



# Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to help you. We look forward to working with you in maintaining your health.

## Patient Information

Date \_\_\_\_\_

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Last Name First Name Initial

Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell Phone \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_ Sex  M  F  Single  Married  Widowed  Separated  Divorced

Patient Employed by \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Address \_\_\_\_\_ Occupation \_\_\_\_\_

How did you learn of this office? Referred by \_\_\_\_\_ (Physician/Friend/Referral Line)

Yellow Pages  Yellow Book  Newspaper  Billboard  Internet  Radio  Other (specify) \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Notify in case of emergency \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

## Insurance Information

Person Responsible for Account \_\_\_\_\_  
Last Name First Name Initial

Relation to Patient \_\_\_\_\_ Birth Date \_\_\_\_\_ Soc. Sec.# \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Responsible Party Employed By \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Address \_\_\_\_\_ Occupation \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Subscriber I.D. # \_\_\_\_\_ Group # \_\_\_\_\_

Does this insurance require you to have a referral to see a Specialist?  Yes  No

## Additional Insurance

Person Responsible for Account \_\_\_\_\_  
Last Name First Name Initial

Relation to Patient \_\_\_\_\_ Birth Date \_\_\_\_\_ Soc. Sec.# \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Responsible Party Employed By \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Address \_\_\_\_\_ Occupation \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Subscriber I.D. # \_\_\_\_\_ Group # \_\_\_\_\_

Does this insurance require you to have a referral to see a Specialist?  Yes  No



Name \_\_\_\_\_

## Payment Policies

**PAYMENT IS DUE AT THE TIME OF SERVICE.**

- For any service not paid for at the time of service, there will be an additional charge of \$5 to cover billing expenses.**
- This office is extending the courtesy of submitting your Insurance claims to your Insurance company. Responsibility, however, remains with the patient in case of non payment or partial payment by the Insurance company.**
- Failure to obtain a referral, if required by Insurance company, prior to treatment in this office, will result in patient responsibility for all charges.**
- We do accept the following forms of payment: CASH, CHECKS, MASTERCARD, VISA, and DISCOVER.
- There is a \$30 charge for returned checks.
- In the event that your account is placed for collection, you will be responsible for all charges incurred, including attorney fees.

I have read and understand the above listed policy.

SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_

## Medicare/Insurance Authorization and Assignment of Benefits

**Name of Beneficiary:** \_\_\_\_\_

**Health Insurance Claim Number:** \_\_\_\_\_

I request that payment of authorized Medicare and/or medical benefits be made either to me or on my behalf to Lehigh Valley Foot & Ankle Surgeons for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related service.

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance, or any other health plan to Lehigh Valley Foot & Ankle Surgeons. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said Insurance. I hereby authorize said assignee to release all information necessary to secure payment.

BENEFICIARY SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_

1575 Pond Road, Suite 202, Allentown, PA 18104 TEL: 610.391.0066  
4331 Easton Avenue, Bethlehem, PA 18020 TEL: 610.882.3600  
21 Corporate Drive, Easton, PA 18045 TEL: 610.258.1855  
341 E. Bertsch Street, Lansford, PA 18232 TEL: 570.645.4334

FAX: 610.391.0096 (all offices)

[www.lvfoot.com](http://www.lvfoot.com)



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**Patient Name** \_\_\_\_\_ **Birth Date** \_\_\_\_\_ **AGE** \_\_\_\_\_

**HT** \_\_\_\_\_ **WT** \_\_\_\_\_

What problem(s) brings you to our office? \_\_\_\_\_

Where is your problem located?  Toe  Ball of foot  Midfoot/Arch  Heel  Ankle  Leg

What type of pain are you experiencing?  Aching  Throbbing  Burning  Shooting  Sharp

Numbness  Stiffness  Cramping  Other \_\_\_\_\_

How would you rate your pain?  Mild  Moderate  Severe

What is the duration of symptoms?  Days  Weeks  Months  Years

Does anything improve symptoms? \_\_\_\_\_

Does anything worsen symptoms? \_\_\_\_\_

Are symptoms worse at a particular time of day? \_\_\_\_\_

What is the frequency of pain? (i.e., episodic, constant) \_\_\_\_\_

Did symptoms occur as a result of an injury? \_\_\_\_\_

Has any treatment been rendered by yourself or a physician? (i.e. medication, shoe gear, ice, arch supports, insoles, injection) \_\_\_\_\_

Does your occupation require prolonged standing or walking? \_\_\_\_\_

Which best describes your activity level?  Inactive  Moderately Active  Very Active

Did you have any foot or ankle problems as a child? \_\_\_\_\_

**MEDICATIONS**

<i>Name</i>	<i>Dose</i>
_____	_____
_____	_____
_____	_____

**ALLERGIES**

<i>Drugs/Medication Name</i>	<i>Reaction</i>
_____	_____
_____	_____

  

<i>Food/Material/Latex</i>	<i>Reaction</i>
_____	_____
_____	_____

**PAST SURGERIES**

<i>Procedure</i>	<i>Date</i>
_____	_____
_____	_____

Patient Name \_\_\_\_\_

## Medical History

### CARDIOVASCULAR

- Heart attack
- Heart murmur
- Pacemaker
- Bypass surgery
- High blood pressure
- Heart failure
- Chest pain
- Swelling of ankles
- Artificial valve
- Cramping in legs

### ENDOCRINE

- Diabetes
- Hypothyroid
- Hyperthyroid
- Low blood sugar
- Other \_\_\_\_\_

### NERVOUS SYSTEM

- Stroke
- Epilepsy/convulsions
- Headaches
- Numbness/tingling
- Fainting/dizziness
- Paralysis

### RESPIRATORY

- Asthma
- Emphysema
- Chronic cough

### MUSCULOSKELETAL

- Arthritis
- Artificial joint
- Gout
- Joint infection
- Weakness
- Spasms
- Back pain

### DIGESTIVE

- Hepatitis
- Jaundice
- Ulcers
- Reflux

### URINARY

- Kidney Disease
- Dialysis
- Kidney Stones
- Burning

### PSYCHIATRIC

- Depression
- Type? \_\_\_\_\_
- Anxiety
- Bipolar
- Schizophrenia
- Other \_\_\_\_\_

### SKIN

- Rash/hives
- Open wound/ulcer
- Blisters
- Dry/scaly
- Change in color

### BLOOD

- Difficult clotting
- Bruise easily
- Anemia

### HEENT

- Hearing Impairment
- Visual Impairment
- Throat Conditions
- Ringing in the Ears
- Balance Disturbance
- Sinus/Allergy Condition

### OTHER

- Cancer
- Type? \_\_\_\_\_

- HIV
- Hepatitis

### SOCIAL HISTORY

- Smoke
- How much? \_\_\_\_\_ packs/day
- Alcoholic beverages
- How much? \_\_\_\_\_



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## HIPAA PATIENT RELEASE

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996 (a federal law). Of significant concern to healthcare organizations is the Administrative Simplification section of the Act, which requires healthcare organizations to comply with specific rules regarding:

- Unique Identifiers for health plans, providers, individuals, employers
- Healthcare Transaction & Code Sets for transmitting data electronically
- Privacy Regulations over disclosure and use of health information
- Security Regulations over protections of electronic health information

All of these rules have been developed by the Department of Health & Human Services and will become "final" in a staged manner - healthcare organizations will generally have 24 months to achieve compliance, as each rule becomes final.

It is the office policy of Lehigh Valley Foot & Ankle Surgeons to not release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Whenever returning telephone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone.

If you would like to have information released to someone other than yourself please complete the following:

I authorize Lehigh Valley Foot & Ankle Surgeons to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

Home Telephone	_____ yes	_____ no
Answering Machine	_____ yes	_____ no
Work Telephone	_____ yes	_____ no
Voice Mail	_____ yes	_____ no
Cell Phone and/or voice mail	_____ yes	_____ no
Pager	_____ yes	_____ no
Fax medical records for referrals to another entity	_____ yes	_____ no

Please list names of authorized people:

Spouse: \_\_\_\_\_ yes \_\_\_\_\_ no

Parent: \_\_\_\_\_ yes \_\_\_\_\_ no

Other Names (please list relationship such as boyfriend, fiancé, girlfriend, sister, etc.) \_\_\_\_\_ yes \_\_\_\_\_ no

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



I consent to the use or disclosure of my protected health information by Lehigh Valley Foot & Ankle Surgeons for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Lehigh Valley Foot & Ankle Surgeons. I understand that diagnosis or treatment of me by Dr. Jay H. Kaufman or Dr. Dean L. Sorrento may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Lehigh Valley Foot & Ankle Surgeons is not required to agree to the restrictions that I may request. However, if Lehigh Valley Foot & Ankle Surgeons agrees to a restriction that I request, the restriction is binding on Lehigh Valley Foot & Ankle Surgeons and Dr. Jay H. Kaufman or Dr. Dean L. Sorrento.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Jay H. Kaufman or Dr. Dean L. Sorrento or Lehigh Valley Foot & Ankle Surgeons has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Lehigh Valley Foot & Ankle Surgeons's Notice of Privacy Practices prior to signing this document. The Lehigh Valley Foot & Ankle Surgeons's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Lehigh Valley Foot & Ankle Surgeons. The Notice of Privacy Practices for Lehigh Valley Foot & Ankle Surgeons is also provided in the reception area and on the Lehigh Valley Foot & Ankle Surgeons's website at [www.lvfoot.com](http://www.lvfoot.com). This Notice of Privacy Practices also describes my rights and the Lehigh Valley Foot & Ankle Surgeons's duties with respect to my protected health information.

Lehigh Valley Foot & Ankle Surgeons reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the Lehigh Valley Foot & Ankle Surgeons's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

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Name of Patient

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Signature of Patient or Personal Representative

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Name of Personal Representative (if other than Patient)

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Date

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Description of Personal Representative's Authority