

WELCOME to Dr. Levesque's office. So that we may serve you to the best of our ability, please complete both pages as accurately as possible and return to the receptionist with your insurance card.

Patient's Last Name: _____ Female

First Name: _____ MI: _____ Male

Mr. Mrs. Home Phone (_____) _____

Ms. Other _____ Cell Phone (_____) _____

Work Phone (_____) _____

Zip Code: _____

Street : _____ Town: _____

Birthdate ____ / ____ / _____ Age: _____ Employed Employer _____

Retired

Marital Status Married Single Widowed Other

⇒ Race (circle): Caucasian Hispanic African American Indian East Asian American Indian Other: _____

⇒ Ethnicity (circle): Hispanic or Latino Not Hispanic or Latino Unknown Other: _____

⇒ Nationality (circle): American Canadian Mexican Other: _____

Who Referred you? Doctor Patient Insurance Internet Other

Name: _____ Address: _____

PODIATRIC HISTORY

Chief foot/ankle complaint (be specific, include area of foot: heel, ball, arch, toe, nails, etc. also include any knee, thigh, hip, and lower back complaints)

Have you been treated by a podiatrist before? _____

Name: _____

Last Visit _____

Do you have/wear orthotics _____

Current exercise/athletic activities (list all and note frequency)

Height _____

Weight _____

Blood Pressure _____

Shoe Size _____

Smoker Non-Smoker

Former Smoker

Chewing Tobacco

Alcohol: None Socially

2+ drinks per day

Check any current or past foot related problems:

Heel Pain

Ankle Pain

Arch Pain

Flat Feet

Low Back Pain

Shin Pain

Knee Pain

Stress Fracture

Cramps

Bunion

Swelling

Tired Feet

Numbness in feet and/or legs

Ingrown Toenails

Athlete's Foot/fungus

Corns & Callus

Plantar Warts

<p>Have you had any of the following:</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> ALS</td> <td><input type="checkbox"/> Arteriosclerosis</td> </tr> <tr> <td><input type="checkbox"/> Arthritis</td> <td><input type="checkbox"/> Back Problems</td> </tr> <tr> <td><input type="checkbox"/> Bleeding Disorders</td> <td><input type="checkbox"/> Cancer</td> </tr> <tr> <td><input type="checkbox"/> Buerger's Disease</td> <td><input type="checkbox"/> Stroke</td> </tr> <tr> <td><input type="checkbox"/> Congestive Heart Failure</td> <td><input type="checkbox"/> Kidney Disease</td> </tr> <tr> <td><input type="checkbox"/> Diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2</td> <td><input type="checkbox"/> T.B.</td> </tr> <tr> <td><input type="checkbox"/> Lymphedema</td> <td><input type="checkbox"/> Ulcers</td> </tr> <tr> <td><input type="checkbox"/> Heart Disease</td> <td><input type="checkbox"/> Heart Attack</td> </tr> <tr> <td><input type="checkbox"/> Hemophilia</td> <td><input type="checkbox"/> Venous Insufficiency</td> </tr> <tr> <td><input type="checkbox"/> High Blood Pressure</td> <td><input type="checkbox"/> Nervousness</td> </tr> <tr> <td><input type="checkbox"/> Chemical Dependency</td> <td><input type="checkbox"/> Gout</td> </tr> <tr> <td><input type="checkbox"/> Thrombophlebitis</td> <td><input checked="" type="checkbox"/> None of the above</td> </tr> <tr> <td><input type="checkbox"/> Numbness in feet and or legs</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Circulation problems of the feet and/or legs</td> <td></td> </tr> </table>	<input type="checkbox"/> ALS	<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Back Problems	<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Cancer	<input type="checkbox"/> Buerger's Disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2	<input type="checkbox"/> T.B.	<input type="checkbox"/> Lymphedema	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Venous Insufficiency	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Gout	<input type="checkbox"/> Thrombophlebitis	<input checked="" type="checkbox"/> None of the above	<input type="checkbox"/> Numbness in feet and or legs		<input type="checkbox"/> Circulation problems of the feet and/or legs		<p><input type="checkbox"/> I Have NO KNOWN <u>DRUG</u> Allergies</p> <p>Are you Allergic to any of the following:</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Novocain</td> <td><input type="checkbox"/> Demerol</td> <td><input type="checkbox"/> Shellfish</td> </tr> <tr> <td><input type="checkbox"/> Iodine</td> <td><input type="checkbox"/> Athletic Tape</td> <td><input type="checkbox"/> Latex</td> </tr> <tr> <td><input type="checkbox"/> Aspirin</td> <td><input type="checkbox"/> Penicillin</td> <td><input type="checkbox"/> Epinephrine</td> </tr> <tr> <td><input type="checkbox"/> Codeine</td> <td><input type="checkbox"/> Sulfa</td> <td><input type="checkbox"/> Local Anesthetics</td> </tr> </table> <p><input type="checkbox"/> Any other Allergies? _____ _____ _____</p> <p>Any medications that you can <u>NOT</u> take? _____ _____</p>	<input type="checkbox"/> Novocain	<input type="checkbox"/> Demerol	<input type="checkbox"/> Shellfish	<input type="checkbox"/> Iodine	<input type="checkbox"/> Athletic Tape	<input type="checkbox"/> Latex	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa	<input type="checkbox"/> Local Anesthetics
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<p>Primary Care Doctor: _____ Address _____ Phone # (____) _____</p> <p>In general, for what does this physician treat you? _____ _____</p> <p>Date last seen _____ How often do you see this physician? _____</p> <p>List all medications you are currently taking:</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 20%; text-align: center;">Dosage</th> </tr> </thead> <tbody> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> </tbody> </table> <p>Your Pharmacy _____ Town: _____ Zip Code: _____</p>		Dosage	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	<p>INSURANCE INFORMATION</p> <p>Medicare ID # _____</p> <p><u>Medicare does not cover Routine Foot Care or Foot Orthotics</u> Routine care may include cutting or removal of corns and calluses and trimming of toe nails. Routine Foot Care may be covered if you have an underlying medical problem severe enough to put you at risk if your foot care was not provided by a medical professional and you are under the frequent care of a medical doctor for your at risk condition. These conditions may include severely reduced circulation, lack of feeling in your feet, abnormal sensations in your feet, lack of pulses in your feet or amputation of toes.</p> <p>Secondary Insurance</p> <p>Company Name: _____ ID # _____ Group # _____</p> <p>Patient's relationship to policy holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse</p> <p>Policy Holder's Name: _____ Birthdate ____ / ____ / _____ Address: _____ Employer _____</p>
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ASSIGNMENT OF INSURANCE BENEFITS: I hereby do authorize payment directly to Dr. Levesque. Since Dr. Levesque accepts assignment with Medicare I am responsible for any deductible and co-insurance amounts, as well as payment for all non-covered services rendered to me by Dr. Levesque.

X _____ Date: _____



Date: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I certify that the information given by me to Dr. Levesque will be included in my protected health information and is correct to the best of my knowledge. I understand that my protected health information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand Dr. Levesque’s Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Dr. Levesque has the right to change this Notice of Privacy Practices from time to time and that I may contact his Privacy Officer at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that Dr. Levesque restrict how my private information is used or disclosed to carry out treatment, payment and health care operations. I also understand that Dr. Levesque is not required to agree with my requested restrictions, but if he does agree then he is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that action has already taken place on this consent.

Patient Name (please print)

Parent or Authorized Representative (if applicable)

Relationship to Patient

X _____
Signature

Dr. David Levesque - 124 3rd Ave. Westwood, NJ 07675
NOTICE OF PRIVACY PRACTICES – Patient Copy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by Dr. Levesque in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

HIPAA requires Dr. Levesque and his staff to maintain the privacy of your protected health information and to provide you with notice of their legal duties and privacy practices with respect to protected health information. Dr. Levesque may disclose your medical records for only the purposes of treatment, payment and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care provider. An example of this would include a physical examination.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running Dr. Levesque's practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

Dr. Levesque and/or his staff may contact you by phone or e-mail to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. A message may be left on your answering machine. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer: Christen Levesque

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with Dr. Levesque's office, or with the Department of Health & Human Services, Office of Civil rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Dr. Levesque's Privacy Officer and contact information: Christen Levesque, 124 3rd Ave. Westwood, NJ 07675
Phone: (201) 722-2929 Fax: (201) 722-1370

This notice is effective as of April 14, 2003. Dr. Levesque and his staff, is required to abide by the terms of the Notice of Privacy Practices currently in effect. Dr. Levesque reserves the right to change the terms of this Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that is maintained. A revised written copy will be posted and you may request a written copy.

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257 Toll Free: 1-877-696-6775