Dr. Thomas D Lim, DPM – Podiatrist – Foot and Ankle Specialist
3367 W 1st Street, Suite 201
Los Angeles, CA 90004
Tel: (213) 483-4642
Fax: (213) 483-7257
www.happyfootsadfootdoctor.com

***New Patient Information**

Last Name:_____ First Name:_____ Middle Name:_____

Date of Birth:_____ How did you hear about us?_____

Social Security #:_____ Sex:_____

*Address
Street:_____ Apt#:_____

City:_____ State:_____ Zip Code:_____

*Phone Number
Cell:(_____) _____ Home:_____

*Email Address:_____

*Emergency Contact:
Name:_____ Relationship:_____

Phone Number:(_____) _____

*Insurance Information:
Name of Insurance:_____ ID#:_____

The above information is true to the best of my knowledge. I authorize my Insurance benefits be paid diretly to the Physician/Provider. I understand that I am finacially responsible for my balance. I also authrorize Thomas D Lim DPM Inc and the Insurance company to release any information to process my claims.

Patient or Legal Guardian (Print):_____

Patient or Legal Guardian (Signature):_____

Date:_____

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Authorization to Pay

Date:_____

I hereby authorize my Insurance company, _____

to pay my Provider directly. My Physician/Provider/Healthcare Profession is Thomas D Lim, DPM, Inc. located at 3367 W 1st St, Ste 201, Los Angeles, CA 90004.

I authorize the medical and surgical expense benefits allowable, and otherwise payable to me under my current Insurance policy to be applied to the total charges for Professional Services Rendered to be paid to Thomas D Lim, DPM, Inc. The payment will not exceed my indebtedness to above mentioned assignee and I have agreed to pay, in a current manner any balance of said Profession Service charges over and above this Insurance payment.

_____ _____

Patient or Legal Guardian (Print) Date

_____

Patient or Legal Guardian (Signature)

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Insurance Disclaimer:

"A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service."

Insurance Liability for Payment:

Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made by this office to have all services and procedures preauthorized by your health insurance company. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service.

Beneficiary Agreement:

I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

_____ _____

Patient or Legal Guardian (Print) Date

_____

Patient or Legal Guardian (Signature)

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HIPAA Consent Form
Notice of Privacy Practices
Acknowledgement of Receipt

I understand that under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I have certain rights to privacy regarding my Protected Health Information (PHI). I understand that this information can and will be used to:

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

I have been informed by the staff and provider of the Notice of Privacy Practices containing a more ceomplete description of the uses and disclosures of my health information. I have been given the opportunity to review such noice of Privacy Practices prior to signing this contract. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the organization at any time at the address listed above to obtain a current copy of the Notice of Privacy Practice.

I understand that I am request in writing that you restrict how my Protected Health Information is used or disclosed to carry out treatment payment or health care operations. I also understand that it is not required to agree with my requesting restrictions.

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

I acknowledge receipt of the Notice of Privacy Practices

_____ _____

Patient or Legal Guardian (Print) Date

_____

Patient or Legal Guardian (Signature)

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Name:_____ Age:_____ Sex:_____

Height:_____ Weight:_____ Smoking:_____ # Years/packs:_____

Primary Care Physician:_____
Address:_____
Phone:_____

***ALLERGIES:**_____

Medications:_____

_____

Medical Conditions that you are currently being treated for:_____

_____

Past Medical History:

***DIABETES:**	Yes	No	Amputation:	Yes	No
Insulin:	Yes	No	Blood thinners:	Yes	No

***WHAT IS THE MAIN PROBLEM**:_____

_____

What happened:_____

_____

When did it happen:_____

_____

*Pharmacy Name:_____

Address:_____

Phone #:(_____)_____