

Lansing Podiatry, PLLC
1500 Watertower Place Ste 300.
East Lansing, MI 48823

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New Patient Information

Patient Name: _____ Address: _____

Gender: _____ DOB: ____/____/____ Age: _____ _____

Primary Doctor: _____ Primary Insurance: _____

Referring Doctor: _____ Secondary Insurance: _____

Ethnic Group: Not Hispanic or Latino Hispanic or Latino Other _____ Decline to answer

Race: American Indian or Alaskan Native Asian Black or African American White

Hawaiian or Pacific Islander Other _____ Decline to answer

Preferred Language: English Spanish Other _____

Contact Information: Home: (____)____-____ Cell: (____)____-____ Work: (____)____-____

Email address: _____

Emergency Contact: _____ Phone: (____)____-____ Relationship: _____

How would you prefer to be contacted: Phone Mail Email

How would you prefer to receive reminders from our office? Home Phone Cell Phone Work Phone

Preferred Pharmacy: _____ Location: _____ Phone: _____

MAIL ORDER PHARMACY: _____

HIPAA Consent for Use and Disclosure of Your Health Information

By specifying and signing below, you are authorizing Lansing Podiatry, and its staff to leave a message on an answering machine, voicemail or with a specified individual, which may include sensitive and/or protected health information.

I **Do**____ **Do not**____ authorize Lansing Podiatry, to leave detailed messages regarding my medical condition or treatment on my voicemail.

____ **Release my medical information to myself ONLY.** Initial: _____

Patient Signature _____ Date _____

(IF PATIENT IS A MINOR- SIGNATURE OF PARENT/LEGAL GUARDIAN)

Insurance Authorization

- I authorize the release of any medical information necessary to process my claim and collect payment.
- I authorize payment of medical benefits to Lansing Podiatry, for services rendered when they request that payment be made directly to them.
- I understand that I am ultimately responsible for payment of services that are rendered to me.
- I understand that Lansing Podiatry, will bill my insurance company, however I am responsible for any balance that my insurance does not pay.
- I acknowledge that I am responsible for all copayments and/or deductibles.
- I am aware I am responsible for all costs associated with collection agency fees, attorney fees, and court costs associated with the collection of my debt if applicable.

Initial: _____

Physician Consent for Medical Treatment

I, the undersigned, hereby authorize and direct Dr. _____ to treat my condition.

I hereby voluntarily consent for care encompassing diagnostic procedures and treatment by my physician, his assistant, designees or consultants, as may be necessary in the judgment of my physician. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made as to the results of the treatments or examination in this clinic. I understand that my medical record may be maintained and authorize access to persons involved in my care.

Initial: _____

HIPAA Acknowledgement of Receipt of Notification of Privacy Practices

I have been made aware of the Lansing Podiatry Notice of Privacy Practices. The notice is posted in the waiting area of the Lansing Podiatry office. By signing below, I acknowledge that I have been offered this notice, offered a chance to read this notice, and am aware that I can request a copy of this notice to take with me if so desired.

Initial: _____

HIPAA Authorization for release of Protected Health Information

If you choose to have your Protected Health Information released to another person, either verbally or in writing, please complete the information below. Initialing the below authorization will not affect your treatment at Lansing Podiatry, PLLC.

I, _____, approve Lansing Podiatry, PLLC, to release my health records to the individuals listed below at my request. I understand this authorization is valid for one year from this date and can be revoked or revised at any time with written notice.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

PATIENT HISTORY

*This is a confidential record and will be kept in your electronic patient chart.
Information contained here will not be released to anyone without your authorization to do so.*

TODAY'S DATE ___/___/___ Social Security # ___-___-___ DATE OF BIRTH ___/___/___
(PLEASE PRINT) LAST NAME _____ FIRST NAME _____ M.I. _____

Family Doctor: _____

Reason for seeing the physician: _____

Have you been exposed to or currently have TB (tuberculosis)? Y N

Have you received the Pneumonia Vaccine in the last 9 years? Y N Date _____

ALLERGIES/REACTIONS TO ANY MEDICATION OR FOOD:

LIST CURRENT MEDICATIONS (include over the counter items)

MEDICATION/DOSAGE

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

PAST SURGICAL HISTORY – Check previous surgeries & provide date (If nothing marked then NONE APPLY)

___ Appendectomy _____	___ Hernia Repair _____
___ Back Surgery _____	___ Hip Replacement _____
___ Bladder Surgery _____	___ Hydrocele Repair _____
___ Breast Surgery _____	___ Hysterectomy _____
___ Cesarean Section _____	___ Kidney Stone Removal _____
___ Cholecystectomy _____	___ Knee Replacement _____
___ Colon Surgery _____	___ Laparoscopy _____
___ Coronary Artery Bypass _____	___ Lithotripsy _____
___ Coronary Stent _____	___ Mastectomy _____
___ Cystectomy _____	___ Nephrectomy _____
___ Cystoscopy _____	___ Pacemaker Insertion _____
___ Gastric Bypass _____	___ Other _____
___ Green Light PVP _____	_____
___ Heart Valve Replacement _____	_____

REVIEW OF SYMPTOMS *(Please circle any symptoms you are currently experiencing)*

Constitutional:	Fever	Chills	Weight Loss
Eyes:	Blurry vision	Cataracts	Glaucoma
Ears, Nose, Mouth, Throat:	Hearing Loss	Nasal Stuffiness	Sore Throat
Cardiovascular:	Chest Pains	Swollen Ankles	Irregular Heartbeat
Respiratory:	Shortness of Breath	Wheezing	Chronic Cough
Gastrointestinal:	Abdominal Pain	Nausea/Vomiting	Change in Bowels
Genitourinary:	Incontinence	Painful Urination	Blood in urine
Musculoskeletal:	Chronic Back Pain	Chronic Neck Pain	Sore Muscles
Integumentary/Skin:	Rash	Persistent Itching	Skin Cancer History
Neurological:	Numbness	Tingling	Dizziness
Hematologic/Lymphatic:	Swollen Glands	Abnormal Bleeding	Transfusion History
Psychiatric:	Anxiety	Depression	

APPROXIMATE HEIGHT: _____

WEIGHT: _____

Have you had your flu shot within the last year? Yes____ **Month:** _____

No_____

Are you A Diabetic? Yes_____ **No**_____ **IF YES what is your Hemoglobin A1C**_____

When was your last A1C checked_____?

APPOINTMENT ATTENDANCE POLICY

We, at Lansing Podiatry, PLLC understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel appointments by calling the following number: 517-351-7640

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call to you is made/attempted one (1) business day prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel your appointment with at least a 24 hours' notice: There is a waiting list to see the clinician's at Lansing Podiatry, PLLC and whenever possible, we like to fill cancelled spaces to shorten the waiting period for our patients.
2. If less than a 24-hour cancellation is given this will be documented as a "No-Show 24" appointment and you will be charged \$25.00.
3. If you do not present to the office for your appointment or notify the office you will not be in attendance, this will be documented as a "No-Call, No-Show" appointment and you will be charged \$35.00.
4. If you already have 1 "No-Call, No-Show" or "No-Show 24" appointments within a one-year time period, your 2nd "No-Show 24" appointment will be assessed a \$35.00 no show fee as well.
5. If you have 2 "No-Show 24" or "No-Call, No-Show" appointments within a one-year time period, you will also receive a warning letter for possible dismissal from our practice.
6. After 3 "No-Show24" or "No-Call, No-Show" Dismissal from the practice will be considered.
***You will be notified by letter if the dismissal was approved.**

I have read and understand Lansing Podiatry, PLLC No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify Lansing Podiatry, PLLC appropriately if I have difficulty keeping my scheduled appointments.

Patient Name	Date of Birth	Date
Patient Signature or Parent/Guardian if minor	Relationship to Patient	
Staff Signature	Date	