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: _____ First Name: _____ MI: ____

☐ Mr. ☐ Mrs. ☐ Female Home Phone (____) _____
☐ Ms. ☐ Other _____ ☐ Male Cell Phone (____) _____
Work Phone (____) _____

Zip Code: _____ email: _____

Street :_____ Town: _____

Birthdate _____ / _____ / _____ Age: _____ ☐ Employed ☐ Not Employed/Retired

Marital Status ☐ Married ☐ Single ☐ Full-time student: School _____
☐ Widowed ☐ Other ☐ Part-time Student

Employer _____ Occupation _____

- **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: _____

If patient is a minor or under someone else's care please fill in below

Responsible Billing Party _____

Full Address _____

Home Phone (_____) _____ Work Phone (_____) _____

Relationship to patient: ☐Child ☐Parent ☐Guardian ☐Sibling ☐Other

Who Referred ☐Doctor ☐Patient ☐Insurance ☐Athletic Trainer ☐Coach
You? ☐Internet ☐ Our Web-site ☐Other Name: _____

Briefly explain your 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 _____

Shoe Size _____

☐ Non-Smoker
☐ 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

Have you had any of the following:

☐ ALS ☐Arteriosclerosis
☐ Arthritis ☐Back Problems
☐ Bleeding Disorders ☐Cancer
☐ Buerger's Disease ☐Stroke
☐ Congestive Heart Failure ☐Kidney Disease
☐ Diabetes ☐Type 1 ☐Type 2 ☐T.B.
☐ Lymphedema ☐Ulcers
☐ Heart Disease ☐Heart Attack
☐ Hemophilia ☐Venous Insufficiency
☐ High Blood Pressure ☐Nervousness
☐ Chemical Dependency ☐Gout
☐ Thrombophlebitis ☐ **None of the above**
☐ Numbness in feet and or legs
☐ Circulation problems of the feet and/or legs

☐ **I Have NO KNOWN DRUG Allergies**

Are you Allergic to any of the following:

☐ Novocain ☐Demerol ☐Shellfish
☐ Iodine ☐Athletic Tape ☐Latex
☐ Aspirin ☐Penicillin ☐Epinephrine
☐ Codeine ☐Sulfa ☐Local Anesthetics
☐ Any other Allergies? _____
_____
_____

Any medications that you can **NOT** take?

_____ _____
_____ _____

Primary Care Doctor:_____
Address _____
Phone # (_____) _____

In general, for what does this physician treat you?

_____
_____
_____

Date last seen _____
How often do you see this physician? _____

List all medications you are currently taking:

	Dosage

Your Pharmacy _____
Town: _____Zip Code: _____

INSURANCE INFORMATION

Primary Insurance:_____
ID # _____ Group # _____
Relationship: ☐ Self ☐ Spouse ☐ Dependent
Policy Holder's Name: _____
Birthdate ____ / ____ / _____

Secondary Insurance: _____
ID # _____ Group # _____
Relationship ☐ Self ☐ Spouse ☐ Dependent
Policy Holder's Name: _____
Birthdate ____ / ____ / _____

Since Dr. Levesque is enrolled with numerous insurance plans which are constantly changing, it is difficult for him and his staff to keep up to date with the various requirements of each individual plan and its set of requirements: referrals, authorizations, lab work, prescriptions, deductibles, copays, coinsurances, etc. It is your responsibility, as the policyholder, to have full knowledge of your insurance plan. Most major insurances have web-site accessibility and you as the policyholder have access to it through a personal log-in which you set-up. Please familiarize yourself with your plan so we can work together to provide you with all the medical benefits that you are entitled to.

ASSIGNMENT OF INSURANCE BENEFITS: I authorize payment directly to Dr. Levesque. I am responsible for Referrals, authorizations, deductibles, co-pays & co-insurance amounts, as well as payment for all non-covered services rendered to me by Dr. Levesque.

X _____ Date: _____

FINANCIAL AGREEMENT FOR RECEIVING ARCH SUPPORTS/ORTHOTICS: All biomechanical conditions can be helped with Arch Supports and Foot Orthotics. These are considered Durable Medical Equipment by insurance companies. If Dr. Levesque deems it medically necessary for me to be wearing Arch Supports or Foot Orthotics my insurance company will be billed. If they are not fully covered by my insurance I agree to be responsible for all charges, including any deductible and/or co-insurance. My cost will be $100 for Dr. Levesque's Sport Arch Supports which I can receive today.

X _____ Date: _____

Dr. David S. Levesque
Sports Medicine of the Foot and Ankle

American Academy of Podiatric Sports Medicine
www.davidlevesquedpm.com
124 Third Avenue Westwood, NJ 07675
Phone: (201) 722-2929
Fax: (201) 722-1370

Date: _____

ACKNOWLEDGEMENT AND CONSENT of NOTICE OF PRIVACY PRACTICES
(summary, please see patient copy for full policy)

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 DESCIBES 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