.
☐OPTION 2. I want the **A.** listed above, but do not bill my insurance . You may ask to be paid now as I am responsible for payment. I cannot appeal if insurances is not billed.
☐OPTION 3. I don't want the **A.** listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if my insurance would pay.

E. Additional Information:

This notice gives our opinion, not an official insurance decision. If you have other questions on this notice or medical billing, call the number on the back of your card.

Signing below means that you have received and understand this notice. You also receive a copy.

F. Signature:	G. Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

1. WHAT IS YOUR PRESENT FOOT OR ANKLE SYMPTOM?

_____

2. WHEN DID IT FIRST OCCUR? _____

3. IS IT THE RESULT OF AN INJURY SUSTAINED AT WORK OR AUTO ACCIDENT? ___ YES ___ NO

4. HAVE YOU BEEN TREATED FOR THE SAME CONDITION IN THE PAST? ___ YES ___ NO

5. HAVE YOU HAD ANY OF THE FOLLOWING:

ANEMIA .....YES / NO
ARTHRITIS .....YES / NO
ARTIFICIAL JOINTS .....YES / NO
ASTHMA .....YES / NO
BLEEDING DISORDER .....YES / NO
CANCER .....YES / NO
CHOLESTEROL …….....….YES / NO
COMMUNICABLE DISEASE ….....……YES / NO
DIABETES .....YES / NO
EPILEPSY .....YES / NO
HEART (AND VALVE) PROBLEMS ….....YES / NO
HEART SURGERY ..... YES / NO
HIGH BLOOD PRESSURE.....YES / NO
KIDNEY DISEASE.....YES / NO
LIVER DISEASE.....YES / NO
NERVOUS DISORDER.....YES / NO
PULMONARY PROBLEMS …….....YES / NO
RHEUMATIC FEVER.....YES / NO
SKIN CONDITION .....YES / NO
STOMACH PROBLEMS.....YES / NO
STROKE.....YES / NO
THYROID PROBLEMS…….....….....…YES / NO
TUBERCULOSIS.....YES / NO

7. DO YOU HAVE ANY MEDICATION ALLERGIES? ____ NO ____ YES (If yes to what?)

_____

8. WHAT OPERATIONS HAVE YOU EVER HAD?

_____

9. DID YOU HAVE ANY COMPLICATIONS FROM SURGERY OR ANESTHETICS?

_____

10. AT WORK, DO YOU PRIMARILY _____ SIT _____ STAND? RETIRED _____ DISABLED____

11. DO YOU SMOKE? ____ NO ____ YES

12. DO YOU DRINK ALCOHOL? ____ NO ____ OCCASIONALLY ____ A LOT

13. DO YOU PARTICIPATE IN ANY SPORTS? _____ NO _____ YES (IF YES WHAT ARE THEY):

_____

14. WHO IS YOUR PRIMARY CARE DOCTOR AND THEIR PHONE NUMBER?

_____

15. NAMES AND PHONE NUMBERS OF YOUR OTHER SPECIALISTS:

_____

MY MEDICATION LIST

Patient Name: _____ Date of Birth:_____

Please list all drugs you are currently taking. Drugs include prescription and over-the- counter medications, herbal products, nutritional supplements, and recreational drugs.

IF YOU HAVE A LIST WE CAN MAKE A COPY

Name of Drug?	Strength of Drug?	How Often Do You Take?	Why Do You Take This Drug?	Who Prescribed Drug? (if prescription)

Please provide our office with your Pharmacy Information.

Pharmacy Name:_____

Pharmacy Address: _____

Pharmacy Phone Number:_____