This packet must be filled **completely** before your appointment.

(* is required information.)

*Last Name: _____

*First Name: _____

*DOB: _____ SS#: _____ Ethnicity: _____

*Height: _____ *Weight: _____

*Home Address:

_____

Street City State Zip Code

*Home Phone: _____ Cell: _____

Email: _____ Occupation: _____

Employer: _____

*Primary Insurance: _____

Policy #: _____ Group #: _____

Policy Holder's Name:_____ DOB:_____

Secondary Insurance: _____

Policy #: _____ Group #: _____

Policy Holder's Name:_____ DOB:_____

How did you Hear about us?

_____

*Primary Care Doctor: _____

Phone: _____

*Preferred Pharmacy: _____

Phone: _____

*EMERGENCY CONTACT:

Contact Name: _____Relationship: _____

*Patient Signature: _____ Date: _____

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*MEDICAL HISTORY

*Name: _____ Date: _____

*CIRCLE ALL THAT APPLY:

- Diabetes
- Fibromyalgia
- Tumors
- Epilepsy
- Neuropathy
- Heart Problems
- Arthritis
- Gout
- Asthma
- Glaucoma
- Cancer
- Skin Disorder
- Anemia Bursitis
- AIDS(HIV)
- Tuberculosis
- Lung Disease
- Stroke Hepatitis
- Sickle Cell
- Osteoporosis
- Kidney
- Colitis
- Rheumatic
- High cholesterol
- STD
- Implants
- Thyroid
- GERD
- Mental Disorder
- Poor Circulation
- Blood Pressure Problems
- Gastric Ulcer

Other _____

*Do you Smoke? **YES NO** - If YES How many per day: _____
*Do you drink Alcohol? **YES NO -** If YES How many per day:_____
*Are you Pregnant? **YES NO -** If YES how far along: _____
*Do you have a Pacemaker? **YES NO**
*Do you have a Defibrillator? **YES NO**

*Patient Signature: _____ Date: _____

*(circle all that apply)

Constitutional:
Fever | Chills | Headache | Fatigue | Weight Loss/Gain

Eye, Ears, Nose, Mouth, Throat:
Blurred Vision | Strain/Pain | Double Vision | Ear Pain
Difficulty Swallowing | Difficulty with Smell

Heart:
Chest Pain | Palpitations | Difficulty breathing when flat
Swelling/Edema | Fainting

Lungs:
Shortness of Breath | Sputum Production | Wheezing/Asthma
Coughing up Blood | Cough

Gastrointestinal:
Abdominal Pain | Indigestion Nausea | Vomiting | Change in Bowel Habit
Blood in Stool | Loss of Bowel Control

Urinary System/Gynecological:
Pain during Urination | Blood in Urine | Urinary Frequency
Urinary Urgency | Vaginal/Penile discharge

Neurological:
Focal Neurological Deficit | Weakness | Numbness/Tingling
Incoordination | Seizure | Stroke | Tremors

Musculoskeletal:
Joint Pain/Spasms | Joint Swelling | Joint Stiffness | Weakness

Integumentary:
Rashes | Loss of Hair | Itching

Psychosocial:
Depression | Anxiety | Insomnia | Recent Stressors
Recent Lifestyle Change

Endocrine:
Excessive Thirst | Excessive Swelling

Blood and Lymphatic Systems:
Bleeding Problems | Swollen Glands

Allergic/Immunologic:
Allergy Symptoms | Allergic Reactions

ALLERGIES:_____
_____
_____

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SURGICAL HISTORY

*Name: _____ Date: _____

Provide history for past 7 years
Procedure / Date of Surgery / Complications

_____
_____
_____
_____
_____
_____
_____

*FAMILY HISTORY

(Check all that apply)

	Father	Mother	Brother	Sister
Diabetes				
Heart Disease				
High Blood Pressure				
Arthritis				
Thyroid				
Cancer				

*Patient Signature: _____ Date:_____

*Name: _____ Date: _____

*MEDICATIONS

Name	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do I Need a Test for PVD?

Peripheral Vascular Disease (PVD) is a serious circulatory problem in which the blood vessels outside of your heart and brain to narrow, block, or spasm. It affects over 3 Million Americans in a year, most over the age of 50. It may result in leg discomfort with walking, poor healing leg sores/ulcers. People with PVD are at significantly increased risk of stroke and heart attack. Answers to these questions will determine if you are at risk for PVD and if a vascular exam will help us better assess your vascular health status.

*Circle **YES** or **NO**:

1. Do you have foot, calf, buttock, hip or thigh discomfort when you walk which is relieved by rest? **YES NO**
2. Do you experience any pain at rest in your lower legs or feet? **YES NO**
3. Do you experience foot or toe pain that often disturbs your sleep? **YES NO**
4. Do you have skin wounds or ulcers on your feet or toes that are slow to heal? **YES NO**
5. Have you suffered a severe injury to the leg(s) or feet? **YES NO**
6. Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)? **YES NO**

*Patient Signature: _____ Date: _____

Physician Signature_____ Date: _____

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*Patient Name: _____ Date: _____

*Chief Complaint:
(check all that apply)

- ☐ Pain Numbness
- ☐ Tingling
- ☐ Shooting shocks
- ☐ Burning
- ☐ Pain with touch
- ☐ Aching

*Where on your body do you experience these symptoms?

_____

*How long have you suffered with these symptoms?

_____

*When were you diagnosed with peripheral neuropathy?

_____

*How was the diagnosis made?

_____

*Neurologist? (please give name of doctor) _____

*EMG/NCS? _____ Date of study: _____

*Are you a Diabetic? **YES NO**

If so...

*When were you diagnosed?

_____

*Current hemoglobin A1C

_____

*Are you blood sugars controlled? **YES NO**

*What are your fasting blood sugars?

_____

*Who treats your diabetes? (please give name of doctor)

_____

*Patient Signature: _____ Date: _____

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RELEASE OF MEDICAL INFORMATION

1) I GIVE MY PERMISSION FOR THOMAS LEBEAU, DPM AND/OR LONGEVITY PHYSICAL THERAPY, ST. AUGUSTINE DERMATOLOGY ASSOCIATES, NEUROPATHY AND PAIN CENTER OF ST. AUGUSTINE, ST AUGUSTINE VEIN CENTER TO OBTAIN MEDICAL RECORDS FROM ANOTHER PHYSICIAN AS DEEMED NECESSARY FOR MY CARE AND TREATMENT.

2) I GIVE MY PERMISSION FOR THOMAS LEBEAU, DPM AND/OR LONGEVITY PHYSICAL THERAPY ST. AUGUSTINE DERMATOLOGY ASSOCIATES, NEUROPATHY AND PAIN CENTER OF ST. AUGUSTINE, ST AUGUSTINE VEIN CENTER ALONG WITH THEIR STAFF TO SPEAK WITH AND/OR RELEASE MY MEDICAL RECORDS TO:

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Patient Signature: _____ Date: _____

Health Insurance Portability and Accountability Act

NOTICE OF PRIVACY PRACTICES

We maintain protocols to ensure the security and confidentiality of your personal information. We have physical security in our building, passwords to protect our databases, compliance audits, and virus/intrusion detection software. Within our practice, access to your information is limited to those who need it to perform their jobs. At this office, we are committed to treating and using protected health information about you responsibly. This notice of Privacy Policy describes he personal information we collect, how, and when we use or disclose this information. This notice is effective April 14, 2003 and applies to all protected health information as defined by federal regulations. Each time you visit, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and plan for future care or treatment. This information, often referred to as your health or medical record, serves as a: Basis for planning your care and treatment, means of communication among the many health professionals who contribute to your care; legal documentation describing the care you received; means by which you or a third party payer can verify that services billed were actually provided; tool in educating health professionals; source of date or our research; source information for public health officials charged to improve the health of the state and nation; source of date for our planning and marketing; tool by which we assess and continually work to improve the care we render and outcomes we achieve. Although your health record is physical property of this office, the information belongs to you. You have the right to: obtain a paper copy of this notice of privacy policies upon request; inspect and obtain a copy of your health record as provided by 45 CFR 164.524 (reasonable copy fees apply in accordance with state law); amend your health record as provided by 45 CFR.164.526; obtain an accounting of disclosures of your health information as provided by 45 CFR 164528; request confidential communications of your health information as provided by 45 CFR 164.522(B) request restrictions on certain uses and disclosures of your information as provided by 45 CFR 164.522(A) – (however, we are not required by law to agree to a requested restriction.) Our practice is required to: maintain the privacy policy of your health information; provide you with this notice as to our legal duties and privacy practices with respect, to information we collect and maintain about you; abide by the terms of this notice; notify you if we are unable to agree to a requested restricted; accommodate reasonable requests you may have to communicate your health information. We reserve the right to change out practices and to make the new previsions effective for all protected health information we maintain. We will keep a posted copy of the most current notice in our facility containing the effective date in the top righthand corner. In addition, each time you visit our facility for treatment, you may obtain a copy of the current notice in effect upon request. We will not disclose your health information in a manner other than described in section regarding Examples of Disclosure for Treatment; Payment and Health Operations, without your written authorization, which you may revoke as provided by 45 CFR 164.508(B)(5), except to the extent that action has already taken. Examples of Disclosure for Treatment, Payment & Health Operations: we will use your health information for treatment. We may provide medical information about you to healthcare providers, our practice personnel, or third parties who are involved in the provision, management, or coordination of your care. We will use your health information for payment. We may disclose you're your information so that we can collect or make payment for health services you receive. We may disclose your health information for our routine operations. These uses are necessary for certain administrative, financial, legal and quality improvement activities that are necessary to run our practice and support the core functions. Consistent with applicable law, we may disclose medical information to the following: to provide appointment reminders, to coroner, medical examiner or funeral directors; workers' compensation or other similar programs established by law; to public health or legal authorities charges with preventing to controlling disease, injury or disability; to researcher when their research has obtained a required waiver from the Institutional Review Board/Privacy Board, who has reviewed the research proposal; to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of donation and transplant; as required by law for reporting a crime, responding to a court order, grand jury subpoena, warrant, discovery request, or other legal process or complying with the health oversight activities such as audits, investigations, and inspections necessary to ensure compliance with government regulations and civil rights laws; for military and veterans affairs or national security and intelligence activities; for services provided in our organization through contacts with business associates (i.e. transcription services) due to the nature of business associates' services, they must receive your health information in order to perform the jobs we've asked them to do and protect our health information we require the business associate to appropriately safeguard your information; to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to health related benefits that may be of interest to you; to your personal representative or personal legally responsible for your care and authorized to act on your behalf in making decisions related to your care; when we believe in good faith that your information is necessary to prevent a serious threat to your safety or that of another person (i.e. abuse, neglect, or domestic violence); to family member or close personal friend health information relevant to that persons involvement in your care or payment related to your care, we may notify these individuals of your location/general condition; to an organization assisting in a disaster relief effort. For all non-routine operations, we will obtain your written authorization before disclosing your personal information. In addition, we take great care to safeguard your information in every way that we can to minimize any incidental disclosures.

_____ Initials

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Health Insurance Portability and Accountability Act

Financial Policy - Welcome to our office. We are committed to providing you with the best possible care. We accept cash, checks, and major credit cards. In order to better serve you, we ask that you please take a few minutes to read the following policies specific to our practice and your insurance. **Insurances -** If you have insurance, we will do all we can to help you receive maximum benefits. The percentage of coverage by your insurance company may be based on your insurance company's own reduced fee schedule for medical services and may be less than actual charges, resulting in lower coverage for you. We have no control over this situation. Lower payment is a direct result of the plan selected by yourself or your employer. Please be advised that we cannot waive co-payment. We are required by law to collect your co-payment. Medicare Patients: This office accepts Medicare assignment. Medicare patients are fully responsible, however for the initial yearly deductible and the 20% co-insurance. This payment is to be made at the time services are rendered. **Medical Records, Releases, and Insurance Assignments -** I request and authorize Dr. LeBeau/Physical Therapist or assistant of their choice to preform podiatric/physical therapy medical treatment. I also authorize the taking of photographs for medical use by this office. I permit a copy of these authorizations and assignments to be used in place of this original, which is on file at the physician's office. **Physician Insurance Assignment -** I authorize payment directly to Thomas LeBeau, DPM for surgical and/or medical benefits. Any services for which assignments are not accepted are acknowledged to be my full and complete financial responsibility. Medicare/Medicaid – I certify that the information given by me in applying payment under title XVII/XIX of the Social Security Act is correct. **Responsibility of Account -** I agree that the amount of insurance benefits be insufficient to cover expenses, I will be responsible for the payment of the difference. I will be responsible for the entire amount due to professional services rendered if the expense is not covered by insurance. **Collection Information -** I understand that my portion of all fees is due at the time treated unless previous arrangements have been made. I will be billed for my portion of any fees not paid at the time of service. Any balance which are 90 days past due will be eligible to be turned over to a collection agency. Collection Agency fees are recognized to be my (the patients) responsibility. There will be a $35.00 fee for any returned check. We know at times patients do not have any insurance. If this is the case the procedure and cost will be discussed prior to service. At this time, a payment plan will be set up. **Attendance and Cancelation Policy** – It is very important to note that, for you to receive the optimal benefit from your office visit/therapy, you must be consistent in attending all your scheduled appointments. Additionally, in order to be as efficient in our schedules as possible we kindly ask for at least 24-hour notice for cancellations. At our discretion, you may be subjected to a $50.00 cancellation fee. If you do not show for an appointment, a $50.00 no-show fee will be charged. In the event that you are unable to attend your appointments constantly, you have 2 same-day cancels, or 2 no-show appointments, you will be discharged from therapy, which will require an additional office visit to your doctor to obtain new orders for you to continue with your rehabilitation. We are very committed to your rehabilitation and improved quality of life. Therefore, we ask that you allow us to help solve any issues that may prevent you from attending the prescribed number of treatment sessions as in your plan of care. **Insurance Benefits** – Please check your benefits co-pays, co-insurance, deductibles, and any limitations to the number of therapy visits allowed. The back of your insurance card has a "member services" phone number which you may call to inquire about and verify the necessary information. You are providing your insurance information and contractually obligated to your insurance carrier's fees, including co-pays, co-insurance, and deductibles. We are contractually obligated to file your claim with your insurance carrier as well as collect any fees associated with your care. Please notify the front desk of any changes in your insurance coverage. **Patient Payments and Charges** – Please be prepared to pay any co-pay/deductible amounts at the time of each appointment. Please note: We do use other facilities such as hospitals, laboratories, etc. for bloodwork, cultures and biopsies. As well as Proscan reading services for MRI. Therefore, you may be receiving billing information from these facilities. Thank you for understanding our financial policies. We are here to help you Please let us know if you have any questions or concerns.

_____ Initials